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Mercredi 17 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

Chair: Ernie Parsons
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 17 January 2007

Mercredi 17 janvier 2007

The committee met at 0906 in room 151.

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.

The Vice-Chair (Mr. Khalil Ramal): Good morning, ladies and gentlemen. It's the second day of hearings for the standing committee on social policy. We're dealing with Bill 140, An Act respecting long-term care homes.

MULTIPLE SCLEROSIS SOCIETY OF CANADA, ONTARIO DIVISION

The Vice-Chair: We have several presentations for the day. We're going to start today with the Multiple Sclerosis Society of Canada, Ontario division. If they are here, they can come. I wonder if you know the procedure.

Ms. Deanna Groetzinger: Yes.

The Vice-Chair: Okay, then. You can start when you're ready. You have 15 minutes; you can split it the way you want. Please state your names before you start.

Mr. John Clifford: Thank you for the opportunity to present the views of the Multiple Sclerosis Society of Canada, Ontario division, on the proposed changes to Ontario's long-term-care system. My name is John Clifford and I am chair of the Ontario government relations and community social action committee of the MS Society. With me is Deanna Groetzinger, MS Society vice-president of government relations.

The MS Society is pleased that the legislation governing Ontario's long-term-care homes is being updated and consolidated through Bill 140. It is vital that our most vulnerable Ontarians receive the best care and protection possible. While many of the proposed changes are good ones, the MS Society believes there is a serious oversight in Bill 140, and that is that the proposed legislation does not contain any provisions that would facilitate the development and delivery of age-appropriate care within long-term-care homes.

Why age-appropriate long-term care? Well, let me tell you about several people with MS and their experiences with the current system. Their stories, unfortunately, are repeated every day across Ontario.

There is a young man with MS who lives in Kingston. He is now 30 years old but has been living in a long-term-care home for more than four years. He is severely disabled because of MS and needs considerable care. Unfortunately, his mother has her own health problems, his father is dead, and there are no other family members to assist him. He desperately wants to leave the facility and live in the community with assistance from home care and other services. He points out that even though the facility is supposed to be his home, he can't have a nap when he needs one during the day. MS can cause severe fatigue, but he has been told that if he lies down in the afternoon for a nap, he would have to stay in bed for the rest of the day. Clearly, a long-term-care home whose primary residents are the very elderly is no place for this young man.

Even when there are community supports available, it is still hard to move out of a long-term-care home, as a Toronto woman knows. She was diagnosed with MS in her mid-20s and able to manage on her own until she was about 45. In 2000, she developed a wound and had to be hospitalized. While there, she was advised by health care professionals that it would not be safe to continue to live on her own. She and her family began the process of finding a suitable place. In the meantime, she was sent from the acute care hospital to a facility for rehabilitation therapy. Frankly, this may have been a tactical mistake, since she was then considered to have adequate housing. She was passed over for attendant care apartments because there were people "in more desperate need" who didn't have housing. After three years, she finally agreed to move to a long-term-care home, where today, at the age of 50, she lives with residents who are very elderly and frail, and many have dementia.

These examples provide some background to our disappointment. When reading Bill 140, we found that the needs of younger people with MS and other diseases and disabilities are not addressed in the proposed legislation.

I'll now ask Deanna to review in more detail our concerns about the proposed legislation and to provide our recommendations for improving it.

Ms. Groetzinger: Thank you, John. Although only a minority of people younger than age 65 with MS require care in a long-term-care home, it is vital for their quality of life that their housing is appropriate for their age. Too often they are placed with much older individuals in settings designed for frail elderly people. This can result

in a significantly reduced quality of life, which can lead to depression and mental health problems.

In the view of the MS Society, the appropriate solution is to have available a continuum of appropriate housing and care. Most importantly, Ontarians who are disabled or chronically ill should have the supports they need to remain in their own homes. If, because of increased care needs, remaining at home is not possible, there should be a range of age-appropriate housing and care options.

This is not just an issue for people with MS and the MS Society. A 2006 study by the Canadian Institute for Health Information found that 20% of residents in continuing-care facilities in Ontario hospitals were younger than 65. The Canadian Healthcare Association reported in 2005 that in the Ontario facilities that provide complex continuing care, about 40% of residents are under 65 and the number is increasing. MS Society research found in 2000 there were 225 individuals with MS living in long-term-care homes, with care needs ranging from moderate to high.

Age-appropriate housing for young adults with disabilities is an issue of growing concern and is of particular significance in the case of MS, which is diagnosed most often between the ages of 15 and 40. People who develop MS must cope with the wide range of symptoms and disabling effects of the disease for the rest of their lives.

The MS Society strongly recommends that solutions for housing and care needs not be developed in isolation. Above all, the government of Ontario should adopt an overall approach of providing sufficient home supports to individuals who require health services or assistance with daily living. The philosophy of "home is best" should guide all subsequent decisions.

What this means is the development of resources for an effective, high-quality, equitable and accessible publicly funded home care system across Ontario for people with chronic long-term diseases like MS. Within this approach, needed mobility equipment and home adaptations should be funded, as should a coordinated system of social supports, including accessible transportation.

The MS Society was pleased to note that Monique Smith, parliamentary assistant to the Minister of Health and Long-Term Care, addressed part of this issue in her report *Commitment to Care: A Plan for Long-Term Care in Ontario*. Specifically, her report says, "There may be some pressure on CCACs to place some seniors prematurely into LTC facilities because of the availability of new beds and the shortage of funding for home care.... We suggest redirecting government funding into community alternatives and home care." And later in the report, "We recommend the ministry re-examine the new bed allocations with a view to stopping the building of those not yet in the ground and redirecting this funding savings to home care...."

The MS Society shares this concern, and has for some time, and has developed a report about age-appropriate long-term care called *Finding My Place*. While having an adequate supply of long-term-care beds is important, we

fear there is and will continue to be increased pressure on CCACs to solve their home care funding problems by persuading people to leave their homes and move into long-term-care facilities. This persuasion can be very direct. Imagine being told that you or your loved one can't have home care but your care problems can be solved easily by your moving to a long-term-care home, no matter if you are in your early 40s and your new roommate is in her 80s.

Therefore, the MS Society recommends:

—The government of Ontario proactively develop a sufficient mix of age-appropriate supportive housing, congregate care facilities and long-term-care homes across the provinces for Ontarians who can no longer live in their own homes.

—The government of Ontario develop clear policies regarding the placement of young adults with MS and other disabilities to ensure they receive age-appropriate care in age-appropriate settings.

—The government of Ontario ensure that age-appropriate long-term-care housing options are available across Ontario so people can stay in their home communities, close to family and friends.

—The government of Ontario include in the legislation a province-wide minimum staffing standard for long-term-care facilities to ensure there are sufficient staff to provide a minimum of 3.5 hours per day of nursing and personal care per resident.

—The government of Ontario ensure there are uniform provincial standards and funding assessment tools to be used by local health integration networks in planning home care and long-term care.

—Finally, while the creation of the Office of the Long-Term Care Homes Resident and Family Adviser appears to be useful and helpful, as is the strengthening of whistle-blower protections, an ombudsman for long-term care position should be created or the existing Ombudsman's responsibilities should be expanded to include long-term care.

On behalf of the MS Society, thank you for the opportunity to present today, and we look forward to your questions and comments.

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 Mrs. Witmer.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): Thank you so much for coming forward and letting the public know about this problem. I have seen it, unfortunately, in many of the long-term-care homes that I have visited where there are individuals with MS. They are unhappy in their placement because it's not the appropriate place for them to be. They're not complaining, but they're certainly pointing out some of the challenges that they're facing. I think it's absolutely imperative that this be a priority for any government of any stripe, to address this issue and to make sure that, with the increasing number of younger people who have MS or other disabilities, we develop a program whereby

there would be appropriate housing found for them. Obviously, if we can keep them in their homes and provide the appropriate support, we should do so.

I would say to you, don't give up. Let your voices be heard. This is a big issue. I found a mother with a daughter the same age as my daughter. I left that home and I thought, "That could be me." That daughter now has no home any more because the mother's home is in the long-term-care home. You know what? We just are not looking after some of these people in the way that we should be. This needs to be a priority for any government. So thank you so much, and don't give up.

Do you have copies of your report Finding My Place?

Ms. Groetzing: Yes, I do. I can provide them.

Mrs. Witmer: I'd appreciate getting a copy. Thank you so much.

Ms. Shelley Martel (Nickel Belt): Thank you for your presentation today. I am pleased to note your recommendation about a minimum staffing standard of 3.5 hours and also the recommendation around an ombudsman, which are two details that I have particularly been pushing.

I want to address, though, more importantly, your concern about inappropriate placements. I agree with what Ms. Smith said in her report; therefore, I was very surprised when I saw a protocol that has been developed between the Ministry of Health and the Ministry of Community and Social Services that was signed in about June of this year. If you haven't seen it yet, I would strongly recommend you get a copy of it. We have copies of it that we could share. Essentially, the protocol sets out how clients with developmental disabilities will be admitted into long-term-care homes. So it doesn't specifically state folks with MS, but clients with developmental disabilities. What was most disturbing about the protocol is that it actively encourages developmental service community providers to urge their clients to move out of their community placements into long-term-care homes in order to make way for the clients who are coming out of the DS facilities like Huronia.

I encourage you to get a copy of this, because it runs absolutely contrary to what Ms. Smith had encouraged, which I agree with, in terms of what she encouraged. Maybe you can add your voice to the voices of many others in the development sector who are encouraging the government to abandon this particular protocol and these particular placement provisions.

I think you are absolutely right. I have an aunt who has had MS for well over 30 years and almost all of that has been in a hospital setting, chronic care, which is not appropriate, but there wasn't any other support in the community for her to go to. So we do, regardless of our political stripe, need to work together to find appropriate placements, both age appropriate and appropriate in terms of dealing with people's needs and disabilities etc. So thank you for your presentation today.

Ms. Groetzing: Thank you. I don't think we were aware of that directive, so I'm happy to receive that information.

Ms. Martel: We will get it to you.

The Vice-Chair: Parliamentary assistant?

0920

Ms. Monique M. Smith (Nipissing): It's great to see you again. We have had a chance to discuss your report and some of your concerns. I'm glad to see that Mrs. Witmer has seen the light. For someone who represents a government that cut home care, it's nice to see that she's coming around to the notion that aging in place is incredibly important and that living in your own home, for those who are suffering from MS and other debilitating diseases, is incredibly important.

I just want to point out that in the legislation we have tried to incorporate some provisions that will address or begin to address some of the concerns, including in clause 7(1)(a) "an organized program of nursing services for the home to meet the assessed needs of the residents" so looking at each resident individually and trying to really meet their needs. Again, in subsection 9(1), we have a recreational program that hopefully will address the specific needs; in subsection 178(2), providing different types of programming; and in the bill of rights, paragraph 19, "...the right to have his or her lifestyle and choices respected." So a few provisions that hopefully will go some way.

We have, of course, discussed the problem of the numbers and trying to find age-appropriate housing to address in some communities a very small number of individuals who need a different type of housing. I know that aging in place is really your first choice. Certainly, in my report and elsewhere I have supported the need for home care and increased resources in the same. We continue to work on that; our government has made substantial investments in the home care sector and we continue to do that.

I just want to thank you again for coming today and raising your concerns and sharing your knowledge with us.

Ms. Groetzing: You're welcome. We did note in the proposed legislation that there are attempts at accommodation for individual service needs. We would urge an amendment to the bill which actually does bring out age appropriateness as one of those. So that might be something that this committee might want to consider, that while the language is already there, this committee might want to consider strengthening that to address some of the concerns that we've raised today.

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

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Vice-Chair: Next will be the Ontario Public Service Employees Union. Welcome. Before you start, please state your name for Hansard.

I recognize Mrs. Witmer. Mrs. Witmer, you have the floor.

Mrs. Witmer: Yes, thank you very much. I'd just like to correct the record. Ms. Smith had indicated that we cut home care. I think if you take a look at the record of the Ontario Progressive Conservative Party between 1995 and 2003, we made one of the largest investments in long-term care and community services. I would like to correct the record in that regard.

The Vice-Chair: Thank you, Mrs. Witmer. Now I guess we can start.

Ms. Leah Casselman: Good morning. My name is Leah Casselman. I'm the president of the Ontario Public Service Employees Union. I want to thank you for the opportunity to speak to the standing committee today. I would like to also point out that I have met Mr. Bavington in the back here; he is one of the folks who was unable to present to your committee. It's unfortunate, because he obviously has some very important issues to raise, as do, I'm sure, the other participants who are not able to present to your committee. It's unfortunate that you weren't able to find the time to hear from all of the citizens who are concerned about this piece of legislation.

OPSEU represents more than 115,000 workers; 30,000 of those are employed in our provincial health care system and included among them are 1,600 members who work in 19 long-term-care homes.

With me today is Debbie MacDonald, who chairs OPSEU's long-term-care sector. She is a clerk at the Sherwood Park Manor nursing home in Brockville. Before she took up that position, she was a health care aide. She's now a clerk, after being permanently injured on the job in 1998. She was attacked by a resident, pulling her right arm out of its socket, tearing her rotator cuff, shattering a disk in her neck and severing a nerve in her right arm. Debbie understands the risks that workers take on a day-to-day basis when it comes to the understaffing issue in homes.

Bill 140, quite frankly, is long overdue. It does achieve some of our shared goals for improvement in long-term care, including random inspections, official recognition of family councils and legislated limits on the use of physical and chemical restraints.

However, our expectations around the introduction of this bill were much higher. We all remember the Toronto Star and the Ottawa Citizen series on long-term care and the minister's tearful promise of a revolution in long-term care. Yet almost all of the new legislation is a formulation of modest policy changes that have existed for the past three years.

While much of the bill focuses on the rights of residents, we believe that these rights lack reasonable means of enforcement or staff to carry out the necessary care. Staffing levels are the primary indicator of quality service. Not only does the bill lack any minimum staffing requirements, it fails to address the impact of ownership on overall staffing. While we have numerous concerns around this bill, I'd like to spend our time on this critical issue.

Staffing standards and ownership: Prior to 1995, long-term-care homes were required to provide a minimum

average of 2.25 hours of care per day per resident. When it was eliminated by the Harris government, the opposition Liberals vowed to restore this minimum. The promise was not forgotten during the 2003 election. In a survey sent out by the Ontario Federation of Labour, Dalton McGuinty said, "Ontario Liberals are committed to reinstating the standards of care for nursing homes that were removed by the Harris government, including a minimum of 2.25 hours of nursing care daily." Shortly after being elected in 2003, Minister of Health George Smitherman led us to believe that action was coming soon, promising a "revolution."

In 2005, the standing committee on public accounts was led to believe again that the ministry was addressing this issue. The November 2005 report of the committee states, "Current work on staffing hours will establish a floor. With a flexible range, the ministry is moving towards being more definitive about staffing expectations."

Despite an expanding body of evidence that demonstrates how critical staffing levels are to good health outcomes in long-term care, despite repeated promises, staffing minimums remain noticeably absent from Bill 140.

Staffing standards need to go beyond 2.25 hours per day. Studies looking at staffing and health outcomes in long-term care indicate that government needs to do more than bring back the cancelled minimum of 2.25 hours per day; it needs a higher standard.

The most empirical study on this issue was conducted by the US Congress, of all places. An 800-page first phase of the study was published in the summer of 2000, reflecting a decade of work that establishes a clear and irrefutable link between low staffing levels and poor health outcomes in nursing homes, including avoidable hospitalizations, incidence of pressure sores and weight loss. The report concluded that minimum staffing levels reduce the likelihood of harm, while higher preferred minimums actually allow the homes to improve health outcomes. What a novel idea. Total staffing minimums just to avoid harm—just to avoid harm—are set by the report at 2.95 hours of care per day. To actually improve health outcomes, the report raises the bar to 3.45 hours per day of minimum care.

The US Congress report on staffing minimums has been very influential on governments: 36 US states have adopted minimum staffing levels for long-term care, and the District of Columbia also adopted standards in 2005. Many have increased their standard in recent years. Total staff hours per resident per day in 2004 averaged 3.6 in the US. The top 10% of US nursing homes average 4.55 hours per patient per day.

The staffing levels of US homes and those in other Canadian provinces continue to be well above Ontario's. In 2001, a PricewaterhouseCoopers study concluded that Ontario offered the lowest amount of total direct care hours among the sample jurisdictions it studied. At the time, Ontario provided 2.04 hours of care per resident per day. The 1995 and 2002 auditor's reports noted inaction

on such issues as the staffing mix and appropriate levels of funding. The latter also noted inaction in addressing the findings of the 2001 PricewaterhouseCoopers report.

If the government refused to be moved by Ontario's low ranking—as we've seen in the college sector—among many sample jurisdictions, it might have listened to the April 2005 coroner's jury's report following the deaths of two nursing home residents at North York's Casa Verde long-term-care home. In 2001, a 74-year-old resident with dementia beat to death two others with a metal bar. Among the 85 recommendations by the coroner's jury was one to set standards requiring long-term-care facilities to increase staffing levels to an average of no less than 3.06 hours of care per resident per day, based on the average case mix measure.

0930

Did Ontario listen? In 2005, the standing committee on public accounts wanted to know. They requested that the Ministry of Health report back on the 2004-05 staffing surveys of long-term-care homes in Ontario. They gave the ministry 120 days to report back. The results of those surveys are still not public, nor have we had an update on the original PricewaterhouseCoopers study.

In our research, we have seen average estimates ranging from 2.3 to 2.6 hours per day. Anecdotal evidence from our members would suggest that these numbers have been very optimistic. Our members are reporting very little change in existing staffing complements. At Sherwood Park Manor in Brockville, where Ms. MacDonald is from, we begin 2007 with fewer staff than we had in 2006, not more staff.

If there is money for new staffing in existing homes, where is it? According to the Ontario Association of Non-Profit Homes and Services for Seniors, of the \$740 million in new money over the past three years, only \$173 million went into operating budgets to support resident care in homes. Show me the money.

Data on the total number of long-term-care beds in the province would suggest that the bulk of new workers and money went into new beds, not existing ones. In just four years, from 2002 to 2006, Ontario went from 10th to fourth in the number of beds per 1,000 residents aged 75-plus. This would indicate that the policy direction has been towards quantity, not quality, of long-term care.

No matter whose estimates you choose, either continues to indicate that Ontario lags far behind other jurisdictions in staffing. According to the US Congress study, we are continuing to do harm to our residents.

We can only speculate on the reasons for the government's intransigence in following through with its promise regarding staffing minimums. Cost is likely to be only a partial factor, given that new staffing would likely offset the public cost of workplace injuries. Cost was less a factor during the election campaign when the present government promised to increase funding to long-term-care facilities by \$430 million annually.

So did the government bow to pressure from the for-profit sector? More likely to be a factor in abandoning

staffing minimums is the percentage of long-term-care homes provided on a for-profit basis. The Harris government dramatically shifted the ratio of for-profit and not-for-profit homes, and this trend has continued unabated by the Liberal government: 60% of Ontario's long-term-care beds are now in the for-profit sector, more than twice the ratio of the next-highest province. That's BC, where they license 30% of their long-term-care beds to the for-profit sector.

The largest cost to any long-term-care home, of course, is its staff. While in the past staffing costs could be reduced by lower wages and benefits, the competition for qualified staff makes it much more difficult for profit-seeking homes to make up their margins in that way. As recruitment and retention problems grow, it is likely that for-profits will migrate from lower wages to even fewer staff to provide sufficient return on investments, of course, because that would be their priority.

For-profit versus not-for-profit beds: A recent BC study published in the Canadian Medical Association Journal definitively shows that for-profits are already in an inferior position with regard to the provision of overall direct care staff. In that province, residents in for-profit homes received an average of 18% less direct care than those in the not-for-profit sector. For-profits averaged 2.8 hours of care per day, while those in the not-for-profit sector provided 3.43 hours of care per day. These statistics, of course, do not take into account the higher number of volunteer hours that not-for-profit and municipal homes attract.

Given irrefutable evidence that higher staff levels predict improved health outcomes, which I think we would all be interested in, we would have to logically conclude that lower staff levels in for-profit facilities would suggest worse health outcomes. Given the direct link between staffing levels and health outcomes, Ontario's rush to for-profit care was ill-advised and contrary to all existing evidence. While the government continues to lecture health care providers on the importance of evidence-based decision making, it appears to be ignoring all evidence regarding the importance of minimum staffing levels and on comparable health outcomes in for-profit homes.

OPSEU has two recommendations on staffing minimums and ownership.

(1) The bill should require government to set a regulation for minimum staffing levels. Ontario should implement a minimum requirement of 3.5 hours of care per resident per day average, based on the average case mix measure. This minimum should be reviewed every three years.

(2) The government should completely ban not-for-profit from selling their beds to for-profit providers. While the government highlights the need for balance, we believe that the system is presently unbalanced with 60% for-profit beds. The government must introduce a moratorium on the awarding of all new for-profit beds until an analysis can be completed on the comparable merits and costs of for-profit versus not-for-profit care in

Ontario. If the results are comparable to the BC and US studies, the government should permanently halt any new for-profit beds. All new long-term-care beds in the province of Ontario should be either not-for-profit or publicly provided.

Patty Rout, who chairs the OPSEU health care divisional council, will be making further comments on the contents of Bill 140 later on this morning. Meanwhile, we would like to be able to field any questions that you may have from our presentation. Thank you very much.

The Vice-Chair: Thank you very much. You used most of your time. You still have ten seconds left. I guess it's not enough for questions.

Ms. Casselman: Thank you. I'm sure Patty will be able to answer any questions you may have with her presentation.

TORONTO HOMES FOR THE AGED

The Vice-Chair: Next will be Toronto Homes for the Aged. Welcome back to this committee.

Mr. Joe Mihevc: Good morning. Good to be here.

The Vice-Chair: It seems you have a big support with you. If you don't mind, can you state their names.

Mr. Mihevc: We're brought a phalanx, yes. I'm Joe Mihevc, city councillor, chair of Toronto's new community development and recreation committee. I'm joined by Sandra Pitters, who's our general manager of homes for the aged, Cheryl MacDonald, and Reg Paul, who are senior policy adviser and senior staff with homes for the aged, as well.

I'd like to first and foremost thank members of the standing committee on social policy for the opportunity to comment on and provide suggestions to improve Bill 140. My comments reflect the city's particular knowledge of Toronto's diverse communities, our responsibility for the well-being of residents, a strong culture of partnerships and collaborative models of care and the values of mutual respect and co-operation embodied in the City of Toronto Act.

Toronto, as you know, is Canada's largest city, but sixth-largest government, home to a diverse population of more than 2.6 million people with complex service needs. To paint a brief picture: of the total GTA population, Toronto has 68% of people who live below the poverty line, 73% of tenant households, 59% of seniors, and 66% of recent immigrants. Toronto Homes for the Aged understands this complexity and is a community leader in services for seniors, providing 10 homes for the aged that provide care to over 2,600 residents; dementia care and other specialized programs; and a range of community partnerships and support programs, including adult day programs, a supportive housing program and a homemaker and nursing services program and meal preparation for community-based Meals on Wheels programs, in partnership with community agencies.

Toronto Homes for the Aged has a history of working with the province, residents, families and community partners to identify solutions, resolve issues and work to

improve care. Our care and service systems are designed to respect the ethno-cultural background, culture, language, family traditions, community, sexual orientation, gender identity, spiritual beliefs and rights of each resident. Through additional city funding, Toronto Homes for the Aged has been able to design and implement creative programming to respond to our community's diverse needs. This would not be possible solely through the current per diem funded by the Ministry of Health and Long-Term Care.

0940

So on to Bill 140. Bill 140 is a welcome and much-needed piece of legislation, a critical component to strengthen and reform the long-term-care system. We support the introduction of new, consolidated legislation for all long-term-care homes in Ontario and support the overarching goal and fundamental principle of building a strong, safe long-term-care system and creating a home environment for residents.

Our submission recognizes the positive aspects of Bill 140, including much of the content regarding care planning and care provision, the zero-tolerance approach regarding abuse, the focus on residents and their families and the move to more community involvement in long-term-care homes. These are principles and processes fundamental to the philosophy of Toronto Homes for the Aged and are already in place.

But while we agree with the spirit of the legislation, we are concerned with its application in a significant number of key areas. Our submission—I think you have it here—identifies areas where we believe you have missed the mark, identifies a number of weaknesses and provides ideas on how we think the bill can be improved. As well, we have provided a detailed clause-by-clause analysis that includes recommendations for deletions or rewording or suggestions for additional comment where the gaps have been identified.

When the government released its Commitment to Care report, we were encouraged and supportive of the vision and direction. Commitment to Care recognized that there are some very good long-term-care homes in Ontario and also recognized the need for increased authority to control those long-term-care homes not committed to providing care in a way that supports the dignity, security, safety and comfort of residents. Commitment to Care was balanced and interconnected. It reflected on the strengths of the long-term-care system and recognized it as an important component of an overall health care system. It suggested to us that the future legislation would adopt principles of quality management and a multi-faceted approach to improve the system as a whole.

Overall, we are disappointed in Bill 140 as we do not see the spirit, vision and intent of Commitment to Care reflected. We do not see a focus on system improvement, but rather, a punitive approach to the entire long-term-care homes system that treats all homes as a single entity, somewhat suspect, that must be closely monitored and controlled. The bill is overly prescriptive and will result in the loss of opportunities for innovation, flexibility and

the achievement of best practice because the primary focus will be on the avoidance of compliance and enforcement penalties.

We also feel that the bill should codify permissiveness for long-term-care homes to adapt both individual and group care and service to respond to ethno-racial, cultural, linguistic, religious or community-of-interest traditions and values as long as the flexibility does not result in negative outcomes.

Research in other jurisdictions indicates that organizations that support innovation and encourage excellence through true quality management principles achieve better outcomes than punitive approaches and highly regulated environments. We believe that positive outcomes are achieved when organizations are committed to meeting community need, operate through a resident-centred approach, include residents, families and communities in planning and delivering care, and effectively use a true risk and quality management framework.

Bill 140 assumes that long-term-care homes operate in isolation from the rest of the health care system—a further point. There is no recognition of the relationship that needs to exist between long-term-care homes, hospitals, community care access centres, local health integration networks and other health care and community organizations in order to meet the goal of a truly integrated, responsive, client-centred system. The draft legislation misses the opportunity to build long-term-care homes into a broader, transformed health care system as a valued partner.

We find it worrisome that the draft legislation offers no commitment to fund long-term-care homes at the level needed to provide the right level of care, achieve the enhanced quality that residents deserve or support homes in meeting the expanded legislative requirements. Although the word “ensure” is used liberally throughout the bill in terms of the obligations on long-term-care homes, it is silent on the obligations of the provincial government to ensure adequate funding to provide high-quality care. As an order of government, municipalities have a mandatory obligation to operate long-term-care homes yet there is no obligation for the province to provide sustainable operating funding or funding for capital renewal. We are concerned that this sets long-term-care homes up for failure.

Lastly, long-term-care legislation must respect the governance and accountability mechanisms already present in the municipal sector and build on its strengths rather than introducing a one-size-fits-all approach for the municipal, charitable and for-profit sectors. The province should respect and work with the city of Toronto and other municipalities as an order of government and as a partner with its own mandate to plan, fund, implement and monitor services across the city to best meet the needs of our diverse citizens.

Our submission provides a list of 29 recommendations; I want to highlight a few in particular. The revised bill must:

(1) Reflect the spirit and intent of Commitment to Care;

(2) Respect municipalities as an order of government with their own governance structures and accountability mechanisms already in place, and develop and codify a collaborative or consensus approach for the municipal sector;

(3) Contain a sunset clause requiring a two- or five-year review of the legislation;

(4) Eliminate use of the word “ensure” throughout the bill, replacing it with phraseology something like “take every reasonable step to ensure”;

(5) reduce the prescriptiveness and rigidity of the bill, building the new Long-Term Care Homes Act into a true risk management and quality management framework, thus realizing a more vibrant long-term-care homes system with improved outcomes and enhanced creativity that cannot be achieved through a strict, punitive compliance, inspection and enforcement system;

(6) Provide reasonableness for directors, officers, physicians, managers and staff of long-term-care homes when they have carried out all of their work-related activities and responsibilities in good faith and with the honest and deliberate intent of meeting the ministry’s requirements and objectives for providing a home where residents may live in dignity, security, safety and comfort;

(7) Provide an onus on the Ministry of Health and Long-Term Care to provide sufficient funding for long-term-care homes—both operating and capital dollars—to provide high-quality care and meet their obligations. This is particularly important for municipal long-term-care homes, which have a mandatory obligation to operate; and

(8) Revise the bill of rights so that it is clear that one individual cannot impose his or her will in a way that violates the rights of another individual or a group of individuals.

To conclude, Bill 140 provides a unique opportunity for the province of Ontario to make lasting improvements to the long-term-care health system, encourage community partnerships, and encourage creative and innovative approaches. This submission lays out recommendations for change. The Toronto Homes for the Aged is prepared to work with the province of Ontario to make the necessary revisions before the bill is passed into law.

I just want to conclude by thanking the standing committee on social policy for providing this opportunity for input.

The Vice-Chair: Thank you very much for your presentation. I have two minutes left. We can divide them for quick questions. Ms. Martel.

0950

Ms. Martel: Thank you for your participation today and for the work that was done, especially the drafting of the amendments, which will be very helpful.

I’m just looking on page 17 of the brief, where you said you were disappointed that “the concept articulated in Commitment to Care related to the creation of an ombudsman office, was not realized in Bill 140.” I wonder if you can elaborate on that for us, please.

Mr. Mihevc: I think Sandra Pitters is in a better position to answer that question.

Ms. Sandra Pitters: Thank you, Councillor. We do believe that there is a valuable role for a strong advocacy concept for residents who reside in Ontario's long-term-care homes. We don't believe that Bill 140 explicitly provides that authority and that opportunity for residents, families and individuals involved with community and long-term-care homes to go to someone to assist with self-advocacy, individual advocacy or systemic advocacy changes that might be required as this bill is being introduced.

Ms. Smith: I just want to follow up on those comments. The role that an ombudsman usually plays is one of investigation at the end of a situation. What you're promoting is more of an advocacy role, which is more in line with what we know that the city of Toronto has and what we were looking at in the Office of the Long-Term Care Homes Resident and Family Adviser. How would you distinguish or how would you create that role without—or do you envision that role also including the investigative and reporting function that an ombudsman normally has?

Before you answer that question, I just want to say to the councillor and others that you are very fortunate to have Sandra Pitters on your team.

Ms. Pitters: I don't know how to answer that after a compliment in public. I appreciate that.

We really did focus on the advocacy component, although we understand that in the advocacy role the individuals associated with the office might be doing some investigative processes, but it really would be in an advocacy spirit to assist the resident, the family, to resolve the issue in the way that meets their needs.

Mrs. Witmer: Thank you very much for a great presentation and recommendations. You've indicated that the bill is very prescriptive, very punitive and, unfortunately, that there's no funding provided. Then, in the amendments, you talk about the need to provide reasonableness for directors and staff etc., meaning what precisely?

Mr. Mihevc: I'll let Sandra answer that as well. But as I understand the draft legislation, it very well may mean, for example, that city councillors, who have an overall policy and leadership function, would be liable for particular mishaps and not meeting standards of care. We think that that piece within the legislation needs to be looked at more clearly and that the principle of reasonableness needs to be incorporated.

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

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION,
HEALTH CARE DIVISIONAL COUNCIL

The Vice-Chair: The next presentation will be by the Ontario Public Service Employees Union health council. Good morning. You can start whenever you're ready.

Ms. Patty Rout: I am Patty Rout. I am chair of the OPSEU health care divisional council. I represent 30,000 members from the various health care sectors, such as long-term care, hospital professionals, paramedics, mental health employees, community health professionals and hospital support workers. Earlier you heard from Leah Casselman and—

The Vice-Chair: Can you introduce the person beside you?

Ms. Rout: Sorry. It's Debbie MacDonald. Earlier you heard from Leah Casselman and you didn't have an opportunity to talk to Debbie or ask questions, so hopefully we'll have time for that after I'm finished. Leah and Debbie both feel the absolute need for staffing minimums and a moratorium on new for-profit beds.

I'd like to share the views of our members with respect to accountability and transparency in the long-term-care sector, as well as whistle-blowing, inspections and the rules around the revoking of licences as outlined in this act.

Accountability: OPSEU shares the government's interest in accountability in the long-term-care sector. But we think accountability is a two-way street. In this bill, almost all the accountability falls on the individual homes and very little of it falls on the government as the funding body, the inspector, the regulator. There is a huge difference between for-profit homes and not-for-profit. The differences should be reflected in the accountability measures. Ontario's non-profit and public facilities have approved beds, which means they can operate as approved by the provincial government. For-profits have licensed beds, which have value on open markets. I believe it would be very scary for a senior to know that they're a commodity which is bought and sold on the market itself. The for-profits' mission is to make money.

Fines: A board member on a not-for-profit home often serves in an unpaid capacity, and their primary goal is to run the facility as a public service. The board members of a for-profit home are paid and have a different primary goal: to maximize profit to shareholders. Yet Bill 140 treats the two in the same way when it comes to individual fines for non-compliance. If faced with the first-offence fine of \$25,000 or 12 months in jail, people may be less likely to volunteer for the non-profit boards. Fines should also be based on the size of the organization to be equitable. A \$50,000 fine may be a slap on the wrist for Extendicare or CPL, but for a small non-profit home, it's huge. Fines should be based on the number of beds held by the organization or company, not just on the individual home.

Transparency: The Web is where many working families go for their information these days. Given the current trend to make health care decision-making more transparent, we believe the reporting of quality indicators and standard violations should be available on an accessible website. The present website is not easy to find, it's not user-friendly to families, it's not easy to navigate, and it lacks the kind of reasonable detail that would allow families the ability to make an informed choice.

Unmet standards are reflected as a vague category on the website now. They give no detail on the level of the seriousness of the unmet standard. The average person reads that there is one dietary unmet standard. That really tells them nothing.

Also, the site only maintains very recent information. There is nothing on the Casa Verde page, for example, that would indicate the headline-making events of 2001 that took place there. You would think that families would want to know that two residents had been beaten to death at the home five years ago.

Staffing levels are a critical indicator. The province should stop hiding the results of its 2004-05 survey and place staffing levels at each home on the long-term-care website. This would not only provide families with the information that they would need, but it would pressure homes with poor staffing levels to upgrade closer to the provincial standard. Detailed results of the inspections should be made available on the website and key indicators should be made public, including the average staffing per hour per resident.

Whistle-blowing legislation: While whistle-blowing legislation is welcome, the new protection for workers is barely more than the existing status quo. While it is possible to grieve a dismissal or go to the Ontario Labour Relations Board, the likelihood of a worker wishing to endure this process while they're suspended without pay is a major barrier to stepping forward. This is true particularly amongst lower-paid workers in the sector and those who are not organized. We believe there should be a strong deterrent to employers wishing to dismiss or suspend staff for whistle-blowing.

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I can draw from an example during SARS, Justice Campbell's report, where he allowed people to come forward knowing they would not lose their jobs. We're talking about the same sort of thing here. The legislation needs to spell out the penalties to homes which punish whistle-blowers. We also believe there should be a provincial long-term-care ombudsperson able to intervene in such circumstances as soon as possible.

Inspections: OPSEU supports placing surprise inspections in the legislation. We support immediate investigations of complaints. We also support the rewarding of homes with exemplary records from the need for annual inspections, much the same as in the hospital sectors. Inspectors should be mandated to speak to staff, residents and families at homes, not just the administration. They should also have the mandate to check all service delivery aspects of the home, including contracted-out services.

We do agree that the focus and necessary monitoring resources should be placed on the consistent violator. We would recommend one further trigger for inspection: that any serious violation in one home of a chain should prompt immediate inspection of others in the same chain. This would pressure large corporate chains to make sure all their homes are compliant.

Screening of directors and corporate officers: While background screening will now be required for all new

staff at the homes, we cannot understand why there is not a similar screening required of new directors and corporate officers in the long-term-care system. Given past incidents such as Ontario's Royal Crest chain scandal, the government has yet to learn its lessons as to where the real problems lie. Background police screening should be extended to new directors and corporate officers who operate long-term-care facilities.

System changes—government's obligation to funding: Bill 140 places much emphasis on the rights of residents. It should also place equal emphasis on the obligations of government to adequately fund the services it asks homes to provide. Without a commitment to funding the change required under the act, we believe the situation for residents could actually worsen. Administrative requirements have been vastly increased by this act. Bedside resources cannot be diverted for such purposes. The act should specify funding levels that would adequately provide for both the administrative requirement and sufficient bedside care.

Regulations: We cannot understand why no public involvement or notice is required for the new regulations in the long-term-care sector. Certainly Bill 36 had its consultation process, and we would hope that the long-term-care act would specify notice periods and public input on the introduction of new regulations.

Revocation: Under the act, an interim manager can be appointed to run the home upon the loss of their licence or the revoking of a license. Under paragraph 155(5)1, the termination of an employee can take place during this period of time in which the employee's terms of severance are determined under the Employment Standards Act. In cases where the employee's termination takes place in the context of our collective agreements, the provisions that are in the collective agreements should clearly take precedence. Collective agreements should take precedence in all interactions with interim managers and unionized employees, and that would include severance.

Under the act, terms and conditions of employment or provisions of a collective agreement agreed to by the interim manager apply only with respect to the period of time during which the interim manager occupies and operates the home. If changes are negotiated to the collective agreement between the interim manager and the employee representative, these changes should be carried on to the successor employer. Any changes to the collective agreement negotiated between the interim manager and the employee representative should be treated as successor rights when the province restores or sells the facility to the previous or new employer.

Thank you for giving me the opportunity. Deb and I are both here to answer any questions.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left for quick questions. The parliamentary assistant.

Ms. Smith: I was interested in your comments about the level of care that we're providing. I don't know if you saw the Toronto Star today, but we have released the number. It's 2.86, from our most recent staffing assess-

ment of hours of personal and nursing care. We've also hired over 4,900 new front-line workers in the last two and a half years, including 1,100 nursing staff, and we've invested over \$740 million in increased funding, or 34%, into the long-term-care sector. So I am a little bit surprised to hear that you're not seeing that on the front lines. I do recognize that the CMI affects the home and the level of care that's required in the home, but I was surprised to hear that you're not seeing any of those investments coming through.

We've also invested a great deal of funding in lifts and other equipment in our long-term-care homes to attempt to assist our staff in order to ensure that there is a safer work environment for our staff.

I just wanted to set the record straight on a couple of the points that you made and to assure you that we are committed to increasing the level of care in our homes and ensuring that our residents have the best quality of life that they can. Thanks for your presentation.

Mr. John Yakabuski (Renfrew-Nipissing-Pembroke): Thank you very much for joining us today. I appreciate your presentation. I'm not surprised that the government would have a press release out today. That's just the way it works, because they're not getting all that good a press from the regular press on this bill and this issue.

Would it be fair to say that regardless of the task you expect anybody to complete, if they're ill-equipped to do it, success is unlikely? What we seem to hear repeatedly from people who are charged with delivering long-term care in this province is that there are an awful lot of demands placed on them with regard to the care that is expected and the policing of that care, if you want to call it that, but the government simply hasn't backed it up with the resources that are necessary. I wonder how we can possibly succeed in improving the level of care in our long-term-care homes if the government is not prepared to back up that tough talk with some real funding that will deliver that.

Ms. Debbie MacDonald: You can't. You will not succeed. The CMI is the most flawed way of funding ever for nursing homes. We went down only 1.7% in my nursing home, which doesn't sound like a lot. That means 10 hours of direct personal care to a resident per day. Ten hours of care means one less staff feeding people breakfast. One staff feeds four to eight people. One staff gets up eight to 10 residents. Now the rest of the staff will have larger numbers, so now they will be feeding 12 people, getting up 15 people; one less person to toilet, so they're going to get toileted less. It means one less person to maybe comb hair, to do all the little, minor things that we just take for granted. There is no one there to do it.

Ten hours means one less person on an evening shift to put people to bed, to help bathe them, to help rub their skin with lotion which will prevent bedsores. Ten hours doesn't seem like much. It's huge in a nursing home in direct care; 1.7 is nothing.

Ms. Martel: Thank you for your presentation today. Let me just follow up with this. My question would be,

when you have staff doing the extra work, you increase your likelihood of someone getting hurt, usually a staff person. You didn't tell the committee, or you didn't have the chance to tell the committee because we didn't get to questions, about how you got hurt. Were you working alone? Is that what happened? Were you trying to lift someone? What was the nature of the incident?

Ms. MacDonald: Yes, I was working alone. I was responsible to get up 15 residents that day. I went in to the first resident and took him into the bathroom. He was an Alzheimer's patient, twice my weight, six inches taller. He panicked, or for whatever reason, and he latched onto me very hard. He pulled my arm out of the socket. At that time, I thought I was going to pass out or be ill, but I couldn't, because I could not let this resident fall; that was my first thought. I started to scream for help from another staff member. Unfortunately, it took 10 minutes before someone heard me and could come. In that time, a disc was shattered in my neck, my rotor cuff was torn, a nerve was literally severed in my in my arm, and nerves from where the disc shattered are permanently pinched in my neck. I will never have full use of my arm and my neck again, or range of motion. I have been an employee of this nursing home for 30 years and now I am a clerk. I don't get to do the job that I absolutely love any more because I don't have full use of my body any more. So in 10 minutes I lost everything.

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

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DENISE BEDARD

The Vice-Chair: The next presentation will be by Denise Bedard. Welcome, Denise. You can start whenever you are ready.

Ms. Denise Bedard: Good morning, everyone. Before I get started, I just want to say this is a wonderful honour and privilege to be here today. My name is Denise Bedard. I am the administrator for Scarborough Leisure-world and have been working in long-term care for almost 30 years. I want to thank you for the opportunity to present to this important committee today on behalf of all the residents in long-term-care homes across Ontario.

There is nothing more invigorating in life than being set free and being able to have a voice. As the administrator of one of the largest long-term-care homes in Ontario, I am proud to be here as a voice for my residents.

The growing demands on an already overburdened and inadequately trained long-term-care service will soar into the future. According to a 2005 Statistics Canada report, in 2001, seniors aged 65 and over accounted for 13% of the nation's population. Projections are that this number will reach 15% by the year 2011. The numbers of those 80 and over increased at the fastest pace and are expected to be an additional 43% from 2001 to over 1.3 million by 2011. This explosive growth in our aging

population will continue to make ever-increasing demands on long-term-care services in Ontario.

The lack of progression in long-term care to a person-centred culture by health care professionals has created a tremendous challenge for the health care field. Psychosocial, spiritual and geriatric therapies simply are not routinely taught to health care professionals. Barriers to the implementation of this culture include systemic, education, funding, and participation by family, staff, residents and the community at large. A major barrier is societal acceptance and awareness of aging and the aged, which are characterized by desensitization and stigma.

Amid the overwhelming level of need in the nursing home, it is easy to forget the enormous challenges inherent in the job of caring for our residents. Our present medical model of care pulls for efficiency and does not convey to the staff that personhood or even psychosocial care is part of one's job. In fact, staff may face explicit conflicts, such as complaints from supervisors and peers, if they try to focus on residents' emotions and psychosocial needs in the face of demands for efficiency.

Within this context, deficits in skill and motivation contribute further to the challenges facing caregivers. Lacking basic emotion-related skills such as listening actively and recognizing emotions in the elderly, the task of providing care may become overly daunting. As a result, recruitment and retention now become a huge issue within long-term care.

A recent report provided by the American Health Care Association in 1997 estimated a turnover rate as high as 97% among caregivers in health care. Only with extensive support to improve education and develop psychosocial skills to meet the enormous challenges of maintaining relationships can caregivers be expected to carry out the emotional work that is the hallmark of their job. We first must care for and re-educate the caregiver to be sensitive and to develop meaningful relationships with the residents. What most of us fear about going into the nursing home is that we have to leave who we are at the door.

Most often, residents and their families have been left out of the change process. For example, educational and informational programs have been run for staff but far less often for residents and their families. Since the care provided to the residents represents a direct interaction with them, and both a direct and indirect interaction with families, it seems necessary to engage residents and their families in any change process. Part of this has been addressed by the establishment of resident and family councils, which represent a positive step toward their participation and interaction.

Several key areas of this legislation need to be addressed very carefully as to their impact on the residents and their quality of life. Allow me to reflect on one example: the impact of the Smoke-Free Ontario Act and its implications on the life of our seniors in long-term-care homes. The Minister of Health Promotion passed this legislation in June 2006 with a view to protecting the health of workers. Unfortunately, he did

not take into consideration, nor did he consult with, residents as to the effect on them and the risk it created for them. With winter upon us, my residents, some of whom are palliative care, must go outside into harsh and dangerous weather conditions to smoke now that the minister has shut down their smoking rooms. With 55 smoking residents in this home, you can see the enormity of this problem. The SFOA is in direct contradiction to the residents' bill of rights issued by the Minister of Health, which requires that we provide care and protection to and address the needs of our residents. These contradictions in legislation make it impossible for us to keep our residents safe and secure without violating one piece of legislation or another. As an example, just this past week a resident went outside in the harsh weather to have a cigarette, slipped and fell, and suffered physical injuries and hypothermia from exposure to the weather. The government has inadvertently put the weakest and least able to defend themselves in harm's way while attempting to protect others.

Another area of concern with this legislation is the government's expectation that this bill will adequately address abuse. Addressing issues of abuse will not be accomplished if arbitrators retain the right to allow staff who have been found to have abused a resident to return to work. Staff are not going to come forward and report abusers if they know that it is likely that the person they are reporting will get their job back. There should be a supported policy of zero tolerance in issues related to resident abuse, and in proven cases of abuse there should be no opportunity for abusers to re-enter work in long-term care. This legislation needs to be amended to add a section to address this critical issue to protect both residents and other caring staff members.

Also, there is the issue of increased monitoring and paperwork from the Ministry of Health, all of which takes valuable time away from the quality of care of our residents. I would ask that the committee carefully review the level of reports and other paperwork required by the ministry with a view to limiting it to what is pertinent and critical. There is no benefit to the quality of life and care for our residents if our staff are tied to producing paperwork for the ministry which at the end of the day provides little or no benefit to their charges. With no additional funding to hire staff to address the ever-increasing paperwork load, the number of hours committed to actual delivery of care to residents diminishes at a time when it should be increasing.

Another critical area that must be addressed is the development and implementation of electronic patient records. When a resident suffers from an illness and is sent to the hospital, quite often there is a delay in receiving, or incomplete record of, that resident's health history. With the use of electronic patient records, care can be provided in an efficient and effective way. Electronic patient records would provide the hospital with timely and accurate information, which would reduce the wait for a paper record to arrive and eliminate the need for unnecessary medical tests or errors in prescription drug records.

Let me reiterate the most important element of my presentation to you here today, and that is the fundamental requirement that all health care workers be educated in the psychosocial skills required to nurture the physical and emotional well-being of those they care for. The time has come for Ontario to lead the way in long-term and specialized care by requiring all health care workers to be educated in psychosocial training. The reason I call it long-term and specialized care is because we are no longer caring for just the elderly in our society but for those of all ages and varied health challenges.

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Best practice can only be established when those responsible for providing health and therapeutic programs take into account the perspective of the resident and refute assumptions that impair their ability to participate in decisions and care. The very essence of long-term and specialized care is currently not found in this legislation, and that is the imperative of psychosocial skills needed, because with that common element, everything else will grow.

Thank you for allowing me to share my perspective with you. I look forward to addressing any questions or comments you may have for me.

The Vice-Chair: Thank you, Denise, for your presentation. We have three minutes left. We can have a quick question from each party.

Mrs. Witmer: Thank you very much, Denise, for your presentation. I do appreciate the emphasis that you've put on the need to focus on the psychosocial training. I do believe and would agree with you that that's extremely important if we're to provide the support that is required.

You raise an interesting point about smoking. I've never been a smoker, but I do appreciate that these people obviously do smoke. I guess if you could change and call yourself a government casino, maybe then you'd be able to do so.

Anyway, you've indicated here that retention is a big issue. What can be done in order to make sure that you have the best-qualified staff possible, very simply?

Ms. Bedard: Well, I think it boils down to the time factor. With how much care we have to do, our orientation sessions—a lot of PSW workers can't read and write. Being able to provide to them the tools they need before they go into the job would probably help, because it would help them understand better what their role as a caregiver is as well. What's happening too often is the worker gets in, and because of the mass job routines that they have to do, it becomes tunnel vision and you forget about what is actually needed for the resident.

Mrs. Witmer: Thank you so much.

Ms. Martel: Thank you for your presentation here this morning. As the administrator of the home, you would have a very clear sense of your costs. I'm interested in whether you've done an analysis of what the increased burden might be to you in the home to deal with the requirements that the government is setting out.

Ms. Bedard: I'm sorry. Can you say that again?

Ms. Martel: Do you have a sense of how much it might cost you, either in terms of having to hire another staff person full-time or part-time, to deal with the requirements that the government is setting out in this legislation?

Ms. Bedard: I think what needs to happen with those psychosocial skills is that whole transformation piece of somebody or a team training the trainers to be able to go in and actually stay there for the time being so that the sustainability piece stays in place. What happens with a lot of great initiatives that take place is that usually the administrator or the DOC are the individuals who are trained, but with the paperwork and the time allotted for everything else, we're not able to sustain that. So having a train-the-trainer team of qualified individuals who are able to teach those psychosocial skills and to sustain that over a period of time—it would be phenomenal to have that.

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

Ms. Smith: Thank you. We certainly do appreciate you coming in, Denise, and providing us with your insight. I appreciated as well the fact that you emphasized the retention and recruitment, because they certainly are issues in long-term care and they're ones that I've been talking about since I started my reviews.

I did want to point out to you that in the legislation under "Training," we have made certain requirements of staff, including that direct care staff receive training on abuse recognition and prevention; caring for persons with dementia—which I think addresses some of your concerns; behaviour management; how to minimize the restraining of residents and, where restraining is necessary, doing it in accordance with the act and the regs; palliative care, which you mentioned as well; and other areas provided for in the regulations. We're giving ourselves the ability in regulation to add to that list, but we certainly believe that training in those particular areas is incredibly important for all of our direct staff in long-term care.

I appreciate what you said today. I think some of what you were calling for is reflected in the legislation, and we're going to continue to work to ensure that your concerns are addressed. Thanks so much.

Ms. Bedard: Thank you.

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

ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

The Vice-Chair: We'll move now to the next presentation, which will be by the Ontario Association of Non-Profit Homes and Services for Seniors.

The Acting Chair (Mr. Mario G. Racco): Please start any time you're ready.

Ms. Gail Carlin: Thank you, Chair. We appreciate the opportunity to be here this morning. My name is Gail Carlin. I am the chair of the Ontario Association of Non-

Profit Homes and Services for Seniors, OANHSS, and I'm also the director of senior services with the region of Waterloo, which operates a 265-bed long-term-care home. With me today is Donna Rubin, our chief executive officer.

OANHSS is the provincial association representing not-for-profit providers of long-term-care services and housing for seniors. Members include municipal and charitable long-term-care homes, non-profit nursing homes, seniors' housing projects and community service agencies.

This is an important time for our members. New long-term-care home legislation will influence our sector and affect the lives of residents in long-term care for decades to come. It is so critical that we get it right.

OANHSS members support the intent of the bill to build a strong, accountable and resident-centred long-term-care system. However, we are very concerned that it falls far short of this goal. We believe the proposed legislation is seriously flawed and significant changes are needed if it is to have a positive effect on the lives of our residents both now and in the future.

Given the limited time available to us this morning, I will not detail the recommendations and amendments in our submission. Instead, I will address the concerns we have in a thematic way, starting with the lack of support for not-for-profits.

The McGuinty Liberals, in opposition and now in government, have consistently been very vocal in their support for not-for-profit health care delivery. We were pleased when the government put words into action by clearly establishing a preference for public health care and the not-for-profit sector in legislation such as the commitment to medicare act and the LHIN legislation. What has surprised and dismayed us is not only the absence of an equivalent preference in Bill 140, but also that it will have serious implications for the viability of the not-for-profit long-term-care sector.

This should be an alarm bell for the public and the government. The not-for-profit sector has delivered valued-added services for over a century. And, in a sector that is seriously underfunded, it is worth noting that all the public funding not-for-profits receive stays within the organization and, on top of that, the sector contributes millions more in added funding through charitable donations and municipal transfers. This figure was well over \$130 million in 2005. There is also growing evidence that not-for-profit delivery of long-term care results in more staffing and improved care outcomes for residents.

The bill requires the government to consider the balance between not-for-profit and for-profit delivery of long-term care when issuing licences. Despite the fact that a similar provision exists in the current legislation, there has been an increasing imbalance in the system, resulting in less choice for seniors and their families. A decade ago, approximately half of all long-term-care beds were operated on a not-for-profit basis. Today, our sector only accounts for about 48% of the total. We are

deeply concerned that we can find no provisions in this bill that obligate the government to reverse this trend.

OANHSS is calling on government to include in the preamble a strong and explicit statement that it is "committed to promoting and supporting not-for-profit delivery of long-term care in Ontario." In addition, we want a governing principle in the licensing section that commits the government to supporting not-for-profit ownership of long-term-care homes.

The second theme I want to pursue is the impact Bill 140 will have on resident care.

Bill 140 proposes a significant increase in regulation. While our association supports measures to enhance standards and ensure full accountability, this legislation is so excessively onerous that homes will be forced to shift already scarce resources to meeting new administrative demands. Staff will be forced to spend more of their time on compliance and documentation, and that will mean they have even less time available for direct care and services.

Long-term-care homes are already challenged by over a decade of inadequate funding. This additional burden of red tape will exacerbate those challenges. We are very concerned that the focus in the bill on prescriptive micromanagement is misplaced and could actually result in a lower standard of care in long-term-care homes.

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At a minimum, the province must analyze what added financial burden will be placed on homes as a result of these new regulatory demands and increase operating funding by that amount. Establishing new requirements and standards without providing the means to achieve them is only a prescription for failure.

A very clear example is the call for care standards being made by many at these hearings. We support this direction, but only if it is fully funded for all homes in Ontario. Ontario already falls far short of the level of care actually needed by Ontario long-term-care residents. Codifying a care standard can only improve the system if we have the financial resources to achieve it.

The provision related to secure units provides another example of imposing a financial burden. Secure units provide residents with significant dementias and behaviours with a safe environment and attention to their needs. Including these units as restraints will require adherence to extensive monitoring and reporting requirements. The workload implications are very significant. For example, meeting the documentation requirements for a 30-bed special care unit is projected to require at least one full-time nursing position with minimal commensurate benefit to the resident.

Another example is training and orientation. While we agree on the importance of homes having knowledgeable and well-educated staff and volunteers, the level of expectation outlined in Bill 140 is unreasonable and will impose a continuous administrative burden and cost on homes. It goes well beyond simply identifying requirements and delves into the specifics of exactly how orientation and training is to be conducted.

Bill 140 utilizes a highly detailed and prescriptive regulatory framework. We are concerned that it will seriously stifle innovation and flexibility in the sector and result in a reduction in the level of care and quality of life for our long-term-care residents.

The third theme I will speak to relates to governance. Our sector relies on community leaders who are willing to give freely of their time as volunteers to serve on boards of our operating organizations. They are not compensated for their time or expertise.

Bill 140 will impose higher obligations and harsher offence provisions on the directors of long-term-care homes than any other sector in health care, including hospitals. The proposed legislation could result in directors being subject to fines up to \$25,000 and imprisonment for any breaches of the act by anyone in the home. This will make it very difficult for the not-for-profit sector to maintain its current directors and attract new ones, especially since penalty provisions are not covered by standard directors and officers insurance in Canada.

The final theme relates to licensing concerns. The licensing provisions in the bill threaten to erode the financial strength of the not-for-profit sector by increasing the cost of borrowing and complicating refinancings. Specifically, the fixed terms for licence renewals puts constraints on the licence that will affect its collateral value. It is critical for financing and asset protection that the collateral value be maximized. All indications from the lending community are that fixed terms for licensing tied to structural compliance without a funded capital renewal program will increase the cost of long-term-care financing for our homes.

Furthermore, Bill 140 includes a provision whereby the licences held by not-for-profit homes may only be sold or transferred to another not-for-profit. This may appear to be protecting the not-for-profit sector, but in fact it will disadvantage us through increased risks and costs. It is like saying you can sell your home, but only to people whose names begin with the letters X, Y and Z.

Putting added restrictions on licences over and above those already resulting from fixed licence terms further reduces the financial viability of not-for-profit homes. There is no such restriction on for-profit homes, giving them an advantage in terms of the market value of their licences and therefore their ability to finance at more competitive rates. This is a major concern with Bill 140 for our members and we have recommended that the restriction on sales be removed.

On the municipal side, while we support the mandatory requirement for municipalities to operate homes, the approval approach deprives municipal homes of any of the collateral value that would attach to licences. This puts them at a distinct disadvantage with respect to recouping any equity the municipality has invested in the home. We are recommending a new provision that will enable municipal homes to protect their investment without applying the licensing approach.

In concluding my remarks, I want to make very clear that while we support new legislation for long-term-care

homes, we are on the wrong track with Bill 140. As stated, we are very concerned with the provisions in the bill that disadvantage not-for-profits and with the many sections that are so prescriptive and excessively onerous, with no significant improvements to care.

Together, government, providers, consumers and their families must work in partnership to create legislation that enables and encourages innovation, flexibility and excellence in the delivery of long-term care in Ontario.

The Acting Chair: Thank you for your presentation. We have three minutes left, one minute each. Ms. Martel, you're first.

Ms. Martel: Thank you for your presentation here this morning. Earlier, the parliamentary assistant said that the government put \$700 million into long-term care. Can you tell me how much of that has actually gone to the residents to enhance their care directly?

Ms. Donna Rubin: In the first budget year, we would suggest that of the \$191 million, approximately \$96 million went; out of the \$264 million in the second budget, \$48 million; and in the third budget, of \$155 million, their own letter says that \$29 million is going directly to the per diem for a \$1.07 increase.

Ms. Martel: So despite what the government has to say, in fact, most of that money, or a good portion of it, didn't go to directly enhance resident care at all.

Ms. Rubin: Not from our perspective.

Ms. Martel: What's the shortfall, in your estimation, right now between what the government promised and where they are at?

Ms. Rubin: We're saying at least \$300 million to get us to a level that they promised back in 2003, and that was to move the sector, in our view, to about 2.75 hours of care.

Ms. Martel: And what about the shortfall in individual funding, the \$6,000 that was promised per resident?

Ms. Rubin: We're only a third of the way there.

Ms. Smith: You talked about the funding that's been received. In your 2004 annual report, you talked about the financial gain to your specific side of the sector—OANHSS—and your members receiving an additional \$110 million that saw per diem increases on average of \$5.50 a day for OANHSS members. How does that jibe with the numbers that you just gave to Ms. Martel?

Ms. Rubin: There was an equalization adjustment to provide not-for-profit members and other members that didn't have a certain funding supplement with added funding. But to be honest with you, that was still early days and we were under the impression that it was \$110 million. Figures now show it was \$96 million.

Ms. Smith: So that was \$96 million in addition to your side of the sector that the rest of the sector didn't receive?

Ms. Rubin: No, I'm sorry. I should clarify. When the minister contacted us early on, we felt that there was a full \$191 million, then there were reports that it was \$110 million, and then it became clear that it was \$96 million. So as months go by, you get a better picture of what the

full picture is. Having said that, you did invest \$191 million in long-term care.

Ms. Smith: In fact, we've invested \$740 million in long-term care in the last two years.

Ms. Rubin: Yes, it's a matter—all we're talking about is, does it go to direct care?

The Acting Chair: Thank you.

Interjection.

Ms. Rubin: Yes. We didn't include the new homes because if you're a person in a long-term-care home, it doesn't affect your level of care.

Ms. Smith: But that money—

The Acting Chair: Thank you. Mrs. Witmer?

Mrs. Witmer: Thank you for a great presentation. I think you've done a great analysis of the bill. We appreciate your input.

I'm a little interested. You indicated that the bill takes a very punitive approach. I'd like to ask you, what suggestions would you have to make the act more balanced between this carrot-and-stick approach?

Ms. Carlin: We would like to see a balance with incentives. We have suggestions for a number of types of incentives. It may include things like less frequent Ministry of Health inspections. It may include preferential treatment for homes that go beyond the standards for new programming; funds that become available for research grants that are available. There are a number of ways in terms of public recognition that the government can indicate that homes are exceeding the standards.

Mrs. Witmer: Thank you very much, Gail.

The Acting Chair: Thank you very much for your presentation.

ALZHEIMER SOCIETY OF ONTARIO

The Acting Chair: We'll move to the next presenter, the Alzheimer Society of Ontario, Linda Stebbins, please. Whenever you are ready, you can start your presentation.

Ms. Linda Stebbins: Good morning, Mr. Chair.

The Acting Chair: Good morning.

Ms. Stebbins: Thank you so much for this opportunity to discuss Bill 140. As you mentioned, my name is Linda Stebbins and I'm the chief executive officer of the Alzheimer Society of Ontario. With me is David Harvey, who is our director of transformation and transition management.

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As you heard recently in the Legislature, last November marked 100 years since Dr. Alzheimer discovered the disease that remains one of society's most frightening diseases and about which major research efforts must continue. January is also Alzheimer Awareness Month, and so it seems a particularly fitting moment to have this conversation with your committee.

We will be providing the committee with our written submission, but today's presentation will address four questions: First, what is the burden of Alzheimer's disease and related dementias in Ontario and in the long-term-care homes in particular? Second, what credibility

does the Alzheimer Society of Ontario have in speaking about Bill 140? Third, what aspects of Bill 140 are distinct improvements for persons with dementia? And finally, what should be added to or amended in Bill 140 to better meet the needs of residents with dementia?

Let me begin with our first question: What is the burden of Alzheimer's and related dementias in Ontario and in the long-term-care homes in particular? In Ontario, 171,000 persons have dementia and this number is growing rapidly as the lifespan of our population increases. Over 50% of residents of our long-term-care homes have dementia and it is the major cause for admission. The average stay of persons with dementia in long-term-care homes is decreasing, with some homes having a 50% admission rate in one year. So people are moving into a home when their illness is at the most debilitating stage. The growing number of persons with dementia places pressure on both the space requirements and staff capacity of the homes.

The second question: What credibility do we bring in speaking about Bill 140? No one wants to get Alzheimer's disease, but if they do, our society's 39 chapters are there for them, their caregivers and for the health service providers in every community in our province. For nearly 25 years, we have remained true to this mission, as well as leading the way in supporting dementia research.

No one wants to live their last years or months in a long-term-care home, but if they must, our society will reach out to partners to ensure adequate staff training, informed and supported caregivers, and to create and disseminate research on better ways to provide care.

The Alzheimer strategy for Ontario that we, along with the government of Ontario and our partners, launched in 1998 continues its momentum. Among other initiatives, the strategy emphasized dementia education, physician education and advanced care planning. While more than 4,000 workers in long-term care have received dementia education over the last seven years, this remains a very small segment of the total workforce in over 600 long-term-care homes in the province.

Our third question: What aspects of Bill 140 are distinct improvements for persons with dementia? Let me begin with rights orientation. The rights-based approach taken throughout the legislation will do much, we believe, to assure that all of the activities of long-term-care homes have the resident as their primary focus. The fundamental principle set out in part I assures that a long-term-care home be operated, above all, as the "home of its residents."

Next, let me comment on consent. Especially laudable is clause 42(11)(d), requiring consent for admission to a specific home. You will hear at this table stories of people in hospital who have been forced to move 60 or more miles from their home and their loved ones to receive long-term care. This must end.

The provisions in paragraph 5 of subsection 43(1), requiring consent for admission to a secure unit, are very positive. Some may ask you to modify this provision because of convenience or ease of management. We ask

that you not do that. One of the great cruelties of dementia is that its progress is uneven. One part of a person's brain may be compromised, while another part may function adequately. We cannot prejudge the impact of an inappropriate placement in a secure unit on an individual.

Last week, we heard of an instance where an older, fully cognizant person in hospital was almost admitted to a secure unit, not because they needed it but because it was the first bed available. The hospital wanted the discharge, the home wanted to fill a bed, and the community care access centre was there to facilitate. Despite good intentions, systemic pressures can distort our judgments. The law is needed to prevent, quite frankly, abuses such as this.

Finally, let me tell you what we like about the classes of beds. Clause 178(2)(h), which calls for the classification of beds, will enable small behavioural assessment units to be established in at least one long-term-care home in each LHIN region, modeled on those already in operation in St. Catharines, Hamilton and Kitchener. Such specialized assessment units would do much to reduce the likelihood of severe aggressive behaviour.

Our fourth and final question, especially important for both the committee and the Alzheimer Society of Ontario: What should be added to or amended in Bill 140 to better meet the needs of the residents with dementia?

Regarding consent, because of the varying cognitive deficits of residents with dementia, we recommend that subsection 3(3) be amended to include the following: "In instances where a substitute decision-maker is acting for the resident, the rights of the resident may be acted upon by the substitute decision-maker." This amendment, in our view, will clarify the role of the substitute decision-maker within Bill 140.

As for training, we commend the bill's provisions on training. We have some concerns about the way section 74 is drafted so that all persons working in the home are subject to similar training requirements. We are concerned that the training requirements may discourage volunteers by requiring a training content that is excessively complex or onerous. Our society advocates that section 74 be amended to identify classes of persons who require training, and that the types of training are matched to each group's particular involvement with the resident population. This is an approach that is consistent with best practices in volunteer management. This change may also alleviate concerns of some providers about the perceived excessive training burden.

Finally, positive incentives: Bill 140 is based on a belief that inadequate care can be remedied by inspection and enforcement, but we contend that excellent care can only be encouraged through positive incentives. The bill needs to give more prominence to its provisions for the minister to recognize and reward excellence in all aspects of training, programming and management of long-term-care homes. Such initiatives as the Alzheimer Knowledge Exchange, the Registered Nurses Association of Ontario's best-practice guidelines and the proposal for

teaching long-term-care homes similar to teaching hospitals and health units are initiatives through which the minister can encourage the pursuit of excellence.

We recommend that clause 178(2)(r) be elevated to form its own clause and that subsection 141(2) be moved to this section. This change emphasizes the minister's obligation and ability to foster positive incentives.

Before concluding, I want to acknowledge the contribution of our working group to this presentation and to our written submission. They have urged us to bring to your attention the need for public consultation on the regulations that are so important to this bill.

As well, we cannot end before clearly stating our concern that the good intentions of you as legislators to ensure quality of care cannot be realized unless you also continue to provide adequate resources to enable front-line workers to succeed. Ontario may stand in front of the line for policies, but without an infusion of funding, it will remain far back in actual performance.

Mr. Harvey and I are prepared to answer any questions from the committee.

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The Acting Chair: Thank you. There are 30 seconds each. Ms. Smith, please.

Ms. Smith: Great. Thank you, and it's nice to see you again. I appreciate all the work you've done.

Just on the training question, we have heard those concerns about the levels of training required and about defining volunteers quite specifically. We are working to address that. Also, to let you know, as I did yesterday, we will be having public consultation on the regulations. So thank you for raising that as well.

I thought it was interesting timing that you would come to us and speak of the need for the consent provisions when we just heard a previous presenter discuss the inconvenience of or the paperwork burden of that requirement. Could you, in 10 seconds or less, kind of give me a bit broader reason or comments on why there is such an important need for consent in moving to a secured unit?

Mr. David Harvey: First of all, removing the right to freedom of movement is—that is a fundamental right. That should be seriously considered. So that's the first point.

The second point is that there can be an uneven impact in dementia, as we mentioned. So one might think that a person may not be very aware of the impact of certain decisions being made, but in fact they may experience it very profoundly.

So those are our two major reasons: It's the gravity; and the impact can't be predicted.

Mrs. Witmer: Thank you very much for your presentation. You've reiterated what we've heard repeatedly, that the act is really quite punitive, that it focuses on inspection and enforcement, and there's a need for balance and more incentives. Can you expand? You've given examples here of some things that could focus more on the positive initiatives. Is there anything else you'd like to say in this regard?

Ms. Stebbins: We really think that getting to excellence requires other measures and that there need to be rewards in place for the really excellent service that is delivered in many of our homes across Ontario, and that does seem to be missing.

Ms. Martel: Thank you for your presentation. Under “classes of beds” on page 3, you say that clause 178(2)(h) will allow for specialized assessment units. I’ve read the section. I don’t see where that comes in at all. There’s no reference to that. Did someone tell you that? Is that what happened?

Mr. Harvey: One might see things where they maybe don’t exist, but it does give the power to the minister to create different classes of beds. One might think of that as only preferred accommodation, for example.

Ms. Martel: Yes, that’s right.

Mr. Harvey: But there are instances where there are dialysis units, for example, in long-term-care homes. So that opportunity to diversify service, I think, can be read into that section.

Ms. Martel: So you hope that’s what it means.

The Acting Chair: Thanks very much for your presentation.

HERITAGE GREEN NURSING HOME

The Vice-Chair: Next, Heritage Green Nursing Home. You can start whenever you’re ready. Can you state your name for Hansard, if you don’t mind.

Ms. Rosemary Okimi: Good morning. I’m Rosemary Okimi. I’m the administrator of Heritage Green Nursing Home. With me is Scott Kozachenko, the assistant administrator.

We thank you for the opportunity to speak to your committee today on behalf of our facility and all other similar facilities in the province. Scott will give you a little history of our facility and some of the things we’re facing, and then I will follow with some additional remarks.

Mr. Scott Kozachenko: Heritage Green is a non-profit home for 167 residents that provides jobs for 200 staff in Stoney Creek and surrounding region. For approximately 24 years, Heritage Green has been providing a continuum of care to neighbouring communities. Families rely on the care provided in our senior apartments, retirement home and nursing home.

The nursing home has an occupancy level of almost 99%, a waiting list that averages 75 on any given day, and an aging population that continues to look to us for long-term-care services to meet their immediate and future needs. Our board and staff have an ongoing commitment to meet these needs. This commitment is stronger today because of the relationship Heritage Green has built between our residents, their families, friends and community at large.

We are here today to ask you to amend the limited licensing provisions in Bill 140 and provide the plan to support us in keeping this commitment. The issues that this section creates for us in our efforts to develop our

home to provide the physical comfort and dignity our residents need are as real for Heritage Green as they are for any other home in the province.

Although Bill 140 is not yet law, the uncertainty created by it has already impacted our decision-making.

Heritage Green Nursing Home has three floors. The first and second floors have existed since 1991, while the third floor is new and was added in 2003. Overall, we are structurally classified as a B home because we have three-bed ward rooms and over 50% of our residents have to take the elevator down to the dining room on the first floor.

As a board and management group, we have been dissatisfied with our structural situation for several years and have been looking for ways to improve the comfort and privacy provided to some of our residents. Early in 2006 we began to actively pursue solutions to address these physical comfort and privacy issues for our residents. We conducted a feasibility study and worked with architects to develop a viable solution with the hope of beginning to move forward this coming May.

Our solution was projected to cost just over \$2 million, not huge as building renovation and redevelopment projects go but still significant for a 167-bed long-term-care home. Our board, residents, families and staff are now most disappointed that we are not able to proceed. We’re financially stable, yet we’re unable to obtain the financing within our current circumstances. With the uncertainty in Bill 140 and the absence of a government commitment to a capital renewal program, I am not sure when, or even if, we will ever be able to proceed.

Ms. Okimi: Over the past few years we have seen the amount of care we can provide based on ministry funding decline through the combination of a lower CMI and increasing wages and other care costs. Even though this was the case, our board was not prepared for our staffing and care levels to fall any lower than they already are. I think everyone in this room today agrees that more needs to be done to address this issue. And while we are talking about that, I might add that in the context of your deliberations on this bill, the extra paperwork and other administrative requirements it will require are only going to make the situation even worse.

In order to sustain our care levels, our board has approved us to overspend our nursing and personal care envelope by some \$200,000 annually. These funds are generated by the resident co-payment and fundraising activities. We also use this funding to pay for things like administration, dietary workers, building and grounds maintenance, cleaning and utilities.

I should also point out that in addition to the other requirements for this funding, our management flexibility is further limited by the fact that, with an existing mortgage, our bank requires us to maintain a surplus financial position.

Over the years we have been able to meet all of these commitments and requirements and, with careful management, accumulate investments and reserves in the range of \$1 million. This was not sufficient to provide the

bank with the comfort to finance our proposed \$2.1-million retrofit proposal. Since we would be adding very little additional revenue generation opportunity, they asked us to increase our surplus by another \$200,000 before they would be comfortable in granting financing. We were left with three unworkable and/or unsatisfactory options.

Option 1 would be to lay off staff and reduce our current care and service levels. We do not think this is an appropriate trade-off, and neither do our residents, families or staff.

Option 2 would be to go to our donor community and try to raise the additional funds. This is a major challenge at the best of times. As we considered this option, our prospects for success dimmed significantly with the tabling of Bill 140. Putting a deadline on our operating licence without identifying what we would have to do to ensure our licence is renewed, or identifying how long our licence would be renewed for even if we did whatever it is the ministry will tell us to do sometime over the next nine years, is hardly a story that will foster donor confidence and support.

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Donors, like any other investor, want reassurance that there will be a long-term return to the community on their investment. With the current uncertainty in Bill 140, we would be unable to provide that reassurance, particularly to the point of convincing them to make multiple-year commitments. As I'm sure you are all aware, multiple-year commitments are an important factor in donor-funded capital projects.

Our board also realized that the same uncertainty in Bill 140 that would make our donors more reluctant to give would also increase the amount we would have to raise. With no reasonable degree of assurance that we would either exist or have the same revenue-generating capacity we have now because we could have fewer beds, our bank would require an even larger surplus before being comfortable in extending us financing. That is just financial reality.

Thus we were left with option 3: maintain our current staffing levels and do nothing structural, and thus maintain an unsatisfactory status quo, despite our committed best efforts to do otherwise.

We are hoping that over the next few days you will take steps to ensure that this is not the status quo when Bill 140 becomes law. We ask this so that Heritage Green's residents can look forward to having, at most, two people to a room, and to not having to line up in their wheelchairs to take the elevator down to the dining room for every meal.

But we also ask this on behalf of all communities, residents and families who depend on the care and services provided by B and C homes. They deserve to know that the home will continue to exist and that it can provide them with the physical comfort and dignity they deserve.

The solution starts with amending section 180 to provide us with a 15-year term licence and to empower

government to fund a capital renewal and retrofit program for B and C homes. As you can see, we are the perfect example of why this program needs to include an option to retrofit as well as fully rebuild.

These amendments need to be supported by an immediate government commitment to work with the sector to implement such a program over the next 15 years. With these elements in place, we would gladly commit to being held to this deadline as a condition of licence renewal, a renewal that should be for the 25 years that Bill 140 would give new homes.

Section 180 of Bill 140 needs to be further amended to provide the predictability of 10-year rolling licence renewal periods following this 25-year term. These renewals should be tied to operator performance and bed requirements in addition to the building structure.

I know that our association, the Ontario Long-Term Care Association, has presented this solution to you in detail. On behalf of our board, residents, families and staff, I urge you to give it your full consideration. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left. We can divide it equally among the three parties. We start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I think that you've certainly emphasized the hardships that are going to be created by this bill: the amount of paperwork, the punitive approach, certainly, and also the inability to focus on eliminating the three- and four-bedroom wards that exist throughout the province of Ontario.

Looking at this bill, what is going to have the most profound impact on residents in your particular home and the level of care that is going to be declining?

Ms. Okimi: Partly, the paperwork is really going to make a lot of difference. Our registered staff are stretched to the limit with all the requirements that are already in place. Every time you add another layer of paperwork, it detracts from the amount of care that can be provided to the resident.

Also, there is the uncertainty as to whether we are going to be able to do the renovations that we so badly need so that our residents can have the privacy and dignity that we would like to provide them with.

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

Ms. Martel: Thank you for your presentation here today. I appreciated the solutions that were offered with respect to the licensing section. I had read some of that already in the ONS brief.

This may be premature, you may not have done this yet, but in terms of the bank you deal with, have they seen those proposals and given you any sense that if adopted or accepted, they would then be in a position to help you? But that may be premature.

Ms. Okimi: We did talk to the bank and we did ask them, with the proposals that we have, and their bottom line was that we didn't have the operational surplus to support paying back a \$1-million loan.

Ms. Martel: So it's the surplus that they're focusing on?

Ms. Okimi: Yes. Right now, we are required to have a surplus because of our existing mortgage—a 1.25% debt service ratio. But we barely make that. That isn't enough to support the additional borrowing.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: We've heard a lot about the paperwork issue and I wonder, as an administrator, if you could outline for us exactly what provisions in the legislation you feel are onerous and will contribute to your paperwork.

Ms. Okimi: I can't tell you chapter and verse, but I do feel that the fact that there will be much more reporting on each of the new standards and much more accountability—and accountability is good; I have no problem with accountability. But the more we have to document exactly what was done, it just keeps adding more and more.

Ms. Smith: Is there any specific area where you feel that more has been added? We have heard about the rights advice for going into secure units; we heard some concern yesterday around the documentation around restraints. But other than that, most of what's in the legislation is already required in policy as far as documentation. Is there any other area that you find is going to contribute?

Ms. Okimi: Not different to those areas that you have talked about, but again, a little bit more reporting on those areas.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, ONTARIO DIVISION

The Vice-Chair: The next presentation will be by the Canadian Union of Public Employees, Ontario division. Welcome. You can start whenever you're ready. If you don't mind, can you introduce the people on both sides?

Mr. Sid Ryan: I certainly will. My name is Sid Ryan. I'm the president of CUPE Ontario. To my left is Judy Wilkins. She's our legislative assistant. To my right is Brian Blakely. He's a researcher with CUPE.

I want to thank you for the opportunity to make a presentation here today on behalf of CUPE's 200,000 employees, 26,000 of whom work in the long-term-care sector.

I just want to preface my comments by saying that once in a blue moon a piece of legislation comes along that I would hope we'd be able to deal with in a somewhat non-partisan way. I believe Bill 140 is such a piece of legislation. It's clearly time for us to take a look at the needs of residents in these homes and say that the grand experiment of the last 10 or 15 years has failed miserably. I'm referring to the time when the Mike Harris government took away the minimum standards in this province and left us to our own devices, if you will. It's proven to be a failure and I do believe that it's time we once again got back into taking a look at reintroducing

those standards which were taken away so many years ago.

Bill 140 will affect, in our opinion, not only the workers but over 75,000 family members and loved ones in those long-term-care facilities, both today and for decades to come. So we have an opportunity now with this legislation, which probably won't get opened up again for the next 20 years. I do want to thank the Liberal government for taking this on. It's a piece of legislation that desperately needed to be revamped.

I also want to say that we've had good access to the Liberal government with respect to our viewpoints. We've got a lot of workers on the front lines who are working in this system and have come forward many, many times with complaints.

We submitted a document to the minister and to the parliamentary assistant, Monique Smith, a couple of years ago, a lot of which we see in the legislation, and we're thankful for that. We think they're obviously listening. There's still a bit more work to be done and I'm hoping that over the next few days and weeks, as these hearings proceed, we can make those changes.

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Our brief is premised on a brief that was written for us by two professors, Pat Armstrong and Tamara Daly, where we interviewed 900 front-line workers to get an up-close view of what's taking place in long-term-care facilities. The survey reinforced the claim that the workload is simply too heavy to allow for a safe and healthy workplace for providers or a home space for elderly and frail residents.

Some of the findings are quite startling, actually. There was a time when front-line workers were able to actually sit down and talk to residents, certainly those residents who don't have family members come visit on a regular basis. So even just a simple chat was part of the daily workload in many respects. Some 70% of our members are reporting today that that whole issue has just disappeared, that there's no time any longer to even chat with the residents; 60% of the time workers don't have time for emotional support; 53% of the time walking and exercising of residents is not done; more than 40% of the time foot care is left undone; and 20% of the time turning residents, bed-changing, room and bathroom cleaning remains undone.

That's a horrible indictment. That's the legacy in many respects of the Harris government of removing standards, that 2.25. I'm sorry to see that Mrs. Witmer has left her seat. It's part of the legacy that this government left us and it's proven to be a horrible exercise over the last 20 years.

In the 1990s, as I indicated, the Harris government eliminated the provincial requirements to provide every resident with a minimum of 2.25 hours of daily personal care. While Harris was busy eliminating Ontario's standards, 13 US states were actually increasing their standards. Today, 37 jurisdictions in North America provide a minimum standard of care. That's why CUPE's whole presentation is premised on this whole question of standards.

There are three priorities that we're looking at. One is adequate standards of care, which we believe to be 3.5 hours of nursing care on a daily basis for every resident; safety from violence; and building a culture of respect and openness in the homes.

Adequate standards of care: Bill 140 abandons a promise that the Liberals made to re-establish care standards, and I'm certainly hoping that before these hearings are over they will live up to that commitment. CUPE workers really love their work, but go home feeling badly every night because there are not enough hands to provide the care residents require. For example, feeding patients in a line is something that has come forward many, many times, both in these hearings and from our members; or receiving this bath in a bag leaves our members feeling frustrated and, quite frankly, broken-hearted to see this kind of treatment of the elderly in their homes. That's got to stop and we've got to have minimum standards that allow the workers to provide a level of dignity and respect to the elderly who are living in these homes.

In 2001, a PricewaterhouseCoopers report found that Ontario lagged behind all other similar jurisdictions in care levels and therapies, while having significantly older residents with complex needs. That's why CUPE is recommending a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per resident.

The bill needs to be amended to provide that the provincial government is required to create and maintain a provincial funding model that is based on a uniform assessment tool across the province to ensure there are uniform provincial standards and funding assessment tools across all of the LHINs, if these nursing homes get rolled into the LHINs. I will say that we know and are aware of a pilot project the Liberal government is engaged in, and we're hoping the results of that will result in a new assessment tool that will more adequately assess the needs of residents in the homes.

In terms of violence, I want to touch upon this because it's an issue that comes up with our members on a regular basis. It must be recognized that these facilities are not just homes, they are also workplaces for thousands of care workers and caregivers. These are workplaces where incidences of violence have actually continued to increase.

In 2004, residents attacked other residents 864 times and attacked staff 264 times—a tenfold increase in a five-year period. Much of the cause is from aging, chronically progressive diseases and age-related dementia. But nonetheless, Bill 140 needs specific amendments requiring that homes be safe and secure for residents and for staff.

We had some recommendations in our brief, particularly around appropriate training guidelines and approved training opportunities for staff and even the operators of the facilities: clear guidelines for admission of residents with dementia and cognitive impairment and aggressive tendencies; the establishment of care plans for those with a history of violence prior to admission; and a stop to

inappropriate downloading of patients from mental health facilities and acute care facilities into long-term-care homes.

Finally, we need to have a culture of respect. There's a significant consensus that Ontario's long-term-care homes require a cultural shift. The legislation must include a recognition that the homes are both homes and workplaces, that staff should be treated as partners in setting and protecting care standards. That's why we believe the bill should go much further in addressing the casualization, for example, of work, discrimination in the workplace and whistle-blowing.

I just want to touch very briefly on the whistle-blowing. We are pleased to see that it's in there. We think it could go a little bit further, because the way we read it, it could mean still that one of our members who would come forward to blow the whistle may in fact still end up getting fired and have to go through the process, either to the Human Rights Commission or to the grievance procedure, to get their job back. We think that should be tightened up. Let's not leave any of those loopholes.

Finally, I'd just like to say that here's an opportunity—the last time possibly in the next 20 years—so let's get this bill right. We're halfway there; we're not fully there right now. If we can introduce the standards, take a look at the homes as a workplace as well as a home for the residents and strengthen the whistle-blower protection, certainly we as a union would be pleased with that. We still hope there's some time when we can continue the dialogue that's going on between ourselves, the Liberals and anybody who wants to listen in terms of our position.

So with that, I thank you for the opportunity to make this presentation today.

The Vice-Chair: Thank you very much. We have five minutes left. We can divide it equally among the three parties. We start with Ms. Martel.

Ms. Martel: Thank you for your presentation today. I want to focus on standards, as I have been for most of these hearings. First of all, the Liberals were very clear that they were going to re-instate minimum standards. That was an election promise. We are in the fourth year of the government mandate, and we haven't seen anything yet. If there was going to be a change, you would have thought it was going to come in this legislation. So I am going to be putting forward an amendment that will recommend 3.5 hours of hands-on care per day, and we'll see what happens then and who votes for what, when.

The second standard I want to talk about focuses on safe environments and making sure that there are appropriate levels of staff to deal particularly with residents who are violent and have a history of dementia. The Casa Verde inquest had a very specific recommendation with respect to that. It said that if a decision is made to place these individuals—that is, people who are violent with dementia—in long-term-care facilities, the Ministry of Health “must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have

expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self or others.” The ministry’s response was, “The ministry is currently considering these recommendations.”

It seems to me that if you are bringing a long-term-care bill forward, you would have implemented that recommendation too if you had the intention of doing it in the first place. So we will be bringing a recommendation forward in that regard.

Maybe you have some other information that would suggest that the government is going to move on these two important matters. But, to date, we don’t see any evidence that the government is intending either to reinstate a minimum standard of care or deal specifically with clients who have dementia. What gives you any hope or confidence that we might see a change of heart in this regard?

Mr. Ryan: Well, I’d be foolhardy to say that I’ve got additional information when I don’t. The only thing I can base it on is my experience in dealing with all three parties when they were in government. We had excellent access to your government, Shelley, when you were in office. We had hardly any access to the Tory government, who just went ahead and eliminated this without consultation with anybody in terms of standards. We’ve had good access to the Liberal government in the last little while in terms of being able to work with them. I have seen some of CUPE’s material, which we presented a couple of years ago, appear in this legislation, albeit in a different forum. So I’m optimistic. As a union leader, we like to use that “cautiously optimistic” expression, but I am optimistic that the Liberals will listen to the preponderance of presentations that have been made, not just by CUPE but by others who are calling for these standards. I think it would be swimming upstream if we saw anything less than the kinds of recommendations that have been made both by CUPE and the majority of the presenters here over the last number of days.

1120

Ms. Smith: I just wanted to address some of the issues that you raised. You talked about training and the need for appropriate training. We do outline that in section 74.

You talked about guidelines for admissions of residents with dementia and cognitive impairment. You’ll see in section 41, on admissions, that we do talk about a fairly thorough assessment prior to the applicant’s placement in a home, including looking at their current behaviour and their behaviour in the year preceding, in order to do a more broad assessment of their behaviour and to try to address any history of violence that we may have to address.

With respect to the plan of care, you talked about staff collaboration. In section 6, we certainly set out that all staff who are involved in the care of the resident be involved in developing the plan of care.

You talked about your concerns around agency staff. We do address the limiting of agency staff in the legislation.

I do take your comments on the whistle-blower protection and wanting to see that strengthened, but it is in fact in the legislation, as you requested a couple of years ago when we met.

My one question for you is—you talked about 37 jurisdictions that have adopted a minimum standard of care. My information—and it is kind of difficult to pull it all together—is that there is only really one jurisdiction in Canada that has a minimum standard. That’s Alberta, which has set a minimum standard of 1.9 hours of care and a target of 3.4, not a minimum standard. Sorry, there are two. Saskatchewan has set a minimum standard of two hours of care per resident. There are a couple of other jurisdictions that have talked about implementing it, including New Brunswick in their recent campaign, but we haven’t actually seen that legislated. Do you have other information that would indicate that there is broader acceptance of legislated, or in regulation, minimum standards across the country?

Mr. Ryan: Just to the comments that you made to preface your question, part of the reason that the whole question of standards with respect to violence is in our presentation is that we recognize that there’s always a pushback from employer associations that don’t want to see any standards. They want to align themselves where the Conservatives were 12 years ago, which is, “Let’s eliminate standards.” We know that has been a failure. So we want to make sure that when standards are implemented—and I recognize that they are mentioned in your bill, but they need to be broadened. We want the workers to be part of a bipartite process, if you will, in terms of developing what those standards would look like, as we have in many workplaces when it comes to health and safety.

So it’s a recognition that it’s in the bill but not as strong as we would like it, but it’s also to send a signal to those employers that they just simply cannot have it their way on every front. You cannot say, “Eliminate standards of care,” which has been a disaster, and at the same time, “Also, let’s eliminate all of the paperwork, and let’s eliminate all of the accountability mechanisms that we build in. Also, let’s eliminate where we sit down with workers and actually take a look at what standards would look like with respect to violence.” That’s the reason why it’s in there.

In terms of Alberta, for instance, I think your information is wrong. We’ve just gone and checked in the last number of days, and in fact Alberta has legislated 3.6 as the minimum standard. I know at one time they were talking about moving towards a target, but the information we’re getting from Alberta is that they have legislated it.

Mrs. Witmer: This is a different Sid Ryan we’re hearing from today. I think you might become a Liberal candidate in the next election campaign. You’re so assured that all of the recommendations that you’re putting forward are going to be implemented into law by the Liberal government. If that were the case, I don’t know why they didn’t put it in the original bill.

Certainly, this is a different presentation than those we've heard from other union members. You maybe have had a private conversation recently with the Liberals that would lead you to believe all is going to change. Might that be the case, Mr. Ryan?

Mr. Ryan: Actually, Mike Harris asked me to run for the Conservatives at one time, so I don't know where you're coming from with that particular question. My roots are well known to all and sundry in this province.

Sure, I've had discussions, like anybody else has had. As I go in the door, I find all kinds of people together; it's a revolving door in the ministry. Of course, we do what we do best: We talk to government. We get the opportunity to speak to government, unlike yours, when you were in office. I'm sorry, Elizabeth; you had a closed-door policy, except when it came to the employers. There was an open-door policy and open season in that respect.

We are talking to them. I'm not saying we're going to get everything we want. As a matter of fact, I'm heading down to Niagara this afternoon to organize a press conference and a protest. I'll be doing the same in Windsor tomorrow, and in North Bay today there's a protest. So we're not backing off. We're saying, "Look, we want these standards implemented." By the same token, I am recognizing that the ministry is listening to our concerns and I am seeing already portions of CUPE's issues being reflected in this legislation. I'm not talking about since the bill got introduced; I'm talking about from presentations that we made two years ago. I'm acknowledging that I'm seeing some of that, which I never saw in any legislation that your government ever brought forward.

So from that respect I'm saying, yes, I'm optimistic that, given not just CUPE's presentation here—I understand there are all types of folks coming to these presentations asking for these standards—that this government will listen. And listen, if they don't come forward in the next little while, we have from now until the Legislature opens at the end of March to continue to mobilize the sector and the community and the residents and their loved ones. There's lots of opportunity and lots of time. So, having been around the block a few times, I understand how the process works and right now I think it's the time to listen, to make our presentations. If the Liberals pick up on what we're saying, good for them. That's an excellent first step on a piece of legislation that I really do believe should be approached in a non-partisan way. I honestly believe that. There are certain pieces of legislation that just don't lend themselves very well to partisan politics, and this is one of them.

The Vice-Chair: Thank you, sir, for your presentation.

ALLIANCE OF SENIORS

The Vice-Chair: Now we move to the Alliance of Seniors. Are they around? You can start whenever you are ready.

Mr. Al Gorlick: Good afternoon, ladies and gentlemen. Thank you for the opportunity of making a presentation today. By the way, my first comment is going to be that I have a vested interest in the outcome of this legislation because my wife, who has Alzheimer's, is a resident in a long-term-care facility with which I have a lot of experience. I'd like to have that upfront so that there won't be any misunderstanding.

The Alliance of Seniors, founded in 1993, is an active, diverse and growing non-partisan coalition of individuals and organizations representing the concerns of over 300,000 older adults residing in the greater Toronto area.

Our mission is to preserve and enhance Canada's social programs on behalf of the present and future generations; to promote a society where all persons have an equal opportunity to live with dignity, to realize their potential and to participate in the democratic process; and to educate and raise public awareness about the values, life experiences and lessons learned by we Canadian older citizens.

As a coalition, the alliance does not presume to speak for each and every individual participating organization nor represent their specific positions. Rather, the alliance seeks to build consensus upon the shared values amongst these groups when addressing issues of mutual concern.

I'd like to bring to your attention the number of senior organizations and individuals who belong to our group: the Association of Jewish Seniors; the Bernard Betel Centre for Creative Living; the Canadian Institute of Islamic Studies and Muslim Immigrants' Aid; Canadian Pensioners Concerned; Care Watch Toronto; Caribbean Canadian Seniors; Concerned Friends of Ontario Citizens in Care Facilities; Congress of Union Retirees of Canada; Elder Connections; Habayit Shelanu Seniors; Jamaican Canadian Association; Korean Inter-agency Network; Older Women's Network; Ontario Coalition of Senior Citizens' Organizations; Ontario Federation of Union Retirees; Riverdale Seniors' Council; Toronto Seniors' Assembly; Yee Hong Centre for Geriatric Care.

I hope you're impressed with that list.

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The Alliance of Seniors, its affiliates and friends endorse the principles of the Canada Health Act: comprehensiveness, universality, accessibility, portability and public administration. I have the honour of being the chair of this organization. Thank you very much.

Mr. Derrell Dular: That's Al Gorlick, chair of the Alliance of Seniors. I'm Derrell Dular, general secretary and executive coordinator for the organization.

We are generally pleased with the government's demonstrated intent in Bill 140 to improve the legal framework for the regulation of care and services for residents in long-term-care facilities. However, we do have certain reservations regarding provisions that leave some essential matters to be dealt with by regulation, while the availability of appropriate funding is to be the determinant for the implementation of other key elements.

Adequate and meaningful public consultation should be a prerequisite to the drafting of the act's regulations if the legislation is to live up to informed public expectations.

Appropriate funding should be assured for the mandatory training of all direct care staff in specified areas, such as dementia care and behaviour management, rather than relegate this provision to a conditional option if funds are available.

Fundamental to the quality of life afforded to persons resident in Ontario's long-term-care facilities is the provision of sufficient personal care to meet the individual needs of each and every resident. To address this necessity, we believe that a province-wide minimum staffing standard for residents' nursing and personal care needs must be reinstated in Ontario.

It must also be recognized that since the previous minimum standard of care, that of 2.25 hours per person per day, was eliminated in 1996, the composition of the resident population in long-term-care homes has generally become older, with increased care needs. Today, without a minimum standard requiring an adequate staff-to-resident ratio, many residents' care needs go unmet, jeopardizing their health and their very lives, as has been documented in the media.

Following consultation with affected parties and our various participating organizations, the Alliance of Seniors recommends that the government undertake to adopt a minimum standard of personal care averaging 3.5 hours per day per resident. We further recommend that the ministry fund each facility on the basis of its real assessed needs, given that individual needs vary and so does the mix of residents' needs in each facility.

In light of Canada's aging population and as all long-term facility beds receive public funding, we recommend reinstating the minimum standard for facilities requiring that at least 60% of beds be for non-preferred accommodation.

To help ensure quality care and value for our tax dollars, we also recommend strengthening family councils and their reasonable access to information; further consultation on the appropriate use of restraints; better training for front-line personnel; continuing unannounced inspections for all facilities, at least annually or in response to formal complaints; and effective sanctions for facilities demonstrating consistent non-compliance with regulations and standards.

We thank the committee for this opportunity to express our support for and concerns about Bill 140.

Before we accept your questions, I would like to advise that despite a generation age difference between myself and our chair, Al Gorlick, we both have loved ones who are resident in long-term-care facilities: in Al's case, his wife and life partner of over 50 years, and in my case, my mother.

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

Ms. Smith: I thank you both for being here. Al, did I see you on TV this week? Were you talking about the legislation? Good to see you. Thank you for coming.

We appreciate the recommendations that you have made. I think you'll find that in the legislation much is addressed. I said publicly yesterday and again today that we will be consulting on regulations in order to address that concern.

Section 74 of the legislation does require that direct care staff receive training in dementia care and behavioural management, so those aren't conditional options but they are requirements in the legislation.

You also spoke about the need to fund a facility on the basis of real assessed need. I think you're probably aware that we're moving towards the MDS model of assessment in our homes for our residents, which will give us a clearer, more up-to-date picture on the actual needs of our residents at any given time. That started as a pilot project under our government by the ministry and has moved now to about—I think 160 homes are now adopting MDS, as opposed to the CMI process. We're hoping to, over the next couple of years, roll that out to all of our homes across the province.

With respect to your recommendation on family councils, as you're probably aware, the Liberal government funded the family council project and ensured that we had the support needed across the province to assist in the development of family councils in various homes across the province.

In the legislation, we set out the criteria for family councils. We restrict membership to those who are really involved in the home, in the lives of the residents, so we don't have staff interference. We provide a mandate for our family councils and encourage them to be created. Where they're not created, we encourage homes to come back to family members on a regular basis to tell them of the possibility of creating one and to encourage them to do so.

With respect to your recommendation on the appropriate use of restraints, I think you'll see in the legislation a fairly detailed protocol on minimizing the use of restraints, and when they are used, there is a very detailed protocol on how they can be used.

Again, front-line personnel training we do address. And we will, obviously, because it's mandated in the legislation, continue with unannounced annual inspections, except in exceptional circumstances, which are going to be defined in the regulations, which may be in order to recognize some homes that have had no problems and that we want to recognize as being really great homes. But of course, we would still be in to the home with an inspector if there was any issue or problem reported.

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

Mrs. Witmer: Thank you very much for your presentation, Mr. Gorlick, and also Mr. Dular. It is a very impressive list of organizations and homes that you do represent.

I appreciate your coming forward. Certainly we've heard from the government what the bill is proposing to do, but I guess we've also heard that contained within the bill there's a tremendous amount of paperwork. It takes a

very punitive approach in the area of enforcement. Also, for many of the changes in the legislation, in order for it to be successful it's going to require a significant increase in funding. You've indicated here that you want to see the minimum standard of care increased to 3.5 hours per day. Of course, none of this is going to happen without any funding, nor can the huge paperwork burden be achieved without impacting on care if the government doesn't give funding.

You've talked about mandatory training for staff. I think that's very, very important. In fact, we've heard from people who have come before us that the personal support worker needs training and needs education. We've heard about some of these individuals not having basic literacy and numeracy skills and the fact that they all need to be sensitive to the needs of the residents in the homes.

I think key to the success of this bill, which needs a dramatic overview, is going to be government assurance that for all of these activities and for all of these changes to have a good impact, there's going to have to be appropriate funding provided. As of now, we've not been assured that that's going to happen. That's key.

I appreciate your bringing forward your concerns and recommendations, and I trust that the government will provide the funding that is going to be needed to achieve any success at all.

The Vice-Chair: Thank you, Mrs. Witmer. Ms. Martel?

Ms. Martel: Thank you for your presentation here today. I want to focus on your concern about appropriate funding being assured for mandatory training so that people have training in dementia care and behaviour management. This is not conditional.

I noted with some interest that the parliamentary assistant took you to section 74 that says that every licensee in a home shall ensure that all staff have the training that's required to deal with all of the people who are coming in. She didn't talk about section 88, the funding section, that says, "The minister may provide funding for a long-term-care home," meaning may provide the funding that will allow for this training.

1140

Mr. Dular: That's why we perceive it as optional.

Ms. Martel: So your reference to optional was—

Mr. Dular: —was the "may" rather than an imperative.

Ms. Martel: I'm glad you clarified that, because this is a concern that has been raised by a number of people in terms of the "may" that should be "shall"—"must" is another requirement—and that the government actually does this, because it is very clear that despite promising \$6,000 more care for each resident in each long-term-care home, the government has delivered about \$2,000 of that. For any of this to fly in the way that the government proposes, it's going to be critical that the government actually meets its election promise and provides the \$6,000.

Can I just go back to your concern about restraint, because you said, "Further consultation on the appro-

priate use of restraints." I'm assuming you've read the bill but you have ongoing concerns about what may be missing or what is in the bill regarding that. Can you provide any further clarification?

Mr. Dular: In general terms, particularly for AI and myself, this is a very personal matter rather than a political or academic exercise. We are concerned that there be adequate consultation with the broader community, not just the professionals involved in the care of the residents of these homes. Our concern is basically that we be consulted and that people outside of the industry be consulted in establishing what is reasonable restraint under what circumstances.

The Vice-Chair: Thank you very much for your presentation. Now we move to our next presentation by—sorry, there's not much time left, sir.

Mr. Gorlick: Is there a minute left?

The Vice-Chair: No, no time left. My apologies. Thank you very much anyway.

AURORA RESTHAVEN

The Vice-Chair: We move to Aurora Resthaven. Welcome. You can start whenever you are ready. Please state your name before you start, if you don't mind.

Ms. Edith Schultz: I'm Edith Schultz, a registered nurse and administrator of Aurora Resthaven, and beside me is Jill Knowlton, a registered nurse and regional director for Aurora Resthaven. We are a 240-bed home that has been providing care and services to Aurora and nearby communities for 32 years.

We are in a unique position. Up until 2003, we were a 176-bed C home. In 2003, we opened 64 new beds attached to the original home as part of the government's 20,000-bed expansion program. This expansion was made possible through a financial partnership between the government and the operator.

While this expansion was necessary and beneficial, it also created the reality of residents and families experiencing the oldest and the newest of Ontario's long-term-care accommodation standards in the same home. We are a living example of this double standard that applies to over half of the residents and their families in long-term care. In our home, residents and families see and experience the difference every day, even though they pay the same fees.

I want to bring this unique perspective to you today to do two things. First, I want to assure you that the residents and their families find this double standard unacceptable. It does not and it cannot meet their expectations for what a long-term-care home should provide in terms of resident physical comfort, privacy and dignity. Second, I want to assure you that without changes, Bill 140 will ensure that this double standard will continue for at least the next decade, with no certainty about what happens then.

Let me begin to try to paint a picture of what the double standard looks like.

The residents in the original building who want to share a room with one person pay a semi-private rate. They have a much smaller room, share a bathroom with three other residents and have very limited space for any personal belongings. In the new part of the home, there are no semi-private beds. Sharing a room with one other person is a basic or standard room with a reduced rate. These rooms are much larger, with extra space for personal belongings, and they share a bathroom with one person. It is most undesirable to rent a semi-private room in the original building when you may have a two-bed room in the newer area for less money.

Two home areas—120 residents—from our Mill Street side must take turns to use the same dining room for all their meals. This means transporting 60 residents per meal by elevator, causing waiting times for meals and to get to and from their home areas. Residents living in the new part of the home have a dining room on their home area, and it serves 32 residents with no waiting times.

The area that is of grave concern is the 60-bed dementia care home area, with more narrow hallways than in new design standards, small bedrooms that mainly hold four beds, and one common room that is used for all services. In contrast, the new dementia care home areas have large bedrooms and many common areas, like activity rooms, dining rooms, sitting areas and large hallways with continuous walking paths for residents.

Now, let me give you the issues this creates for residents and families. Constantly, when residents and families come for an initial tour to visit the home, their first request is to be admitted to the new area of the home. When they learn there is a waiting list, they are most disappointed with the process of being admitted to the original building and then transferred later when a bed becomes available. Residents and families cannot understand why residents who are paying for private, semi-private or basic accommodation in the original home are receiving less for their money as compared to residents in the new part of the home. These residents have their own dining rooms, lounge area, activity area and outdoor seating area on each home area, and may go freely about their areas without relying on others and elevators. In the original building, just manoeuvring the more narrow hallways is a challenge, and they must leave their units for any extra space.

Our home has one of the largest home areas—60 beds—for dementia care, serving the assessed needs of our community. Our home meets C standards but there is limited space in the bedrooms, contributing to very close living quarters and the challenge of providing much-needed quiet and privacy. A key factor with the limited personal space is the ability to meet the basic resident right of being able to have your personal possessions and furnishings displayed in your room. These residents are so restricted in their space that only minimal personal items can be allowed, to ensure the safety of others, a factor which is not an issue with homes built to the new design standards.

Further, the multi-purpose room, which is 625 square feet, is used as a lounge to visit with family and friends, a room to watch TV, an area for activity programs and entertainment, and then it is utilized as a dining room, where food is served to only 20 of the 60 residents at a time due to lack of space.

In 2007, our most frail residents have to wait for several meal settings. Many of these residents waiting for their mealtime require redirection from the dining room while others are being served. This home area has limited quiet or small private areas for residents to enjoy personal time or small group activities.

Families and residents are devastated when they see this area for the first time. The staff has spent countless hours reassuring families. Consequently, they have a favourite statement: “We are not a pretty environment or sight, but we are the best care there is.” Families who get to know the level of care provided to their loved ones support this statement and cannot understand why the government is not taking action but is allowing residents to live and staff to work in this inadequate environment.

I am very passionate about the care given to residents with dementia. In fact, I am so passionate I wish to invite you to come to our home and join myself and the residents for dinner. Seeing our environment first-hand is worth a thousand words. This is your opportunity to see, understand and take action while you are in a capacity to do so. It is without a doubt that someone near and dear to each one of us will need this care someday, and if you fail when you have an opportunity, are you really able to live with the consequences? This environment needs change now, and if you were to join me and see first-hand, I know you will be marching to the halls of Parliament with your strongest message to change Bill 140 immediately.

1150

Many of our residents, families and staff cannot understand why this environment continues while the government made so many changes with the new beds and all of the new homes. It is frustrating for me, and sad and disappointing for them, when I have to tell them that the new Long-Term Care Homes Act provides no hope that we will be able to address these issues any time soon. In fact, with the uncertainty created by the fixed-term licensing provisions, I can't even honestly tell them that they will ever be addressed in this home or in this community.

Our staff take little comfort for the security of their job from this either. Recently, I had a conversation with a staff member. She's a senior registered practical nurse who asked me when and how soon any changes will occur on our dementia care home area. When informed of the uncertainty in Bill 140, she felt that staff and residents cannot continue for long in this environment.

We are seeing an increase in aggression in our residents, requiring regular high-intensity-needs funding due to their unpredictable behaviours. One factor that contributes to this increase in behaviours is the dense population, resulting in the overstimulation that occurs. It

is well known that this fact can lead to stress in persons with dementia and an escalation of unpredictable and/or undesirable behaviours. It is not an environment where efforts to implement evidence-based best practices are successful. Staff have limited space to separate residents or provide privacy within the area for one-to-one care or interventions.

This environment acts as a catalyst for staff burnout and dissatisfaction. Health human resources are one of our most precious resources in our home and indeed in Ontario, and must be protected. We need more nurses in long-term care, and actions must be taken to prevent losing them due to job uncertainties.

Any time from the day Bill 140 is passed up until three years before our licence expires, the ministry can tell us to do any one of a number of things. The problem is, none of these options works for the residents, families and staff in our home. Closing the home doesn't do it. Neither does closing some of our beds and moving them to another community, as they are clearly needed in Aurora. We are living proof that rebuilding without government as a financial partner in a capital renewal program is impossible.

With no way of knowing if our operating licence will be renewed, or for how long, it is extremely difficult, and likely impossible, that we will be able to finance millions of dollars in building upgrades. Even if we could, we would still have three- and four-bed wards and bathrooms that are not wheelchair-accessible.

I have heard comments that one of the options might be to take some three- and four-bed rooms and turn them into doubles. Without rebuilding, this measure would lead to fewer beds and, since our funding is based on occupancy, even less funding with which to finance the renovations. In addition, this would only serve to increase our waiting list, with our present occupancy level of 99% and 25 potential residents waiting for admission. Reducing our number of beds is hardly a progressive care and service option. That then presents the ministry with the option of doing nothing at all, which leaves us right where we are now.

What residents, families, staff and the community of Aurora need is reassurance from this government that homes like ours will be there for the increasing number of frail and elderly people who need long-term-care services. They also want a plan that will reassure them that government will treat them equitably and that the structure of these homes will meet their needs and expectations. I know that yesterday you heard the Ontario Long Term Care Association outline such a plan. On behalf of our residents, families, staff and our community, I urge you to give it your full consideration and support.

I cannot overemphasize the importance that, as part of this plan, government commits to move immediately to implement a capital renewal program for B and C homes. Along with the amendments and other initiatives in the solution before you, it is the difference that will make a difference.

In my 40 years of nursing, and 26 of these years as a long-term-care home administrator working in northern Ontario and throughout the province, there have been few, if any, things that would give me more satisfaction than to call a resident and family meeting to tell them that government has not only removed the uncertainty over the future of their home that has been created by Bill 140, but also that it has committed to immediately fund, develop and implement a program that will allow us to plan to eliminate the double standard in accommodation service that is a reality for them every single day. I can tell you, without reservation, they would welcome this message with enthusiasm and support. They would know that government had truly listened and responded to their concerns.

Thank you. I welcome any questions.

The Vice-Chair: Thank you very much for your presentation. There is no time for questions; you used all your time. Thank you again.

ABBNEYFIELD HOUSES SOCIETY OF CANADA

The Vice-Chair: Now we move to our next presentation. The last presentation for this morning's session will be by Abbeyfield Houses. Welcome. You can start whenever you're ready.

Dr. Bob Frankford: Good morning. My name is Bob Frankford. I'm a director of an Abbeyfield House. With me is Mr. Bob McMullan, who is the executive director of Abbeyfield Houses Society of Canada.

I'd like to thank you for the opportunity to discuss with this committee the implications that we see in regards to the Long-Term Care Homes Act, Bill 140. It doesn't directly affect us. Abbeyfield Houses Society of Canada is a registered national charity that supports a model of supportive housing in over 30 societies across Canada.

Mr. Bob McMullan: I've asked to chip in, I'm afraid.

First of all, in the agenda it's got "Abbey Fields" as two words. It's actually one word. It started with a road in south London, England, for which they named this society. The story I like is that the housekeeper in one of our houses had the plumber in and as the plumber left, he said, "Who do I send the bill to?" "Send it to Abbeyfield." "All right, Mr. Field, we'll see to that."

Thank you for the opportunity to participate. Although, as Bob said, we're not impacted directly by Bill 140, and although we regard it as a triumph if Abbeyfield is a resident's last address, we know that some of our residents will inevitably need to move to long-term care.

I'm now going to hand back to Bob. By the way, my name is Bob McMullan, executive director of Abbeyfield Canada.

Dr. Frankford: We'll be affected by this legislation not directly, but in the long run, if further legislation and regulations are introduced in regards to homes, because we are a viable, cost-effective alternative for an import-

ant section of the population. We serve many seniors who benefit from our shared family-like accommodation for 10 to 14 seniors living in a shared house designed for the purpose of providing safe accommodation, sound nutrition and a shared social environment to combat the fragility of seniors and provide for their needs.

Abbeyfield is a member of the Ontario Association of Non-Profit Homes and Services for Seniors, OANHSS, and we are aware that they have submitted a more detailed analysis of the proposed legislation. We concur with their basic concerns and have repeated them where appropriate.

I'd like to mention a summary of the issues which are of concern to Abbeyfield.

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One is lack of support for non-profits. The McGuinty government has been a vocal champion of not-for-profit health care delivery. We are disappointed, therefore, that Bill 140 does not go further in support of the not-for-profit sector, and in fact may work to weaken this special sector. Abbeyfield relies on its volunteer boards, good people who often raise funds, and our volunteer house committees who participate to enhance the quality of life for our housemates.

For example, Bill 140 imposes personal liability on directors for failing to take all reasonable care to ensure their home meets all the requirements of the act. As well, directors could even conceivably go to jail for such a breach. We are concerned that this may present a significant barrier to recruiting and retaining directors, especially our volunteers and other directors in the not-for-profit sector.

Bill 140 will also impose harsher offence provisions on the board members of homes than on those serving on hospital boards. The Public Hospitals Act has general offence provisions, but the penalty on conviction is minor: \$50 and not more than \$1,000. A fine of \$25,000 or a 12-month jail term, as per Bill 140, is a severe deterrent to recruiting or retaining board members.

We are asking the government to include in the proposed legislation a strong and explicit statement of support for the non-profit sector, a statement that commits the province to preserving and promoting the not-for-profit delivery of long-term care in Ontario. We do not have access to the resources that a for-profit does. Abbeyfield creates social dividends, not financial ones.

On residents' rights, we support the bill's focus on residents' rights. We are concerned, however, that the proposed legislation might put homes and their residents in adversarial positions by giving individual families and residents the right to enforce individual rights even where such enforcement may infringe on the collective rights of all residents.

On the question of finance and less money available for resident care, Abbeyfield is a registered charity sponsoring over 25 Abbeyfield Houses across Canada. Although we are not a licensed care facility, the spinoffs will have an impact on retirement homes immediately and in future legislation on retirement homes. We will be

affected by this legislation because we offer support, services and accommodations to frail and lonely seniors.

Bill 140 proposes a significant increase in regulation. Long-term-care homes will have to spend a great deal more of their time and resources on compliance and administration. For example, obligations for the training and orientation of staff alone take up three full pages of Bill 140. This would be a real hardship to Abbeyfield, where each house only has one full-time staff person. Our small scale is our strength and an important and viable option within the range of accommodation and services for seniors who are not suffering from cognitive impairments.

Abbeyfield concurs that, without question, homes must be held accountable. We support measures that will enhance standards. But unless the government provides new staff funding for non-profits, and especially the Abbeyfield model, our houses may be forced to close, thus reducing the housing options for vulnerable seniors who benefit from the more cost-effective Abbeyfield model. Because Abbeyfield residents can manage outside of a more costly, medically supported alternative, meeting all the new administrative requirements of the act should not result in less money being available for seniors' needs.

Concerns about licensing: We appreciate the need for the ongoing upgrading of homes to meet the changing needs of residents, but the government cannot simply mandate this to happen by making structural compliance a condition of licence renewal. What would happen to an Abbeyfield when we have never had to be licensed? The province must establish a multi-year capital improvement program that will help homes to meet these requirements.

As well, fixed-term licensing tied to structural compliance will increase the cost of long-term financing. Lenders will likely attach a premium to cover the risk of licence non-renewals. Each Abbeyfield House has its own mortgage, so this is a very real concern and potential added cost.

Mr. McMullan: I'd just like to comment on the danger of overregulation for a place like ours. Around the world we have 880 houses of 10 to 14 people. We're now in 16 countries, including Japan and just recently in Mexico.

Whenever a scandal surfaces, like at a retirement home, there's a natural wish to make sure this never happens again. But overregulation can kill small houses like ours, not just by smothering them with paperwork. Some 35% of woman over the age of 65 live alone. Are they at risk? Of course they are, but risk is a fact of life. Countless numbers of caregivers are family members. Are some of them abusive? Of course they are. But regulations are not necessarily the answer.

With the Abbeyfield model, volunteers at the houses are going to see and do something about anything out of the ordinary. We've even had complaints from residents, or their family members, directed to the chairman of Abbeyfield International in England.

I'd like to comment on non-profit compared with for-profit. Studies have shown that the quality of life and the

level of care in a non-profit are usually better than one that is motivated by the bottom line. An ideal resident for the latter, the for-profit sector, would be someone who would keep quiet, often with sedation, limit calls for assistance and have an iron bladder.

Our philosophy is to remember that living like a family means getting on, but it also means not getting on. Our 9,000 residents may be very aged—the average age is now 86—but they have had interesting and fulfilling lives. They do not want to be treated like zombies.

Lastly, please help us grow Abbeyfield in Canada, a cost-effective niche for senior seniors between living independently and requiring the assistance of a long-term-care establishment or a nursing home.

Is there time for any questions?

The Vice-Chair: We have two minutes left. I'm wondering if each party can have a brief question, if that's possible. We'll start with the NDP.

Ms. Martel: Thank you for your presentation today. I see that on page 1 you said you're a model of supportive housing. Does that also mean that a number of your residents have disabilities or mental health needs that you are meeting? Is that what the reference is to supportive housing?

Mr. McMullan: We say it's for frail elderly, but if somebody is a bit of a wanderer and is not going to do any damage to anybody, we keep them as long as we can. Our philosophy is that if you have a very dear mother or grandmother living in your house, you're not going to send them to long-term care until you absolutely have to. That's the attitude we take.

The Vice-Chair: Thank you. Parliamentary assistant.

Ms. Smith: Just so we're clear, Abbeyfield Houses do not fall under Bill 140, right? You're not covered by—

Mr. McMullan: Yes, we've tried to emphasize that.

Ms. Smith: How many homes do you have in Ontario?

Mr. McMullan: In Ontario, we have four. We have another three planned or under construction.

Ms. Smith: That's great; we appreciate your presence in the continuum of care. I just wanted to make sure that you knew that the seniors secretariat has undertaken a review of the retirement home sector, and that would probably better qualify for you. You may want to make some submissions there as well.

The Vice-Chair: Thank you very much. Mr. Yakabuski.

Mr. Yakabuski: I've spoken to directors of some of my non-profit homes and some of them intend to resign if this bill is implemented. But I want to ask you one quick question: Given the punitive nature of the regulatory aspects of this bill and the fact that it's a one-sided situation, do you believe that without proper funding this bill will actually lead to less care for our residents, if implemented the way we see it drafted today?

Mr. McMullan: I think the main problem is that if we overregulate, we're going to have a problem with staffing. As you know, Abbeyfield is run entirely by 11,000 volunteers worldwide, but the staff is the house-

keeper. Now, if we overregulate, we're going to have a devil of a problem here.

The Vice-Chair: Thank you very much.

Ladies and gentlemen, the morning session is over. Now we are going to recess until 1 o'clock sharp.

The committee recessed from 1210 to 1303.

ONTARIO INTERDISCIPLINARY COUNCIL ON AGING AND HEALTH

The Vice-Chair: Good afternoon, ladies and gentlemen. The afternoon session just started. Now we can start with the Ontario Interdisciplinary Council on Aging and Health. You can start whenever you're ready, sir. Please, before you start, can you state your name for Hansard.

Dr. Larry Chambers: Yes, I'm Larry Chambers. I'm with the Élisabeth Bruyère Research Institute. I'm the president and vice-president for research for the SCO Health Service. I have accompanying me Judy Muzzi. She'll introduce herself.

Ms. Judy Muzzi: Thank you. I'm Judy Muzzi. I'm with OICAH, which is the Ontario Interdisciplinary Council on Aging and Health, among other committees.

The Vice-Chair: The floor is yours.

Dr. Chambers: Honourable committee members and others, thank you for giving the Ontario Interdisciplinary Council on Aging and Health, of the Council of Ontario Universities, the opportunity to present this brief to the committee today.

A coalition of representatives from universities and community colleges across Ontario—and we've attached a list of the members—the Ontario Interdisciplinary Council on Aging and Health has as its goal the enhancement of the well-being of older persons living in Ontario through education, research and service.

The Ontario Interdisciplinary Council on Aging and Health works to promote partnerships and collaboration among universities and relevant stakeholders. It also informs and advises the Council of Ontario Universities and its affiliates on interdisciplinary issues related to aging, wellness and health.

There is a substantial increase in the number of individuals entering long-term-care homes who require complex health care. In Ontario, the 600-plus long-term-care homes employ approximately 100,000 staff members to serve 70,000 frail individuals. A project conducted in 2001 by PricewaterhouseCoopers found that over three quarters, or 77%, of the residents in long-term-care homes were women whose average age was 82.1 years, and 53% had Alzheimer's disease or some other form of dementia. The most common other diagnoses were arthritis, 30%; stroke, 22%; congestive heart failure, 11%; and diabetes, 19%.

Residents with these complex illnesses have a great need for extensive health care from physicians, nurses, pharmacists, dentists and other health practitioners. A 2005 survey of the Ontario university health sciences education programs by the Ontario Interdisciplinary Council on Aging and Health found opportunities for

education in long-term-care homes lacking in the curricula of these programs. Funded education in long-term care will overcome many of the challenges of recruitment and retention of practitioners in long-term care while making the area of study attractive to students. The development of a well-trained and committed cadre of new professionals will ultimately improve the care of seniors.

As Monique Smith, parliamentary assistant, Ontario Ministry of Health and Long-Term Care, stated in her spring 2004 report entitled *Commitment to Care: A Plan for Long-Term Care in Ontario*, “The ministry should consider how to develop better expertise in the long-term-care sector including professional development, development of protocols and standards of care, and the dissemination of knowledge and best practices to front-line staff. Several suggestions were made to us in this regard including establishing centres of excellence and pilot projects that linked an academic research centre to a LTC facility. The ministry should consider the many options available for achieving these expertise goals.”

The proposed 2006 Long-Term Care Homes Act should enable selected long-term-care homes to have responsibility for the education in long-term care of physicians, nurses, pharmacists, dentists and other practitioners who are in community colleges and university health sciences programs.

One example is the Ontario Health Protection and Promotion Act of 1983, which stated in section 3 of the Ontario regulation the following:

“The minister may pay a grant to a board of health in an amount of up to 100% of the expenses incurred by a board of health in providing human and physical resources and facilities for training undergraduate and graduate students enrolled in a community college and university health science program provided that the community college and/or university enters into a written agreement with the board of health in respect of such training and the agreement is approved by the minister.”

These legislative provisions enable the Ministry of Health and Long-Term Care to provide special funding to selected public health units for the support of health sciences education for practitioners to learn public health skills.

This provision in the public health service legislation led to selected public health units becoming teaching health units. These units are now part of Ontario’s public health research, education and development program.

Another example is the 1990 Ontario Public Hospitals Act, which states in the Ontario regulation 964/90 that additional funding be provided to hospitals to offer opportunities for education of health professionals as well as classifying some hospitals as teaching sites.

Bill 140 assumes that there will be compliance with what is prescribed. However, what is prescribed may not lead to the intended and/or expected outcomes. In fact, completely different outcomes may result. Bill 140 should support the dedicated workers who are striving for excellence in their job performance. The bill should also

include that these dedicated workers are responsible for their actions and that they can continue to learn from experience without the fear of reprisal or punishment. Our experience has demonstrated that when staff are worried about being punished, they hide things, they are cautious and unlikely to change, they are overprotective, they do not say much, and their innovation and creative spirit is discouraged.

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Organizations in health care and other sectors have a long history of using positive approaches for quality assurance, risk management, resident safety, as well as research, education and development. Regular and systematic reviews by peers through the Canadian Council of Health Services Accreditation is an excellent example of a positive approach to improve the structure, process and outcomes leading to quality and safety of care provided in the long-term-care homes.

The central role of positive strategies that promote organizational leadership, innovation and creativity is summarized in the following quote from Dr. Mark Poznansky, president, scientific director and CEO of the Robarts Research Institute in London, Ontario: “Health care organizations with a long tradition of excellence”—as mentioned in Monique Smith’s report—“have demonstrated that research enhances the vitality of teaching, teaching lifts the standards of service and service opens new avenues of investigation.”

We are fortunate in Ontario to have long-term-care homes in most communities in Ontario. They are an important community resource. Bill 140 should explicitly recognize their contribution to community life. As part of the community, they must be valued for their contributions.

Positive incentives should be incorporated into Bill 140, such as incentives for volunteering as early adopters supporting an affiliation with community colleges and universities to collaborate in education, knowledge exchange, development and/or research.

Ontario should invest in building the capacity of its long-term-care homes in collaboration with universities and community colleges, as recommended in Monique Smith’s *Commitment to Care* report. The bill should include a section that ensures that there is long-term-care training in education programs that prepare new professionals as well as skills development opportunities for the continuing professional development of practitioners working in long-term-care homes.

Our recommendation to the committee for changing Bill 140 is that it should include the following section, which is worded to minimize editing in order to be inserted into the bill:

“The minister shall provide for formal agreements between long-term-care homes and universities and community colleges to jointly provide financial support for the training of health care practitioners in the care of the elderly. The Ministry of Health and Long-Term Care shall provide financial support to enable some long-term-care homes to participate in these teaching arrangements

through a funding formula outside the formula for resident care. Long-term-care homes provider and professional associations shall be invited to participate in the development and promotion of such affiliation agreements.”

Thank you for giving us the time to speak.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left, and we can divide them equally. Every party, one minute only, please. We'll start with the parliamentary assistant.

Ms. Smith: One minute only. He's getting strict with us.

I want to thank you, Dr. Chambers, for coming. Judith, it's nice to see you again as well.

Dr. Chambers, we have in fact funded some post-secondary education and other institutes in the last two years. I actually don't have the details in front of me—I've been rustling through my papers looking—but I know that there was some funding that was provided in Waterloo to Mr. Schlegel and his group in affiliation with the University of Waterloo, to Baycrest here in Toronto, and I think to your organization, to assist in the transfer of research to learning for front-line workers. Could you perhaps just extrapolate on that for us, please?

Dr. Chambers: Yes. That's an excellent initiative. It's called the Ontario Seniors Health Research Transfer Network. The idea is to link practitioners, researchers and policy makers. The main focus of that initiative is knowledge exchange. We're very thankful and pleased that the ministry has provided this, and we look forward to continuing to work on that. In addition to that, we would like to more formally have the ministry support the resources required for some of the long-term-care homes in the province to be centres of excellence, as you've described.

The Vice-Chair: Thank you very much. Mr. Yakabuski?

Mr. Yakabuski: Thank you very much for joining us today and for your presentation.

We're on record as having commended Ms. Smith for her report as well, but that's when they lost us, because the report was tabled and they haven't followed through with the recommendations in the report. I'm just wondering if you can help us on that. Where did they lose it? It seems now that they've taken the political route of trying to pit themselves against long-term-care homes in this province and make them the scapegoat for what's maybe not right. If they're not going to give them the tools to operate and provide these enhancements, how can anything but failure be the result?

Dr. Chambers: I think that Monique Smith's report was an excellent report, and it pointed to some excellent things that should be done, including the centres of excellence. We're very optimistic that what we've presented today will be looked at carefully by this committee and recommended to the government. We also are very concerned that this act is only opened up every 10 to 15 years, and it's very incumbent on this committee to take action now because we'll be stuck with this for

quite a few years after if we don't get it right this time. That's our approach, that—

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

Ms. Martel: Thank you for your participation here today. Given that Ms. Smith said what she did about potential centres of excellence in the spring of 2004, are you surprised that that recommendation didn't make its way into the bill and that we have to look at an amendment that might give life to that recommendation now?

Dr. Chambers: I'm fully appreciative of government processes. We're here today because we think it's not too late; it's in the third reading and, again, as we understand the way this process works, this committee can intervene, as you suggest, Ms. Martel, and we would be very keen to have this committee support this. We have other presentations that are being made to the committee to allude to this same initiative. It is a theme that you'll be hearing, have heard and will be hearing more of.

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

ALEXANDRA SACKS

SUE FAGAN

The Vice-Chair: The next presentation will be by Alexandra Sacks. Welcome. You can start whenever you are ready.

Ms. Alexandra Sacks: I've been given a letter by a family member from the nursing home. Can I hand it in? Can I start?

The Vice-Chair: Sure. You can start whenever you are ready.

Ms. Sacks: Good afternoon, everybody. My name is Alexandra Sacks. I'm the president of the residents' council at Leisureworld, Richmond Hill location. I have been a resident here for the past three years and president of the residents' council for the last two years.

Leisureworld Richmond Hill is home to 160 residents and employs 150 staff members. As a representative of the residents at Richmond Hill, I would like to state that we support the abuse prevention and residents' rights portion of Bill 140. However, there are other areas which we do not support, and we have concerns regarding their negative impact on care and the home environment. We would like to increase the number of baths per week from two to three. But, with the increased demands for documentation outlined in this bill, this wish will not be realized. A third bath a week would improve the quality of life for all of us, but an additional bath could only be achieved by increasing the funding for staff, especially the personal support workers. Extra personal support workers would also assist in controlling other issues faced by our dedicated staff, such as improved response time to residents' requests and needs.

This bill is going to introduce more documentation to be done by the nursing staff. This is already in place in

our home, and it is easy to see that so much time is taken up by this that the residents do not get the full amount of attention required. Therefore, when we require assistance, we will have to wait quite a while before help arrives. We need extra funding for additional staff so we get the care we deserve.

Another aspect of life that does not seem to be mentioned in this bill is food. Currently, the allotment for food funding is \$5.46 per resident per day. We, the residents, have been working diligently at this home with the dietary department to achieve the best possible menu solutions with this amount of funds. However, frustration is mounting as we, the residents, want more than basic requirements. We would like to truly enjoy our meals. Some examples: We feel it is not too much to ask for salad daily. In addition, there is insufficient fresh fruit provided for each resident per day.

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Generally, the description of food on the menu and what we actually receive is quite different. The food that's presented is often disappointing. For example, it is too cold when served, and the fish is usually too thin and dry and unappetizing. To improve our enjoyment of meals, we need to have better quality of raw food purchased and more options at mealtimes. This can be achieved through increasing the food funding per resident per day. While long-term-care residents receive \$5.46 a day for food, prison inmates receive \$7.09 for food a day. Surely, we elderly deserve more.

An idea that I would suggest is for our cabinet ministers to try the \$5.46 meals for a few days. If you're wondering why I look so well-fed, that's probably because my family supplement my meals with Swiss Chalet etc., as do many other residents' families.

Another area that needs addressing is that of physiotherapy and restorative care. In our home, we originally had three days of short physiotherapy sessions, but this was cut back recently to two days because of the lack of funding. The times of the sessions are still very short, so that not every resident has an opportunity to participate.

In general, the residents of Leisureworld Richmond Hill are very happy with the range of activities and the care provided. However, there's always room for improvement.

I understand that the Ontario Long Term Care Association has given the committee a list of changes that would benefit us, the residents. It would be much appreciated if these matters could be given your serious consideration before this bill becomes law.

The Vice-Chair: Thank you very much. I guess we have some time, about eight minutes left. We can divide it equally among the three parties. We'll start with Mr. Yakabuski, two and a half minutes.

Mr. Yakabuski: Thank you very much for joining us, Ms. Sacks. I'm looking at the letter that you've brought from Florence Matta as well. She's talking about her mother, who's an Alzheimer's patient at Leisureworld, and wondering how they're going to get enough time to get exercise and all of the care that they need.

I've visited long-term-care homes in my riding and I had the opportunity to feed some of the Alzheimer's patients. That in itself can be a challenge because they're not necessarily co-operative at that or any other time, depending upon how they're feeling that day, perhaps. I'm wondering how we're going to improve the care of seniors in this province when it seems to be the approach of the government to hit nursing homes with all kinds of new demands and standards and to talk about the penalties they're going to suffer if they don't meet those standards, but not to meet the needs of those homes with regard to the funding that is necessary.

They promised \$6,000 per resident as part of their election campaign, and so far we've seen a little over \$2,000. If one third is the goal, how are we going to improve the care, which you've clearly indicated is necessary? I think we all support the spirit and the intent of the bill. The question is, how can you support the bill—not its spirit, but how can you support the bill—when you know that it is not backed up by the necessary tools to allow the people who are there on the front lines, there on the ground, charged with the job of delivering that health care to seniors? I'm just asking if you would respond to that, please.

Ms. Sacks: Well, I'm not terribly sure what you expect me to say, other than that the government should give more funding to the long-term-care homes.

Mr. Yakabuski: Now, you're a resident—

The Vice-Chair: Thank you, Mr. Yakabuski.

Mr. Yakabuski: Are we done?

The Vice-Chair: Yes.

Mr. Yakabuski: Boy, that's quick.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you, Ms. Sacks, for taking the time to come here today to make this presentation. We appreciate it.

First, with respect to the desire to have three baths a week, in fact it was a promise made by the Liberals in the last election that there would be three baths a week. I suspect that if the government actually provided the \$6,000 per resident that they also promised, you would have the staff who would be in place to allow residents to have three baths a week. One is clearly linked to the other, and the whole issue of appropriate funding really does have a direct impact on people's care.

Let me ask you about the physiotherapy services, which you mentioned have been cut back. Is this a recent development? Do you know how many of the residents were able to access this service and have now had a reduction?

Ms. Sacks: I can't tell you the exact numbers. I just know that going around to the physiotherapy exercises and having the physiotherapist come to see us, we are all finding that there isn't enough time for everybody to participate.

Ms. Martel: So the physiotherapist came to Leisureworld three times a week and is now coming twice? Is that the situation?

Ms. Sacks: I've come with my administrator. Perhaps she can answer that question.

Ms. Martel: Is that a possibility, Chair? I know it's close to being the end of time.

The Vice-Chair: Is anybody here? Okay, you can come forward and answer the question, if you want. Come to the mike, and please state your name before you start.

Ms. Sue Fagan: It's Sue Fagan. I'm the administrator at Leisureworld Richmond Hill.

What Alex is saying is that the physiotherapists were allotted so many visits per resident, and then they had to assess the residents who actually required the physiotherapy services. Then there was a cutback, and the additional visits weren't actually brought forward. They had anticipated that and had planned out their year that way, and when it was cut back, they then had to reduce the number of residents they were seeing so that they could finish their year. So it was a reduction.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: Maybe I'll just finish up with that thought. Was your Leisureworld affiliated with one of the schedule 12 physio clinics? Were you previously affiliated with one of the clinics that were providing services?

Ms. Fagan: We are affiliated with a service, yes.

Ms. Smith: Right. I think what happened, just for the information of the members of the committee, was that there were certain homes receiving a great deal of physio care and there were homes across the province that weren't receiving any, so we've gone to a system where we're allotting a certain amount per resident in all of our homes to ensure that we have more services, although some homes did receive less service because they were receiving a lot more than others. So we've gone to a bit of an equalized system.

I do want to ask, Ms. Sacks, if I could—one of the things that we've heard about from some of the operators is the increase in paperwork that they're seeing. One of the requirements in the legislation is that if you're moved to a secure unit in the home, you're entitled to rights advice. I just wondered, as a resident, if you think that is a requirement or if that is something that you would like to see happen for the residents in the home.

Ms. Sacks: I think it would be a good thing.

Ms. Smith: Also, I know that in the legislation we've got some provisions around residents' councils and family councils. Maybe you're not familiar with all of them, but we do require residents' councils, and we're looking at supporting family councils and requiring that homes, if there's not a family council, tell family members regularly that they could have one in order to try to encourage the creation of one. Do you think that those are good initiatives that will help?

Ms. Sacks: Very good. We've got a very good family council at our home and get a lot of attendance at the residents' council meetings.

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

ADVOCACY CENTRE FOR THE ELDERLY

The Vice-Chair: The next presentation will be by the Advocacy Centre for the Elderly. You can start whenever you are ready.

Ms. Jane Meadus: Thank you. My name is Jane Meadus and I'm a lawyer with the Advocacy Centre for the Elderly. I'm the institutional advocate, which means that my job consists of representing clients who are in long-term-care homes. I'm here today with my executive director, Judith Wahl, and Pauline Rosenbaum, another lawyer who helped—we all helped write the brief which is in front of you. I just wanted to thank you for seeing us today and letting us have a few minutes to provide some information to you.

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We're generally in support of the legislation. It's too bad that the hearings have been shortened, because this is a very, very important piece of legislation. I think there are a lot of groups that are missing, and it's too bad that there's not more representation from the actual residents of the homes. I was very pleased to hear the resident we just heard from.

My comments today are going to be focused on the issue of the detention and restraint of long-term-care residents. We know that many of the speakers have not been supportive of rights in long-term-care homes with respect to admission to the secure units and restraint issues and we want to say that we're fully supportive of that. There's an appendix to your material that we've actually written, a lengthy section that we think should be put into the Health Care Consent Act, but I want to put it in terms that you can understand: people oriented.

With respect to the general restraint issue, it comes up a lot, and just so you know, about a third of the clientele at our office are from long-term care. One of the issues that we get all the time is what I call our Tim Hortons problem, which is the senior who wants to go down to the local Tim Hortons for a cup of coffee and is prevented from leaving the facility because of environmental restraints, because the facility has a policy that no resident may leave the facility without an escort, or perhaps the daughter of someone says, "Oh, I don't want her to go out. She might fall down," even though that resident is competent. It has always been our position that these environmental restraints have been illegal, but at the moment there's no way for the person to challenge that restraint, nor is there any way of the facility knowing that there's a process on how to do it properly. We have asked that any kind of restraint be included under the HCCA treatment section so that it gives a person rights under that section.

The more important issue is secure unit detention. I'm going to tell you the story of Sandy Shook. Ms. Shook is sitting here in the front row. Sandy, do you want to wave? Sandy is here today at our request. When she was 51 years old, she was placed into a locked unit in a long-term-care facility. She did not at that time meet the criteria under the Mental Health Act, so she was not held

in a secure unit in a psychiatric facility. She does suffer from a bipolar disorder, as well as physical issues, and was placed in that unit by her power of attorney for personal care. She began complaining to get out of that unit and there was no process there. It wasn't until about 2002 that she started really being able to reach out into the community. So it was from 1997 to 2002 that she was in locked units. She was told she was not allowed to leave the locked unit. She was actually being kept there by what was really her guardian of property, who had no authority to keep her there.

Once she transferred to a new facility, things got worse. They would let her out for one or two outings a week to programs that she was taking in the community, but if she wanted to go out and visit her children, who lived in the community, or go to an art show or something like that, she was prevented from doing that. She was followed if she did get out of the facility on one of her infrequent outings. She would have been followed if she was going to the store. The staff there followed her. She was basically told she wasn't allowed out. It wasn't until the end of 2004 that she was able to contact our office. She was only lucky in doing that because she actually had a phone. Most people in locked units do not have a telephone. They have to use the telephone at the front desk. Because there isn't any information, there's no understanding of the fact that these are locked units. She was actually very lucky in being able to get someone. Most people in those units can't access anyone.

If you've ever been in a locked unit in a long-term-care facility, you've had people coming up to you all the time saying, "Help me. Help me get out," and you're told just to ignore those people. There are usually signs around saying, "Do not let Mr. and Mrs. So-and-so out." There is no authority at the present time for those facilities to do that. There are lots of people in there who shouldn't be locked up. These units should be used for preventing people with dementia from wandering, but that's not what happened in our case and it's not what happened in many of our cases, in fact. These units are used sort of as a quasi mental health ward because people are being downloaded out of mental health facilities into long-term-care homes. Many of the groups that have come before you have said that having rights advice and all these sorts of protection is going to be burdensome on them and difficult to manage. But just imagine that it was you who were kept against your will. As I said, Ms. Shook was 51 years old when this happened to her.

In Canada we have the charter. We have other rules that say you cannot be detained against your will unless it's done in accordance with the law, which includes the charter. We've set that out for you in our presentation.

We think the issue of emergency beds and emergency placements is a bit of a red herring, because there's rarely a bed. Secondly, the purpose isn't to deal with these emergency situations. We do have the Mental Health Act if the person really needs to be locked up and to prevent them from harming other people. There are specific issues. You can also look at the Casa Verde Elroubi

inquest materials, the recommendations for the types of things they were dealing with and suggestions they had to deal with some of these people.

We also want to address very quickly that we've heard lots of complaints that there are going to be too many rules dealing with this legislation. We can tell you that we do get a lot of complaints from long-term care. At present there are many laws which deal with long-term care, such as the Health Care Consent Act and the Personal Health Information Protection Act. They're not being complied with but they're also not being enforced. We're hoping that this legislation will help to enforce them.

The last point that I want to make is that we're asking that there not be any exemptions from the annual inspections for this reason. There are too many variables in long-term care that change. One home can be very good one year and very poor the next year, and vice versa, so we would ask that you don't change that part of the legislation. Thank you.

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

Ms. Martel: Thank you for the presentation today and for the extensive brief for the committee members. You're quite correct that we have heard from a number of people, with respect to rights advisers, making the argument that there are emergencies, and by the time you contact a rights adviser and the adviser comes and provides advice, you may have a serious incident on your hands. There was also some suggestion that one compromise might be to set a time limit within which a rights adviser would have to provide advice to either the resident or a substitute decision-maker. I don't know what your thoughts are on the second one, some kind of time limit around the provision of that advice, or if the view really is—I haven't read the whole brief, so I apologize for that—that in all circumstances with respect to secure units, rights advisers have to be given that opportunity and there shouldn't be a limit on the time. It's as soon as they can get to it, and that's what happens.

Ms. Meadus: In fact, the brief that we have, the appendix that we put in, which is a whole new section to the Health Care Consent Act, actually deals with those kinds of emergency situations. In the mental health area, it's of course done through the Psychiatric Patient Advocate Office, whom you heard from yesterday. They're actually very quick at coming out, and it's sort of forthwith, so it's generally a very quick process. It'll obviously be a little longer because they're not going to be in-house here.

We actually put in an emergency provision in the sections we had, saying that rights advice could in fact occur after, so if it were that kind of emergency situation, you could place, and then the person could have rights advice and potentially have a hearing. Then, if it was found that they didn't need to be there or whatever, they could go back into the regular population.

The Vice-Chair: The parliamentary assistant.

Ms. Smith: I note that in your submissions there are a number of recommendations. One of them was to include in the bill of rights a right to have a friend or an advocate of her own choosing attend any meeting. Why would you be requesting that that right be included?

Ms. Meadus: This has come about through our practice. We've had many clients in many homes tell us that we are not allowed to go to meetings with our clients in the homes. This is generally where there's an issue that the person is having problems with the home. Maybe they've been making complaints, and it may be a special meeting or an annual meeting. The facility will likely have nine or 10 people—administrators, nursing assistants, nurses, doctors etc.—at the meeting and perhaps only the resident or the resident's substitute decision-maker, which can be extremely overwhelming. But they're in fact told point-blank, "You are not allowed to bring anyone to a meeting." We think that they have a right to have someone there for support, someone who may be a little bit more knowledgeable about the process and what should be occurring to help them advocate on behalf of whatever the issue is that they have.

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Ms. Smith: You also, in one of your sections, are requesting that inspectors be able to enter homes without a warrant in emergency situations. Have you ever had a situation or are you familiar with a situation where an inspector hasn't been able to enter a home?

Ms. Meadus: Not to my knowledge, but we thought that was important.

The Vice-Chair: Thank you very much. Mr. Yakabuski.

Mr. Yakabuski: Thank you very much for joining us, and thank you to Sandy for joining us as well.

You talked about patients with mental health issues being downloaded into long-term-care centres. We're seeing that patients from developmental services homes, such as Rideau Regional Centre or Huronia—that's happening right now.

I certainly support what you're talking about, that we have to protect people who are being held against their will. But when we're giving the people in long-term-care centres these kinds of additional challenges—because I think it's safe to surmise that perhaps those people with mental health issues are going to require a higher level of care than someone who does not have any. So we're giving all our health care workers in these homes more and more challenges and higher expectations with regard to the tasks that they must carry through, yet I see nothing from this government in this bill that is going to assist them from a financial point of view in making this happen.

Do you have an opinion on this bill, having looked at it not only from your own perspective but from the broad perspective of how it affects everybody, as to whether or not the laudable goal of this bill could in fact, as some people have said—that the result could be the exact

opposite, which is a reduction of the actual level of care for the most vulnerable people in our society?

Ms. Meadus: Our position is that this bill can't go ahead without additional funding. It has to have the funding to support it. As you pointed out, we're getting a different kind of clientele in the long-term-care homes. You're getting a lot more people with mental health issues, a lot of younger people, a lot of people with developmental issues. The staff have to be properly trained for that. That's very different from people who have Alzheimer's or other related dementias or are simply frail. The bill, quite frankly, I don't think will work without the funding in place. We're not supportive necessarily of certain numbers of hours or anything like that, because we want the care to be specific to the residents. But that has to go hand in hand with the appropriate funding.

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

CANADIAN AUTO WORKERS

The Vice-Chair: The next presentation will be by the Canadian Auto Workers. Welcome.

Mr. Corey Vermey: Thank you. My name is Corey Vermey. I'm presenting on behalf of the Canadian Auto Workers, and Darlene Prouse is at my side. Darlene is the elected president of the Ontario Health Care Council, representing the CAW members working in particularly long-term-care facilities but generally in the health sector.

As our submission is being passed out to the committee, I want to welcome this opportunity to consult on this very important piece of legislation. Long-term-care reform has been a long-awaited effort. It obviously requires the collaboration of all advocates for quality care for our elderly, and I know that there are certainly advocates at this table and in this room. The government is to be commended for bringing this bill forward, and we acknowledge the work of the parliamentary assistant in her efforts as well in terms of the commitment to care and the broad overview and that this legislation has many important elements that reflect the government's agenda but also sets aside other key initiatives that have had a significant impact in long-term care.

Having said that, we want to use our allotted time to press home on the policy argument in terms of a minimum staffing standard. We see a minimum staffing standard as absolutely critical to any real, meaningful reform in long-term care. We want to review it in two parts: first of all, the support for the principle of a minimum standard and, secondly, what an appropriate number would be to attach to a minimum standard for Ontario.

We certainly acknowledge that there has been considerable work making improvement in a system that had been allowed to deregulate or allow market forces to govern in terms of the care. The abandonment of the minimum staffing standard in 1995 saw care levels plummet, and as a result the Legislature, when it was

presented with a resolution in November 2002 by Lyn McLeod, supported that resolution. To quote the first page of our submission, in her concluding remarks after that debate in the Legislature, Lyn McLeod stated, “Minimum standards are not adequate quality of care. I would never argue that for one moment.” She concludes by stating, “Minimum standards are at least a way of holding a government that does not care to a very basic minimum standard.” We would certainly trust that all governments should be held to a minimum standard as basic as one in terms of the level of care to our most frail and vulnerable seniors.

More recently, the Minister of Health has indicated, in introducing this proposed bill to the Legislature, that it is the cornerstone of the government’s strategy to ensure the best possible level of care and that it is intended to make Ontario a leader. That is a challenge that we wish to join the government of the day in pursuing. We want the best possible level of care. We want Ontario to be the best amongst comparable jurisdictions. We think the most pressing means by which we reach that end is a minimum staffing standard.

The first piece, in terms of the actual drafting of the proposed legislation: We think the fundamental principle recorded in the bill at section 1 needs to be significantly revamped to reflect not just that long-term-care homes are homes—they are, indeed—or that residents are entitled to dignity, security and comfort, but that some very fundamental aspects are taking place there. One is that it is a site where skilled nursing and personal care is being provided to residents—it’s more than simply a home; few of us have those services available in our home—and, secondly, that the goal is the highest possible or practicable level of well-being for residents, that there is something beyond just comfort and security that we hold ourselves to.

Ontario has always had a minimum standard, until 1995, since the Nursing Homes Act was introduced. It has evolved over time. It started, as I understood, at 1.75 and evolved to 2.25. When it was abandoned, the results were predictable. According to Statistics Canada, the levels of care plummeted from levels generally at or above that minimum standard to levels below it, and at the same time, as we know, the acuity of residents, the provincial case mix measure, was increasing steadily and significantly. So you had the perfect storm: falling care levels, rising resident acuity. The difficulties that ensued in terms of Natalie Babineau or Casa Verde were almost predictable in that perfect storm.

Ontario continues to regulate other elements of staffing, and we show that at table 1: a range of administrator, director of nursing, registered nurse staff, the food service supervisors and handlers and various activation and therapy services, as well as a registered dietitian. So it’s not that Ontario is averse to minimum staffing standards; it’s whether there’s a broad, encompassing standard that will measure the bulk of time that is provided to residents on a daily basis for their nursing and personal care. Secondly, Ontario has con-

siderable minimum standards in other aspects of regulation in terms of the size of the bedroom, the width of a corridor, the amount of food that is daily dispensed, and in what portions, to residents.

1350

We would also emphasize again the coroner’s inquest recommendation, the jury recommendation in Casa Verde that calls specifically for minimum staffing standards.

Finally, in terms of being the best jurisdiction, we have compared Ontario to its neighbours around the Great Lakes. Of the eight US states around the Great Lakes, as we show on table 2, all but New York state have a minimum staffing standard. All have, in consequence, average hours per resident per day well in excess of three—the lowest is 3.3 hours per day and the high is 3.9, specifically in Ohio and Pennsylvania. These are states with significant populations in nursing home facilities. The last column is their ranking in terms of 50 states, where they rank in terms of their population within a nursing home facility. So they are very telling comparators. Just as a side note, only one of those states has a 24/7 RN staffing standard, but all but one have other regulation directed to direct care and registered nursing staffing.

So the operators that are for-profit and operate south of the border, like Extencicare—roughly 75% of its operations are in Ohio and Pennsylvania—know this regime well. They know how to operate their business with a minimum staffing standard. It doesn’t behoove them to come to Ontario and say, “We cannot live with a minimum staffing standard,” when their operations in the US do.

Similarly, we’re cognizant of the fact that in Ontario municipal homes for the aged, municipalities are subsidizing the levels of care, have maintained their hours of care consciously. But it shouldn’t be the wealth of one’s community that determines the level of care for residents in Ontario. It should be a provincial obligation to ensure that across Ontario residents are provided at least a minimum standard.

We also want to speak to the research in regard to the evidence in terms of continuity of care and the quality of care. Obviously, the envelope system in Ontario has leakage. Only \$4.17 of a \$6.33 per diem increase flowed to staffing salary and wage costs. Other portions flowed elsewhere. The envelope system, in and of itself, will not necessarily be a dollar-for-dollar means by which we can increase staffing levels. There will always be some offsets there.

At the same time, we also want to note that particularly for-profit operators instantaneously seem to wish to readjust their staffing levels when CMM and CMI results are known to them. After the release in December, Extencicare, in one facility, immediately corresponded with our union and said, “Our CMI has just dropped from 100.77 to 99.88”—less than a 1% decrease—“and we’re going to therefore give you notice that layoffs and reduction in hours are necessary.” At the same time, they

were aware that the provincial CMM increased by 3.15, an offset more than sufficient for their 1% decline. But the staffing levels are adjusted that quickly and that specifically to resident acuity fluctuation.

The last pieces I wish to speak to are simply that a minimum staffing level will ensure that the risk to health and safety of residents and the care providers, the workers, is reduced. There is considerable evidence in that regard in terms of injury rates, infection etc.

Finally, it is about accountability. We appreciate that it has a significant element of funding, but it is about accountability of government and providers to the residents and to the public in Ontario that they are committed to and providing quality care.

Ms. Darlene Prouse: We would also like to see that we achieve that minimum nursing staffing standard averaging 3.5 hours. We submit that the fundamental purpose of reinstating a minimum staffing standard is to ensure the level of care provided each individual in a long-term-care home does not place the resident at risk of poor care outcomes. While every staffing standard is expressed as a quantity or a number to have operational relevance, the standard ought to be inherently dynamic and variable based on resident acuity. The staffing standard must be an aggregate measure, a reflection or composite of numerous individual care requirements or needs such that it provides a minimum guarantee that each individual resident will receive not less than the minimum standard in care on average over the relevant reporting period. To be relevant, the minimum must be expressed relative to the case mix index.

Some of the averages in other comparable jurisdictions are:

—3.7 hours was the average in all certified nursing home facilities in the US in 2005;

—3.63 hours was the average nursing hours per day in eight neighbouring states bordering the Great Lakes with Ontario in 2005, ranging from 3.3 to 3.9.

The 1995 Nursing and Personal Care Provider Study—over a decade ago—found, prior to the elimination of the minimum staffing standard, that long-term-care residents were receiving about 140 minutes, or 2.33 hours per day, including indirect, non-nursing time, or about 21 minutes of direct care on an average shift. This study was intended to empirically develop the resource-use weights for the new levels of care categories being implemented under the CMI system.

The subsequent 2001 study reported staffing levels in Ontario at 2.04 hours per day and highlighted the existence of considerably higher average staffing levels in other, presumably comparable, jurisdictions—other Canadian provinces, US states or countries. The study noted that 34 of 50 states in the US in 2003 had average nursing staff hours per day in nursing home facilities of 3.5 hours or more, and all 50 states were providing for greater than three hours. At the same time, the report noted that Ontario ranked higher on measures of resident acuity or assessed needs than many of these same jurisdictions.

The 2001 report to Congress identified distinct minimum staffing standards: an absolute minimum staffing threshold of 2.95 hours per day applicable to all residents and a preferred minimum staffing standard of 3.45 hours per day, subject to resident case mix or acuity. The absolute minimum is a threshold below which the association with quality problems was compelling; it placed residents at considerable risk of poor-quality outcomes. The latter standard of 3.45 hours was cited as the preferred minimum level at or above which residents were not at increased risk—

The Vice-Chair: You have one minute left.

Mr. Vermey: We've also provided detail in terms of the jurisdictions where we can obtain information on their current staffing levels or their targets for the Ministries of Health in those jurisdictions. You'll see that Alberta is similar to Ontario—the Auditor General's reports on the system, an obvious flashpoint—and have committed now to fund at 3.6. In Manitoba the actual is at 3.3. New Brunswick, after the election there, is moving to 3.5 on a funding level; this is not a minimum standard but a funding level. Nova Scotia is at 3.25.

What's compelling is that the role of long-term care is evolving at all times. We know that Alzheimer's and other forms of dementia are a higher percentage of the population. We know that palliative care is increasingly important in long-term care. There have been a number of studies of palliative care in Ontario facilities. Directors of nursing have been surveyed; care providers have been surveyed. They conclude that staffing is inadequate. They had a particularly poignant quote from a respondent: "We've barely enough staff to provide care for the living.... We don't have the staff to provide the proper care for the dying."

Certainly in the last year, months, days of life, we as a province must do the best we can possibly do for these residents. Nursing homes are increasingly sites that must have adequate palliative care for residents.

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

1400

ONTARIO NURSES' ASSOCIATION

The Vice-Chair: Now we move to our next presentation, the Ontario Nurses' Association. They can come forward if they are ready. Welcome.

Ms. Linda Haslam-Stroud: Hi. Thank you.

The Vice-Chair: I guess you know the procedure. You've been here many different times, so it is familiar.

Ms. Haslam-Stroud: Yes, and I've met you many times here too.

The Vice-Chair: I would ask you, if you don't mind, to state the names of your colleagues.

Ms. Haslam-Stroud: Yes, I will. Good afternoon. My name is Linda Haslam-Stroud. I am a registered nurse and I'm president of the Ontario Nurses' Association, ONA. With me today are Bev Mathers and Lawrence

Walter, two of my colleagues who work very closely with long-term-care nurses in Ontario.

I am speaking on behalf of 52,000 front-line registered nurses and allied health professionals whom we represent. Those also include registered practical nurses, PSWs and social workers. All of these members deliver care to Ontarians. Included in those are 3,000 registered nurses in long-term-care facilities.

ONA has been advocating for an improved long-term-care system for many years. Our submission has a number of recommendations. The only one I'm going to speak of today is in relation to minimum staffing levels. I know it seems to be a new topic and you haven't heard anything about it in the last two days. That will be my priority.

The other two priorities that I just wanted to point out to you that I'm not speaking of are whistle-blowing protection for workers and also the transparency in the inspection process.

I'm going to now move to the whole issue of minimum staffing standards.

We made 52 recommendations that were adopted by the April 2005 coroner's jury for the homicide at Casa Verde nursing home.

A key coroner recommendation directed the government to fund staffing standards in nursing homes. More than a year later, the Ministry of Health and Long-Term Care has yet to implement these important staffing measures that we believe would prevent a similar tragedy.

Many of the residents in long-term care are in need of complex nursing care, and you've heard that. I was trying to relate it to my nursing life. In 1977, I was a nurse at St. Joe's hospital in Hamilton as a new graduate. The complex patients we took care of—the elderly in the hospitals—are no longer there, generally; they are now in long-term-care facilities. That's when we talk about the acuity and complexity. That role for the caregivers in Ontario has transferred over to these very long-term-care facilities that we're talking about today. Our members continually tell me that our long-term-care residents require the broader assessment skill set that registered nurses bring because of that type of acuity. Those are both physical assessments and also from the cognitive care perspective.

Bill 140, however, is missing key elements that are essential to safe long-term-care home environments. Today, we comment on the need for evidence-based staffing standards and levels of resident care. While the focus of Bill 140 is on resident safety, we also believe that safety and working conditions are equally important for us to actually provide that quality care.

ONA believes the government should also be concerned about recruitment and retention issues in long-term care, particularly in light of the coming wave of RN retirements. While ONA recognizes that the government has invested more funding in long-term care, we believe that enhanced transparency and accountability are needed to ensure that public funding is properly targeted for resident care.

And at the same time, the care needs of residents living in long-term-care facilities in Ontario have increased. Their conditions have become less stable and more complex, as I was speaking about just a few minutes ago. Nursing and personal care staffing, however, haven't kept up with those increases in resident acuity, in part, we believe, because of the elimination of minimum staffing standards. I believe that was in 1996 under the previous government.

Bill 140 does not reinstate minimum hours of care that residents will receive, and we believe there are no assurances then that our residents will receive the level of care they need. There is no fundamental principle clearly setting out that residents have the right to access the care they need. There is not even a statutory requirement that the long-term-care home have sufficient staff to meet its statutory obligations.

This omission is very perplexing to us as nurses across Ontario because the government is well aware of recommendations from Casa Verde. Three key recommendations in that inquest actually related to establishing minimum standards and levels of care. Recommendation 28 directed the Ministry of Health and Long-Term Care to have an evidence-based study conducted to determine appropriate staffing levels for Ontario, given the significant number of Ontario residents with cognitive impairment and complex care. That was a key priority.

Recommendation 30 directed the Ministry of Health to set out standards, based on study findings, to ensure that residents are given appropriate nursing and other staff care hours. I'm sure you've been told this already but I would like to identify it to you again: There is no requirement in Bill 140 for an evidence-based study to determine the hours of care for residents with different acuity levels.

Another recommendation in the Casa Verde inquest—it was number 29—actually directed the ministry in the interim when this report came out, pending this evidence-based study that I've mentioned, to fund and increase staffing levels to no less than 0.59 RN hours per resident per day. That may be different from some of the previous submissions that you've heard in relation to total hours. This inquest actually looked at the issue of RNs and identified 0.59 RN hours per resident per day and 3.06 hours of nursing and personal care per resident per day overall.

The government has stated that some residents in long-term care do not require the coroner's recommended interim minimum staffing, but to date, we haven't really seen the evidence to support that assertion, so we'd be interested in having some more discussion on that. On the contrary, we believe that there is evidence from other jurisdictions in Canada that are moving to higher levels of staffing and care for residents; I think some of the previous speakers have highlighted some. I'll point out two, Manitoba and Saskatchewan. They provide over three hours of care per resident per day. In Alberta, they have funded paid hours of care per resident at 3.6 hours

per day. Another one is New Brunswick, which is moving to 3.5 hours of care by 2008.

In the United States, 16 experts have reviewed previous studies on staffing for quality of care, and they have concluded that to improve the quality of care of nursing home residents, staffing levels should be increased to 4.55 hours per resident per day, including 1.15 RN hours per resident per day. In Ontario, by comparison, the Ontario Long Term Care Association reports that its members' homes provide on average 2.5 to 2.6 hours per resident per day, although I understand the government is indicating that it is slightly higher than that.

No matter whether it's 2.5 or slightly higher, that is not enough to provide the quality care that our residents deserve. And given the increased acuity levels, much higher care levels per resident per day are required. Moreover, the proportion of total care provided by RNs is actually decreasing.

The 2004 Provincial Auditor's report also made two staffing recommendations to the ministry. The first one was to track staff-to-resident ratios, the number of registered nursing hours per resident and the mix of registered to non-registered nursing staff, and to determine whether the levels of care provided are meeting the needs of our residents. The second recommendation from the auditor's report was to develop appropriate staffing standards for long-term-care facilities.

Clearly, the auditor was concerned that in order to meet resident care needs, the Ministry of Health had to determine whether the needs were being met and then to adopt appropriate levels. Bill 140 will not improve the levels of care that residents receive on a daily basis unless this bill mandates staffing standards and levels of care.

Therefore, we are recommending—no surprise—that Bill 140 be amended to reinstate minimum staffing standards of 3.5 hours, including 0.68 RN hours. That would bring Ontario in line with staffing standards in other jurisdictions. The number of hours for RN care and other staff could be determined by regulation. In addition, the government must implement the coroner's recommendation for the evidence-based study that I referred to to determine the appropriate levels.

I want to conclude by talking about RN care. The requirement in subsection 7(3) to have at least one RN on duty and present in the home at all times, although an excellent principle, does not actually guarantee residents will have a greater amount of RN care. It does not guarantee that each resident will be assessed by an RN. It does not guarantee that each resident will even be given the smallest amount of RN care. The only way to guarantee resident hours of care is to set and to fund minimum hours of care, including minimum standards for the RN component.

I want to talk a little bit about the assessments that we do with our residents in long-term care, assessments of the resident's functional capacity and behaviour. Section 41 provides that assessments can be carried out by

professionals other than physicians or registered nurses, and this has caused us some concern. If the initial assessments of residents coming into long-term care are not carried out by the highly skilled professionals we have before us, we are concerned that we are then not being proactive in trying to prevent further illness of our elderly. At the end of the day, if we proactively assessed our residents with the highest skill level that we have available to us in our homes, we actually could be saving the health care system money by preventing readmissions to acute care facilities and increased complexities of diseases that could have been prevented.

1410

In relation to the initial assessments of residents, we would support adding to the proviso regarding the residents' assessments to ensure that situations like the Casa Verde never happen again. Therefore, we recommend initial resident assessments and the ongoing assessments are conducted by RNs. I've explained to you why I believe that's a proactive measure for health and for the financial stability of the system.

In summary, residents of long-term care receive their care from a great component of skilled front-line workers. However, we believe that this bill has chosen to ignore the care requirements of residents by failing to include evidence-based or even interim minimum standards for staffing and levels of care in Bill 140. We believe this is the fatal flaw in the bill and it must be addressed.

As I mentioned, we have provided 38 other recommendations for amendments to the bill in our submission. We, as the nurses of Ontario and the allied health professionals of Ontario, who work each and every day with our elderly residents of Ontario, request that these recommendations be given serious consideration by your committee so that our residents in long-term care will receive the care they deserve. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left, which we can divide equally among the three parties. We'll start with the parliamentary assistant. You have one minute.

Ms. Smith: On your assessment requirement, under subsections 41(4) and (5), we require that the original assessment of the physical and mental health of the applicant be done by a physician or a registered nurse, and that,

“An assessment of the applicant's,

“i. functional capacity,

“ii. requirements for personal care,

“iii. current behaviour, and

“iv. behaviour during the year...” be done by an employee or agent of the placement coordinator, who is more than likely a nurse, because the placement coordinator is usually through the CCAC—sorry, we also require that it be a nurse or a social worker. Are you saying that you don't think social workers or doctors should be involved in the assessment of these residents prior to their placement?

Ms. Haslam-Stroud: The fact is that physicians aren't usually part of the component of that initial assessment that we're filling out. Social workers have a broad base of knowledge, certainly with the cognitively impaired component of the elderly, but they do not have that higher-level-of-assessment critical thinking skills in relation to the physical assessment of these patients. So our proposal regarding RNs is very specific to the fact that we, as RNs, hold both those components of assessment skills.

The Vice-Chair: Thank you very much.

Ms. Smith: Can I just ask one more? The 0.59 RN: Is that "RN" as in "RPN"?

Ms. Haslam-Stroud: No. That's "registered nurse."

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

Mrs. Witmer: Thank you very much, Linda. It's very interesting, when presentations have been made, to hear that the Americans seem to be allowing for a greater number of hours of care than we currently are doing in Ontario. That was held up to us yesterday and today.

But I want to ask a question about the issue of abuse. If someone is found guilty of abusing a resident, there's been some concern expressed about the individual being reinstated. We've been asked to include an amendment that an individual, an employee, found guilty of abuse not be reinstated and not be allowed to work in that long-term-care home again. What would be your position on that issue?

Ms. Haslam-Stroud: Since we do represent the majority of registered nurses, we're under the college standards. So the reality is that if we are not registered with the college because of a separate regulatory body removing our registration, we wouldn't even be in the capacity, I don't believe, Mrs. Witmer, to actually provide the care because we would not have our licence. That, of course, is up to the regulatory body.

Mrs. Witmer: That's right. So once it's gone, you wouldn't qualify to work in that home again.

Ms. Haslam-Stroud: As a registered nurse, no.

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

Ms. Martel: Thank you for your presentation today, and for ONA's participation at Casa Verde during the whole inquest. It was very important.

I've been focusing on minimum standards and the need to reinstate them, especially given the government's promise during the last election to reinstate them. I think it should be 3.5 because of increased acuity. From your perspective, even though you've provided lots of evidence of other jurisdictions, just on a practical level, why do you have to have something regulated, why do you have to have something legislated, in this case in order to meet the needs of these residents?

Ms. Haslam-Stroud: When we look at where the money is invested in long-term care—and there are some different pots that have to be reimbursed to the government if they are not spent. But the reality is that with the financial challenges, we believe, of long-term-care homes, as the complexity of the resident increases, the money is being stretched. We as the front-line

caregivers, and, frankly, the registered nurses and patient advocates, know that when we go into that facility, we are not even providing the basic quality that these residents deserve. So if it's down to the point where we're fighting about where the dollars are going to go, if the employers and the facilities have a mandate to meet those standards of care—and that was in my speech—we can give them the capacity to have a framework to work from. Otherwise, if you look at all the facilities across the province, it's all over the map.

The Vice-Chair: Thank you for your presentation.

Ms. Haslam-Stroud: Thank you.

CARP, CANADA'S ASSOCIATION FOR THE FIFTY-PLUS

The Vice-Chair: The next presentation will be by CARP, Canada's Association for the Fifty-Plus. Welcome back. You can start whenever you are ready.

Mr. Bill Gleberzon: I want to thank the committee for this opportunity to make a presentation. Rather than describe CARP, I'll just say we represent consumers, families, children, spouses etc., and that's the point of view we're bringing in our presentation. In general, we congratulate the Ministry of Health for producing a comprehensive and integrated act. Obviously, a great deal of thought has gone into developing Bill 140. In particular, CARP lauds its primary and principal focus on resident-centred care in long-term-care homes.

CARP has heard from some that the act may be overly prescriptive and leans towards micromanagement by the government. However, we do not find that to be the case in our reading of the bill. Moreover, given the particular vulnerability of the seniors who inhabit long-term-care homes, the breadth and depth of the bill is a very good thing. Having said that, we have some concerns, and you've heard some of them from other organizations that have made presentations.

Adequate additional funding must be forthcoming from the ministry in order to enable long-term-care homes to comply with all the directives in the bill; for example, if hiring more staff for this purpose is necessary.

You've heard quite a bit about hours of daily care, and we want to add our voice to that issue. We applaud the ministry for increasing the hours of daily care from 2.25 to 2.5. However, 2.5 hours is still below the standard of daily care in other provinces of 3 to 3.5 hours. So we urge the ministry to phase in additional hours of care, from 2.5 hours to 3 hours to 3.5 hours and more, where needed, beginning immediately, and completely implement it within a year.

Personal hygiene: There's no reference to personal hygiene in the care and services section. While the new policy that mandates two baths per week is an increase of 100% over the previous policy, that is still not adequate hygiene, particularly for people who are incontinent. Those with incontinence problems should receive as many baths, or at least sponge baths, per week as they

require in order to maintain their comfort and dignity. We recognize that providing more baths may necessitate more staff. Well, if that's the case, then so be it.

The well-being of the residents must be the paramount consideration. In addition, the bill should be amended to include the provision of dental care for residents.

All long-term-care homes must provide foot care, through podiatrists, for residents as needed. As you know, many older people have particular problems with their feet.

1420

Subsection 10(2) states, "Every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied." However, we are concerned that allocating just over \$5 per day per resident for food seems inadequate to meet this directive, even with the most frugal bulk buying; in fact, it's about \$2 less per day than the amount allocated for those who are incarcerated in jails and prisons. Even taking into account the difference in caloric intake between the two groups, a review of the adequacy of funding to meet the nutritional needs of residents is required.

Nor does the bill take into account the fact that Ontario has two primary seasons, one that requires heat and the other that necessitates air conditioning. Also, long-term-care homes must be prepared for the climate change that is occurring in Ontario, across Canada and the world. Bill 140 does not mandate that air conditioning must be available in each long-term-care home to service the health and comfort needs of residents and staff. We think that is an oversight that should be rectified.

Sections 67, 156 and 177 impose personal liability on all members of the board of directors of a home if they are found guilty of failing to ensure that their long-term-care home meets all the requirements of the act. In such cases, each director, individually and collectively, could face heavy fines up to \$50,000 and 12 months in jail. This personal accountability could prevent individuals from volunteering to serve on boards. CARP recommends that the ministry provide sufficient funding for each long-term-care home to enable the purchase of adequate officers' and directors' liability insurance. Just in passing, I point out that this is a concern in any kind of volunteer agency. It's something that the province should be looking at regardless of what that agency is.

Subsection 74(6) talks about training for all staff, particularly direct care staff. We think that training must include geriatrics, because they must know at least the basics about the people they're serving.

There is a dire need to address the shortage of staff, as you've heard from the other presenters, in long-term-care homes—in fact, in the health care system generally—and in particular, direct care staff in long-term-care homes. Although we're not talking about home care, the same is true about personal service workers.

CARP recommends that the Ministry of Health and Long-Term Care, in collaboration with the Ministry of Education, establish special grants to pay for the cost of

the high standard education in post-secondary institutions for those individuals who want to train in this profession. Our experience is—and we hear from a lot of people who are direct care workers or professional service workers—that they pay on their own for the training, and then they find, if they do get jobs, that the jobs are inadequate in relation to the amount they pay.

Finally, there are some endorsements that CARP would like to make. We support the Ontario branch of the Canadian Legion's recommendation that the ministry establish an arm's-length ombudsman to whom seniors and their families can turn in regard to long-term-care issues in general, including long-term-care homes. It is very important that such a position be established and that that position be absolutely independent, perhaps responsible directly to the Legislature to ensure that independence.

CARP also endorses all of the observations and recommendations expressed in the Advocacy Centre for the Elderly, ACE, response to Bill 140. That document is attached. I know you heard from ACE earlier this afternoon, so there's no need, and I had no intention, to go through it, which is why we give it a blanket endorsement. We urge that the items in the ACE submission be given serious attention and be implemented by the ministry.

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

Mrs. Witmer: Thank you very much for your presentation. You always do a great job, Bill, on behalf of the people you represent in the province.

You spoke about the air conditioning, and that was one of the issues that was brought to my attention over the course of the summer, the fact that it was an unusually hot summer and that's likely to continue. But currently, there's no obligation to ensure that the residents are comfortable in their rooms as far as temperature. I hope the government will take into consideration the need to consider adding some sort of amendment that will reflect that concern, because it was a big, big issue over the course of the summer.

Mr. Gleberzon: We know the predictions are that this summer is going to be worse.

Mrs. Witmer: Is it going to be worse?

Mr. Gleberzon: That's what I've heard.

Mrs. Witmer: Well, that's maybe good news. But anyway, we thank you for all the work you've done.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you for being here today. It's nice to see you again. I want to just focus on your endorsements, the first one with respect to Royal Canadian Legion, Ontario command, and their call for an ombudsman. The government has tried to put forward the notion that this Office of the Long-Term Care Homes Resident and Family Adviser is going to do the trick here. The Legion certainly doesn't seem to think so. I wonder if you have any views that you want to share as to whether

or not an adviser who essentially is not independent is going to be what is required so that families have comfort that their complaints are being investigated properly and that they are getting some redress for the concerns that they're raising.

Mr. Gleberzon: Our experience with ombudsmen—ombudspersons, whatever—with some exceptions, is that generally they become the defenders of the institution they work for and often try to deflect the complaints that are being raised. That's why the issue you've raised, the fact that what's being suggested in the bill would not be an independent office, is one that has to be reviewed very seriously. We think that an independent ombudsman is the way to go. We think the Legion is absolutely correct in that regard, because the office will be totally independent, beholden to no one other than those people who come forward with their complaints and concerns.

Ms. Martel: So if the current Ombudsman had his mandate expanded to include oversight, would that suit your purpose too?

Mr. Gleberzon: Sure it would, because the current Ombudsman is one of the exceptions that I talked about.

The Vice-Chair: The parliamentary assistant?

Ms. Smith: I want to address some of your concerns. With respect to the reference to personal hygiene, the bill of rights does require that the person's needs are met. If you look at section 4, I think you'll see it there. In the plan of care in sections 6(3) and 6(4) and again in section 7 we talk about nursing and personal care needs being addressed. So I think your concerns will be addressed through those sections and those requirements in the legislation.

On the air conditioning, the irony of Mrs. Witmer's position today is just too much for me to bear, given that under her regime they set the building standards for 20,000 new beds across the province and didn't include the requirement for air conditioning. So for her to say now that over the last summer she's become aware of a concern about air conditioning is just way too much for me to handle.

Obviously, we have concerns about the building standards that were set by the previous government as well as the build that they did, in some cases, in a lot of the wrong places, and we're trying to address that through the tools that we're providing in the legislation. So I do hear you on the air conditioning and I just wanted to draw to Mrs. Witmer's attention that she did have the opportunity to address that.

On your concern about personal liabilities for directors, we do hear that.

With respect to training, we do have a list of provisions on what kind of training we expect and we do have the ability in regulation to add to that list. So I will take that.

Do I have one more second? Look at him; he's looking at me badly here.

On your issue with respect to the ombudsman, just a quick question: For the most part, the generic role of ombudsmen is to investigate an issue that has already

taken place. We've had different submissions on people wanting advocacy, wanting assistance with the system and wanting investigation of issues. Do you see the role that you envision being an investigative role, an advocacy role or one of assistance to seniors who are trying to manage the system?

Mr. Gleberzon: All of the above. If we take the example of Mr. Marin's study on realty tax, he covered the whole waterfront in all those three areas. To me, that's the kind of model that we would be looking at.

Can I just make some other points? In regard to hygiene, we think it's necessary to have a specific item or clause on the issue of hygiene. I agree that they can be covered under those areas.

The Vice-Chair: Thank you very much for your presentation. We went a couple of minutes over the time.

1430

FAMILY COUNCIL NETWORK FOUR

The Vice-Chair: Now we move to Family Council Network Four. Welcome, sir. You can start any time you are ready.

Mr. Robert Gadsby: Good afternoon. My name is Robert Gadsby. I am chair of a local family council in Hamilton but I come to you this afternoon in my role as chair of Family Council Network Four. The handout will provide you with my remarks today.

Family Council Network Four represents the family councils, which are all volunteers, from the 87 long-term-care homes, comprising about 10,000 beds, in the Hamilton Niagara Haldimand Brant region, the region which is also referred to as local health integration network 4.

Our goal is to support local family councils as we strive to make a difference to improve the physical, emotional and social well-being of residents in the homes. Our focus is on our loved ones—family and friends—who often cannot speak for themselves.

We have received input from family councils both inside and outside of our region. This is a consolidation of key issues and concerns regarding Bill 140, which we hope will help the committee with its public hearings and reviews.

Residents of our long-term-care homes include senior citizens who have made a major contribution to what we have in Ontario today and veterans who have fought for our freedom. They deserve a homelike environment where there is respect, dignity and quality of life.

We applaud the government for its initiative in Bill 140 to: enshrine the Residents' Bill of Rights; encourage the formation of family councils in all long-term-care homes; ensure that all long-term-care homes provide high standards of care.

Our major concern is not with what Bill 140 says, but rather with what it doesn't say. The following is a summary of key issues and concerns.

On the preamble to Bill 140, this is a description of beliefs, goals and objectives that are excellent. However,

it is not clear how these good intentions are reflected in the bill itself. For example, the terms “quality of life,” “homelike environment” and “resident-centred care” appear only once in the bill, and that is in the preamble. By contrast, the term “quality of life” appears over 20 times in the earlier report by Monique Smith, *Commitment to Care: A Plan for Long-Term Care in Ontario*. We are concerned that the bill does not address some of the key commitments necessary to help to improve the quality of life for our loved ones in long-term-care homes.

Regarding hands-on personal care time, we had expected to find a commitment to more time for hands-on personal care in the bill. Ontario remains well below many other jurisdictions in the amount of personal care provided to residents. Bill 140 does not stipulate minimum staffing levels or minimum hours of care.

We have a great deal of respect for staff members, but there is a chronic shortage of staff in our long-term-care homes. The increased number of residents with dementia or serious disabilities means that front-line staff are stretched to the limit simply to meet the day-to-day needs of all residents. Despite the best efforts of staff, and even with volunteers and families pitching in, residents are often only receiving the barest essentials of care. For those who have dementia or need one-on-one attention, some families have had to resort to hiring a health care aide from an outside agency to help feed and care for their loved ones. This situation does not reflect a suitable quality of life and it results in an institutional rather than a homelike environment.

We look forward to the government providing the funding and staffing commitments to permit at least 3.5 hours of hands-on personal care per resident per day.

Regarding training and standards, we endorse the requirements for adequate staff training and for high standards of care in all long-term-care homes. We expect the government to provide adequate funding and staffing commitments to ensure that the training needs can be met without any loss of hands-on personal care.

Regarding the use of temporary, casual or agency staff, we support the goal of ensuring that our loved ones, particularly those who are suffering from dementia, experience continuity and consistency in their care. However, we are concerned that by limiting temporary, casual or agency staff, there may be times when this results in short-handed shifts. In an ideal world, we would like to see the same staff caring for our family members day after day. However in the real world, we know that having an adequate number of staff is far more important than striving for consistency.

Regarding meeting long-term-care needs in the local community, we are concerned that seniors need to have access to long-term-care homes which are close to their local communities so that their families can visit easily, often via public transit. We are also concerned with the uncertainty that has been created regarding the future of some older long-term-care homes. In many communities, these long-term-care homes are the only facilities

currently available. Family members are worried that these homes may not be available or that their loved ones may be moved to other homes, where it will be much more difficult for them to visit.

There needs to be a defined program to assess and establish future needs for long-term care within local communities, but there is no reference to this process in the bill. Once our loved ones become residents, there needs to be sufficient staff and funding for outings, recreational and social activities, which will help maintain their links to the local community.

Regarding equality and access to services, we expect the government to help ensure that accommodations with modern standards of comfort and dignity are available for all long-term-care residents, now and in the future. For example, semi-private rooms with wheelchair-accessible washrooms should be the minimum standard. In Manitoba, there are currently only 63 four-bed rooms in the entire province. Ontario has thousands. Funding for capital renewal is needed to help bring accommodations for all residents up to modern standards now, not in 10 years' time.

Regarding funding, we are concerned that the bill does not indicate how the government will fulfill its election promise to “invest in better nursing home care, providing an additional \$6,000 in care for every resident.” Regarding food, we are concerned that the funding provided to long-term-care homes for raw food is only \$5.46 per resident per day. We had expected to find a commitment to improve the funding in the bill or in the government's budget.

Regarding family councils, we are pleased that Bill 140 provides a mandate for family councils. We recognize that while it is difficult to make a volunteer organization mandatory, all long-term-care homes should be strongly encouraged to have a family council.

We welcome the opportunity for “a person who lives in the community where the long-term-care home is located” to become a member of the family council. We would note that the individual must also be interested in making a positive contribution to the activities of the family council.

Regarding quality of life, quality of life includes ensuring that there is adequate staffing and funding available for recreational and social activities, physiotherapy and restorative care, counselling and special needs. The support of a social worker is also an important element to help not only the resident, but also the family. It is not appropriate for a long-term-care home to be placed in a position where it must depend on the efforts of family members and the community to pick up the slack in order to meet the needs of residents.

We look for the government to make the funding and staffing commitments that are necessary to truly achieve the objectives referenced in the preamble to the bill: “preserving and promoting quality accommodation that provides a safe, comfortable, homelike environment and supports a high quality of life for all residents of long-term-care homes.”

I'm sure that all member of the committee share the goal of ensuring that our loved ones in long-term-care homes enjoy a high quality of life. I thank you for your attention.

1440

The Vice-Chair: Thank you very much for your presentation. We have three minutes left. We can start with Ms. Martel. You have one minute.

Ms. Martel: I apologize that I was out of the room for part of your presentation. I'd want to start with the last thing that you had to say, which is that "We look for the government to make the funding and staffing commitments necessary to achieve the objectives..." I think that is key. The government promised \$6,000 per resident in enhanced funding; they're at about \$2,000. If they actually met their commitment, you probably would be able to have the staff necessary to implement 3.5 hours of hands-on care per day, as an average. So we will see what will happen there.

Generally speaking, in your work and in your colleagues' work, what are the top concerns that you see as family members with respect to your loved ones in the homes that you're representing?

Mr. Gadsby: We're looking at their day-to-day attention, and so the front-line workers are really important to facilitating the needs of our family members and friends; in addition, recreation, to make sure that people in the homes feel that they are still part of the community and it's a homelike environment. I'm fortunate with the home I'm associated with, but not all family councils are in a similar position, where residents have the opportunity for recreational outings and social activities.

The Vice-Chair: The parliamentary assistant, one minute.

Ms. Smith: I want to thank you, Mr. Gadsby. It's nice to see you. I know I was supposed to see you in October. I'm coming next month, so I look forward to it. I appreciate the great work that you're doing in your family council network in the Hamilton area.

I just want to address a couple of things that you raised. When you talked about the quality of life, home-like environment, resident-centred, I think if you look through again, in our section 6 on "Plan of care" we talk a lot about a resident-focused plan of care and ensuring that the resident and their family or substitute decision-maker understand the plan of care, making sure that everyone who's involved in the care of that resident is involved in setting up that plan. So we really do try and make the care for the resident resident-focused. As well, with the presence of the residents' council and the family council, we try to include the broader family of that resident in the life of the home.

I appreciate your comments on the staffing. On the limiting of agency staff, obviously we're going to ensure that they're only used when necessary, but we will always make sure that we have the amount of staff that's needed.

You talked about the needs for activities. I know that you're familiar with the activity coordinators and the fact

that we funded their program last year. They're developing a best practices manual across the province which we hope will be implemented in all of our homes. In the legislation, we do mandate that there be activity programs for our residents in our homes, as well as a volunteer program, which is not intended to pick up the slack but is intended to increase community in the home.

The Vice-Chair: Thank you.

Ms. Smith: Sorry, we could go on.

The Vice-Chair: I know you can go on.

Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I certainly appreciate it. You've given us some good insight into what family councils feel are important for residents. I guess, despite what we hear from the government, the reality is that we could be providing more hands-on care and more time with the residents if the government would live up to the promise it made to provide an additional \$6,000 per resident. They have not lived up to that promise; they've only delivered about \$2,000.

As a result, I'm just seeing now, for the first time, the fact that people are having to hire these health care aides. I'd not heard about it before, but recently I've been in to a couple of homes. That concerns me because, again, it's two-tier. If you can afford to hire someone, then obviously your loved one has that additional staff support, but we should be ensuring that the government live up to the obligation, invest the money per resident for additional care, and we wouldn't be in that state.

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

YEE HONG CENTRE FOR GERIATRIC CARE

The Vice-Chair: The next presentation will be by the Yee Hong Centre for Geriatric Care. Welcome, sir. You can start whenever you're ready.

Dr. Joseph Wong: Thank you very much for this opportunity to address you. I am Dr. Joseph Wong. I'm the founder and chairman of the Yee Hong foundation and also the Yee Hong Centre. Florence is the CEO. We are very, very glad to be here to, first of all, let you know that we are very glad about many of the initiatives which are being proposed in Bill 140. There are a number of focuses that have not been given due consideration, and for the Yee Hong Centre, this is our most important task.

The Yee Hong Centre was first built in 1994. For seven years before that, we were actively lobbying the government and soliciting help from the government to establish a home that is sensitive to the different cultural and language needs of the residents of the GTA and also of Ontario.

As many of you know, Ontario is home to many immigrants. In the recent past, 30 to 40 years, most immigrants have come from Third World countries—over 70% as a matter of fact—and most of them came to Ontario, in particular to the GTA. More than 51% of

Toronto's population was born outside of Canada. In particular, many are from Asia—China, India and south-east Asia—and have now claimed Toronto as their home. In this regard, I'm very glad that in the preamble of Bill 140 you did address that it is important for long-term care homes to pay particular attention to the cultural and language needs of various residents.

But let me give you my example, the reason why Yee Hong was set up in the very first place. Let us not just pay lip service to the cultural and language needs of these long-term-care residents. Let me tell you my own experience with working in nursing homes in downtown Toronto when I was a resident at Toronto Western Hospital.

A number of years ago, back in 1978, I encountered a lot of Chinese seniors in different nursing homes in downtown Toronto. Of course, I was told various horror stories. Many of these were not due to inattention on the part of the nursing home but were actually due to barriers because of language and culture. They were not getting appropriate services from those homes because of unfamiliarity and also because people were not able to understand them fully. Their physical needs and emotional needs were not met.

Many of the Chinese residents who I met through these homes asked me, "Dr. Wong, can you help me kill myself?" That is the kind of life that they led. They really could not tolerate life without anyone understanding them. They were not able to express very simple life needs, such as going to the washroom, a headache or whatever, and did not get proper attention from the staff because of the language and cultural barriers.

So I started dreaming of Yee Hong and also planning for Yee Hong beginning in 1987. The first home was established in 1994. Subsequently, in the last 10 to 12 years, we further expanded the original centre and also built three more new centres, not only for Canadians of Chinese decent but we also dedicated many beds to different communities. For example, we have a floor of 50 beds dedicated to Canadians of south Asian decent in our Markham home; in Mississauga Centre, we have a wing of 25 beds dedicated to serving Canadians of Filipino origin; and in our new Scarborough home, we have one wing of 25 beds also dedicated to serving Canadians of Japanese decent. In that way, we really are able to deliver culturally and language-appropriate services.

Now, this is very important as it's different from a hospital, in which anyone would say at the end of their stay, whether it be 10 days or 30 days, "I will be able to get the hell out of here." But in a nursing home, you just cannot. You have to spend the rest of your life there. The barriers in culture and language really make them feel so much more isolated. They are very frustrated and they don't see the light at the end of the tunnel. That is why they prefer death rather than living.

At the Yee Hong Centre, our experience has been extremely positive. In the last several years that we have been serving not only Chinese but also different seniors

from different communities, life has been very positive and life has been worth living again. With the initiatives in Bill 140, I believe that every home will improve. But on the other hand, I don't think that you have put appropriate time and effort into making sure that our homes offer language- and culture-appropriate services to these residents. So this is number one, the most important thing that we want you to address today.

1450

Number two, for those of us who organize a centre for seniors, not only an isolated nursing home but actually a geriatric care centre for seniors offering them comprehensive services in a continuum-of-care fashion, taking care of the healthy to the very frail and many in between—and in housing, which is next to the nursing home. We have a lot of people who have to depend on supportive housing services in order to be independent, in order to continue to live in their own dwelling, in their own units. They find a lot of freedom and a lot of independence and dignity living that way. There's no reason why this could not continue. We are actually saving the government a lot of money because we are delaying these people from entering nursing homes on a premature basis. Even if they are rightful candidates for the nursing homes, because of our effort, because of our supportive services, they are able to continue to live there without applying for nursing home accommodation.

So this is really a win-win situation: Win because they are able to lead a better life in our housing units and win for the government, win for the public because they are not using so much public money in this regard. On the other hand, when they really need it, at the end of the day, when they reach the road that services, no matter how good at home, would not be able to deliver such professional—and also, some services are only able to be delivered in nursing homes. So in this regard, they really need to go into a nursing home, but we penalize them by asking them to go to a different nursing home than the one we established next door. This was the very original idea why we needed to establish a centre: so that we could give them a choice of going into a housing unit. And then when they need it, they could go into Yee Hong just next door, under the same roof, as a matter of fact. This is the reason why we ask you to consider giving centres such as Yee Hong, established for the mere purpose that these people can continue to live in Yee Hong even though they do not need nursing home accommodation at a particular time—at the end of the day, they might need it and they might be given a priority or some sort of choice to go into Yee Hong at the time when they need it. So these are the two extremely important points that I want to address today. I would like to ask Florence Wong, my CEO at the centre, to give you specific recommendations.

Ms. Florence Wong: Thank you, Dr. Wong. In our written deputation we have listed nine areas in which we really applaud the government in this bill. Because of time, I'm not going to go over them. As well, we do share in two general concerns expressed by other depu-

tants to this public hearing. Again, because of time I'm not going to go over that, but instead, we will focus on aspects of the bill pertaining to ensuring continued availability of culturally and linguistically appropriate services in the long-term-care sector.

Dr. Wong has gone into a lot of detail about giving priority to seniors in the continuum. I'm not going to repeat that, but I would like to continue with our four other suggestions. The first one is respecting cultural, ethnic and linguistic diversities in the bill itself. The bill in its preamble talks about respecting diversity in communities, but in setting out the fundamental principles, it seems to have lost what is available in the long-term nursing home act right now referring to the cultural and spiritual needs of each resident being adequately met. So we recommend that this wording from the nursing home act be put back into Bill 140.

Our second recommendation pertains to the "how" in delivering long-term-care services. Subsection 6(4) of the bill listed all the services that are to be provided, including medical, nursing, personal care, dietary etc. However, it missed the essential point of how these services have to be provided in order to meet the residents' ethnocultural and linguistic needs.

We therefore recommend that the bill make explicit that operators of long-term-care should demonstrate cultural, ethnic and linguistic sensitivities in planning and delivering long-term care. We believe that this is very important in ensuring the quality of life of these residents.

Our fourth recommendation pertains to, when the minister considers whether to grant a licence, to renew a licence or withdraw licences in certain areas, that he consider the capacity locally and in other places as well as funding. However, we strongly feel that long-term-care homes that meet specific cultural and linguistic needs of residents typically serve seniors from many geographical areas that cross political and LHIN boundaries, Yee Hong being one of them. It is therefore very essential, in determining whether to grant or withdraw licences for culturally specific long-term-care services, to consider population needs beyond the specific local area, and to make explicit that the cultural and linguistic needs in the area and other areas be considered in granting and withdrawing licences.

Our fifth and last recommendation pertains to who is entitled to be a member of the family council. In fact, we are presenting this on behalf of the family council of the Yee Hong McNicoll long-term-care home. The family council expressed grave concern about the provision that a person who lives in the community where the long-term-care home is located can be a member of a family council. Our family council feels strongly that an outsider—someone who just lives in the community—may not have the same knowledge and vested interest as a family member or a person of importance to the residents or a former resident. They feel that if expert advice is required, they would rather develop an expert panel for a specific purpose. They really want us to request the gov-

ernment to remove the provision for a person who is not a family member or person of importance to a resident or former resident to be a member of the family council.

Once again, we want to applaud the government for its commitment to improving resident care through Bill 140. We sincerely believe that the recommendations that we make would make the bill even stronger in ensuring the continued availability of culturally appropriate care in the long-term-care sector. Thank you.

The Vice-Chair: Thank you very much. We have one minute left. I guess we won't open the floor for questions. We're going to move on to the next presentation, which will be—

Mrs. Witmer: Mr. Chair, I'd just like to thank Dr. Wong and Ms. Wong for being here.

I think you've done a tremendous job in providing culturally and language-sensitive homes for the people in this community, and I applaud you for your efforts, and also in educating us. I know that I appreciated meetings that I had with you. We need to look to the future, because it's going to be equally important; in fact, perhaps more so.

Ms. Smith: Just because it's a rare occasion that Mrs. Witmer and I are agreeing these days, I do want to join with her—and I'm sure Ms. Martel does as well—in thanking you both. I've had the privilege of visiting two Yee Hong centres. You're doing a great job. Thank you so much for coming today.

The Vice-Chair: Ms. Martel, since everybody spoke, go ahead.

Ms. Martel: Thank you for being here today. I've seen you before on other pieces of legislation as well. You take a very acute interest in health care issues, and we appreciate that.

The Vice-Chair: Thank you very much.

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CANADIAN PENSIONERS CONCERNED, ONTARIO DIVISION

The Vice-Chair: The next presentation will be by Canadian Pensioners Concerned, Ontario division.

Ms. Christine Mounstevan: Thank you. My name is Christine Mounstevan. I am president of Canadian Pensioners Concerned, Ontario division. To my right is Gerda Kaegi, who is a past president and now standing board member.

We are grateful to the members of the standing committee for giving us time to make a presentation to you on this proposed legislation.

Canadian Pensioners Concerned Inc. was founded in 1969. It is a national and provincial voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

We are grateful and particularly pleased that the government has taken the time to research and review the evidence that has been accumulating that there is a need for new legislation dealing with this complex area of

health and social policy. We commend you for the effort you have made to consult widely and to listen to what we have heard. We are very supportive of most of what is included in Bill 140 but believe that there is room for some improvements.

We have five overarching themes that inform our brief: (1) the primacy of non-profit—which includes public sector homes—provision of care in the Ontario health care system; (2) the need to give explicit and precise recognition to the ethnocultural needs of Ontarians in this legislation; (3) the critical importance of protection for the residents of long-term-care homes; (4) the need for training for all those providing services in the system of long-term-care homes; and (5) the need for long-term sustainable funding that will ensure that the excellent objectives of the legislation can and will be carried out.

Our detailed brief follows the order of topics found in the bill; however, for the purposes of our presentation we will focus on the five themes noted above.

(1) The primacy of non-profit provision of care: Section 95 refers to the balance between for-profit and non-profit provision, and we believe that this is inadequate. As in the discussions over the act creating the LHINs, many people argued for the primacy of the non-profit sector—and won. We are also concerned about the one-sided handling of the transfer of beds, section 103.

(2) The need to give explicit and precise recognition to the ethnocultural needs of Ontarians in this legislation: The absence of explicit requirements to meet the ethnocultural needs of Ontarians is striking. We have provided recommendations in a number of areas where this must be addressed, such as the residents' bill of rights and training programs.

(3) The critical importance of protection for the residents of long-term-care homes: Too many cases over too many years have brought the public's attention to the vulnerability of people living in long-term-care homes. We strongly support the actions taken by the government in this legislation to ensure protection for residents, but we believe that more can be done. Some examples are the use of more definitions in the interpretation section; the number of registered nurses; minimizing of restraints; inspections and enforcement; and training requirements.

(4) The need for training for all those providing services in the system of long-term-care homes: We commend the government for recognizing the importance of training for all those working for and with residents in long-term-care homes. However, we argue that more can be done, and there is a need for clarification of the requirements found in the bill. Some examples of what we have looked at are the standards and programs of training and the requirement for training in the ethnocultural needs of residents, the elimination of abuse and neglect.

(5) The need for long-term sustainable funding that will ensure that the excellent objectives of the legislation can and will be carried out: We realize that levels of funding are not part of this legislation, nor can they be. However, we are deeply concerned that unless the

funding is stable and adequate to carry out the excellent intentions of this bill, the system will fail and the people of Ontario will have lost an important opportunity to protect the lives of their vulnerable citizens. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have a lot of time—about eight minutes left. We're going to divide it equally between the parties. We'll start with the parliamentary assistants. Ms. Smith.

Ms. Smith: I appreciate what you had to say. I'm sorry, I was following along with you and then flipped forward to see some of the particulars that you were looking for around definitions. When you talked about the importance of protection of residents and that there was more work to be done, aside from the definitions of "abuse" and "restraints," I was interested in what more you thought could be done around minimizing the use of the restraints and our sections on inspection and enforcement. Are there specific areas that you feel could be strengthened?

Ms. Gerda Kaegi: Yes. Let me deal with compliance and enforcement. We're really pleased with the fact that you're going to have unannounced inspections. When I was on the advisory committee of what was then the Metro Homes for the Aged, we knew weeks in advance before the inspectors were coming in, so they were really a farce. At the time we were pleased, but still—we're delighted, but we believe there should be no exceptions at all in this area, so we have problems with that.

The minimizing of restraints: Unless there is clear definition of the meaning of "restraints" and the range of restraints that can be used, we are concerned because there are now examples of people who are "restrained" from leaving a home who are perfectly capable of leaving a home, but it's somehow not defined as being restrained from leaving a home. We're concerned that that kind of legal definition be spelled out. We refer to the expertise that the Advocacy Centre for the Elderly would have around something like that.

Ms. Smith: One of the suggestions that had been made around the exception for annual inspections was a way of recognizing the good homes that, for three or four years or whatever number we come up with, have had no unmet standards. They would then be given a gold star and exempted from an annual inspection the following year—with the proviso, of course, that if there is any report or any issue that arises, obviously an inspector would be in to review that immediately, just as they would with any other incident in any other home. I take it from what you're saying that you don't agree with that type of recognition.

Ms. Kaegi: No, we don't.

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

Mrs. Witmer: Thank you very much for your presentation. You've emphasized in number (5) that despite the fact that this bill is well intentioned—and it certainly is; there are certainly many good points made within the bill—unless there is stable funding provided to carry out some of the additional tasks and some of the additional requirements, it's not going to lead to improved quality

of life for the people in the system. I hope that the government, who did make a commitment almost three and a half years ago to provide the additional \$6,000 per resident for care, will follow through on that, because if that money was needed three and a half years ago, with the additional requirements in this bill and the additional paperwork, it is going to become even more necessary.

I do appreciate that you've also indicated the need to recognize the ethnocultural needs of Ontarians in the legislation. I think if we take a look at who's living in the province of Ontario today, that's going to become much more significant in the future than it even is today. I certainly do appreciate the input you've provided.

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

Ms. Martel: Thank you for your participation here today. I want to focus on section 103 in the bill. You said on page 2 of your brief that you are concerned about the one-sided handling of the transfer of beds. That section of course refers to the ability of the director to transfer a bed under a licence. I'm assuming you want some broader consultation or a committee or something that has more input.

Ms. Kaegi: Yes, we would like more input. We also believe that that section reflects primarily on the non-profit side. If you are looking at non-profit beds—they are community-based, they come from the community, public tax dollars and so on—we believe that if necessary, if beds have to be transferred, those particular beds should go back into the ministry to then come back to another non-profit facility. We don't believe that there should be a transfer from the non-profit sector of beds, as necessitated by perhaps a closing of beds in the facility, to the for-profit sector.

Ms. Martel: In terms of a closure, okay; just a bit about that: The director is not required to provide reasons for deciding whether or not to issue a new licence.

Ms. Kaegi: We believe that they should provide reasons.

Ms. Martel: And that should be public.

Ms. Kaegi: Everything should be public and there should be reasonable grounds, I mean an appeal route, for the decision of the director. But, ultimately, every bit of documentation must be in the public domain.

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

BAYCREST GERIATRIC HEALTH CARE SYSTEM

The Vice-Chair: Now we'll move to the Baycrest Geriatric Health Care System. Welcome to the standing committee on social policy. Before you start, please state your name.

Mr. Stephen Herbert: Dans quelle langue? Is English preferable?

The Vice-Chair: Yes, as long as we don't have interpreters.

Interjection.

The Vice-Chair: We do have interpreters.

Mr. Herbert: Good afternoon. My name is Stephen Herbert. I am president and chief executive officer of the Baycrest Geriatric Health Care System.

On behalf of Baycrest and its clients, families, staff and board of directors, thank you for this opportunity to speak to you about Bill 140. I'd like to introduce three people who have accompanied me and help us stay connected to the needs of long-term-care residents and families whom Baycrest serves. On my right is Irma Singer, chair of the Baycrest residents' council. On my left is Gail Kaufman, chair of the Baycrest family advisory council. On my far right is Paula Schipper, counsel. Today, Irma and Gail have asked me to outline the comments of the council on their behalf. They're here to make sure I get it right and also to respond to any of your questions. Needless to say, Baycrest heartily supports the insightful comments of its residents and family advisory councils. They know what they're doing.

By way of background, the Baycrest Geriatric Health Care System is an academic health centre affiliated with the University of Toronto. It is a charity that provides a range of health services for seniors, including independent living, assisted living, supportive housing, a rehab and complex continuing care hospital, community services, research and, last but not least, the Apotex Centre, Jewish Home for the Aged. The Apotex Centre is a 472-bed, long-term care facility currently comprising 372 approved home-for-the-aged beds and 100 licensed nursing home beds.

Baycrest applauds the government's decision to combine homes for the aged and nursing home regulation under one statute. It makes sense for all long-term-care homes to be licensed under one regulatory scheme.

Bill 140 goes further than a licensing scheme. It establishes rules to control the use of restraints on residents, to prevent abuse, to set an appeal mechanism for admission to secure units, to have annual satisfaction surveys and family councils, and to require that employees, volunteers and contractors undergo criminal screening and prescriptive training. All of these are laudable measures. They are designed to protect residents of long-term-care homes and also ensure their voices are heard. We support that. The care of the elderly is why we are all here today and what Baycrest is about.

But it cannot go unsaid that the measures proposed by Bill 140 come with a price tag—all regulation does—and we are afraid. We're afraid that no additional funding to implement and sustain these changes may compromise the ability of long-term-care homes to do their essential tasks: to provide the care and supervision that long-term-care residents need. We're concerned for Baycrest and, frankly, we have no idea how smaller homes will cope. We will be submitting several proposed amendments in writing. I'd like to highlight some issues for you now and explain why some parts, not all, of Bill 140 are problematic.

Research shows that seniors' health is impacted positively when they reside in a culturally sensitive environ-

ment. For seniors of the Apotex Centre, Jewish Home for the Aged, this means providing kosher food, programming of a Jewish nature, including spiritual support, and providing special support to our residents and their families who survived the horrors of the Holocaust. Approximately 50% of the Apotex residents are survivors. Baycrest is one of the only organizations the Jewish community can turn to for a culturally sensitive environment. The cost of this is approximately \$500,000 in operating costs annually for the Apotex. Other non-profit organizations such as Yee Hong and Villa Colombo also provide culturally sensitive care and service which ultimately benefits the welfare of residents. I believe it contributes positively to their quality of life. The legislation should promote the provision of culturally sensitive care and service and help support it through appropriate funding.

We support the recognition of family councils under Bill 140. Baycrest's family advisory council has existed for 15 years, and before that, for many years, floor councils. We believe that this has made a valuable contribution and is essential to our ability to provide client family-centred care.

Both the family and residents' councils do not believe that a substitute decision-maker should have the right to sit on a residents' council, as allowed under subsection 54(2). Their experience is that while at times families and residents share the same concerns, most often their issues are different. Irma has told us that our residents' council is worried that families sitting on the residents' council may influence the direction of the council. You might think that our family advisory council would support a substitute decision-maker sitting on the resident's council as well as on the family advisory council. They do not. In their words, "Families can dominate the discussions and the resident's voice may not be given fair weighting against the family perspective if the membership exists" as written.

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Under subsections 56(1) and 59(2), a long-term-care home shall appoint residents' and family advisory council assistants who are acceptable to the councils to assist them. In our experience, each of these have been Baycrest employees, as the duties can be time-consuming and require people familiar with the home's operations. It is inappropriate for an employee to take instruction from the residents' or family council. The assistant's role is more about bridge-building; the assistants act as liaisons between the licensee and the councils and report back to the councils. Baycrest supports its family council's submission, which provides as follows:

"We assume the assistant will be an employee of the long-term-care facility and thus cannot function as a completely neutral individual. We are also concerned that no new funding will be added to support this role within the ... facility; a council assistant should not be hired at the expense of programming or some other aspect of residents' care. The Baycrest model has worked quite well if the person is able to act as a liaison between the

two parties. Bringing information and issues back and forth from the two groups has been a significant role of our liaisons to the residents' and family councils at Baycrest. We believe that this proposed reporting may set up an adversarial role between the councils and the long-term-care administrative staff."

Under subsection 23(5), the government's director for long-term care may receive information about the operation of a long-term-care home and decide not to send an inspector. Instead, the director may refer the matter to, among others, the residents' council or family council.

Baycrest's family advisory council has advised us that they do not want to be positioned as an adversary to Baycrest under the legislation. Furthermore, residents' and family councils are not equipped to do investigations, as would be the case with an inspector. This is an ombudsperson or government role. In the words of the family advisory council, "As highly functioning as Baycrest's councils may be, we are not equipped to mediate or serve an inspection role. Smaller long-term-care homes would be even more challenged in this role."

I'd like to mention one other proposal that our family council feels strongly about. Currently, there is an expectation that a long-term-care bed must be given up after a 21-day medical leave. This can be extended for a further 30 days, but only if the resident pays a bed-holding fee on top of the regular charges. This is in regulation. Many residents on reduced co-payment do not have the means to pay the bed-holding fee. The council feels that this regulation does not recognize the importance for a person to return to their previous environment following a hospitalization. This could be accommodated by giving these individuals priority on the waiting list, which they lose now, or by offering more flexibility if the person's medical leave is longer than 21 days and the person is ready to return shortly thereafter.

Regarding the mandate for policies on zero tolerance of abuse under Bill 140, Baycrest, of course, believes abuse or neglect of residents is intolerable. "Zero tolerance" is a buzzword that refers to an admirable principle. The reality, however, is that labour proceedings often require an employer to maintain an employee in his or her position notwithstanding that some abusive or neglectful behaviour on the employee's part has occurred. If not amended, this provision means that Baycrest and other homes may eventually be put in breach of their own policy and the Long-Term Care Homes Act, despite their every effort. We strongly advise that either the rule of zero tolerance be modified or, if abuse is truly not to be tolerated, that arbitrators at labour proceedings be prohibited from reinstating an employee where there has been a finding of abuse.

Subsection 43(1) governs rights advice and the appeal process for residents being admitted or transferred to a secure unit in the home. The bill defines a secure unit as "a part of a long-term care home that residents are prevented from leaving."

The Vice-Chair: You have three minutes left.

Mr. Herbert: What I miss will be sent in to you.

The Vice-Chair: No problem.

Mr. Herbert: In Baycrest's Apotex Centre, over 75% of residents are in units that are locked unless a button or keypad is pressed. Although such secure units by definition prevent residents from leaving, they are neither sufficiently secure nor adequate for the care of very difficult-to-manage residents. Care for such residents requires a greater number of employees and extra equipment, like helmets and door posies, than the funding by government currently enables. However, homes are funded for secure units no differently than regular units. If having secure units as defined under the bill means that long-term-care facilities such as Baycrest will be targeted to receive more difficult-to-manage clients, then we are very concerned about risks to our residents and staff.

While it might be appropriate for such locks on unit entrances to be considered a restraint for purposes of section 30 and to trigger rights advice and an appeal, subject to reasonable limits, a truly secure unit must have much more than a locking device on a unit entrance. It needs a higher staff-to-resident ratio, adequate training and funding for specialized equipment.

We are concerned about the potential number of Consent and Capacity Board hearings this provision could trigger. Such proceedings, while designed to be expedient, are often time-consuming and take staff away from the care of other residents. They could also slow the flow of admissions from hospitals and the community to long-term-care homes. The waiting times for people occupying alternative levels of care in acute care hospitals will increase. With regard to transfers within the long-term-care home, already stretched staff resources will be necessary to give rights advice, unless an outside agency will be given this task in regulation, and to appear on behalf of the long-term-care home as a party at hearings.

There are several staffing requirements under the bill.

How am I doing?

The Vice-Chair: Half a minute.

Mr. Herbert: I'll just finish this one point, then.

The first enables the government to limit by regulation the number of temporary, casual or agency staff a home may use. For continuity of care, we agree that permanent staff is optimal for residents. However, temporary or casual staff will always be necessary to fill in for permanent part- and full-time staff who are entitled to have vacation, leaves and the like.

Maybe I should stop there and just see if there are any questions. We'll forward the rest to you.

The Vice-Chair: There's no more time for questions. As you mentioned, please send us your presentation and we'll send it to all the committee members.

Mr. Herbert: Yes, we will.

The Vice-Chair: Thank you for your presentation.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Vice-Chair: The next presentation will be by the Ontario Dental Hygienists' Association. Welcome. You can start whenever you are ready.

Ms. Margaret Carter: Thank you. My name is Margaret Carter. We are here today representing the Ontario Dental Hygienists' Association, known as the ODHA. I am the executive director of the association. With me here is Margaret Detlor, a dental hygienist practising primarily in long-term care in the Kincardine area and currently serving as vice-president of the association.

ODHA is the voluntary professional association representing Ontario's registered dental hygienists, one of the health professions regulated under the RHPA, or the Regulated Health Professions Act. Dental hygienists are highly skilled in helping clients to attain and maintain optimal oral health.

On behalf of our entire membership, we are pleased to be here today to provide our comments regarding Bill 140.

As a whole, the ODHA supports in principle the intent behind Bill 140. Consolidation and improving the regulatory framework for Ontario's long-term-care homes is a laudable goal. There are sections, however, that we have serious concerns about and urge you to consider amending.

As members of the oral health care team, dental hygienists are responsible for client-centred professional treatment that helps to prevent periodontal or gum disease and dental caries or cavities. They provide a process of care that involves assessing the oral condition; planning treatment according to individual, community or population needs; implementing the treatment plan; and evaluating the success of the treatment and planning for the future.

Dental hygienists also focus on disease prevention. Clinical research has established a strong link between oral health and overall health. For example, did you know that some heart surgeries are delayed or cancelled because the patient needs to have his or her teeth scaled or cleaned before surgery to reduce the risk of post-operative infection, or that diabetics who keep their mouths clean and healthy require less insulin? Since diabetes can lead to complications with vision, kidney function, neuropathy, wound healing, cardiac function, cerebrovascular and peripheral vascular problems, good oral health helps reduce the risk of further complications.

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Did you know that bacterial respiratory infections may be caused by the aspiration of bacteria from the mouth and throat into the lungs? When these bacteria reach the lower respiratory tract, they may cause infection or worsen pre-existing lung conditions.

Dental hygienists do more than just remove plaque and floss teeth. They contribute in a large part to their

clients' overall health through the prevention of oral disease and the promotion of oral health care.

Today's seniors are keeping their natural teeth far longer than seniors of the past. After committing a significant number of resources to their teeth and oral health, it is unfortunate that many residents in long-term-care homes in Ontario find their oral condition declining rapidly once they have been admitted to a home. Part of this is likely due to the private funding aspect of oral health care and is compounded by a significant misunderstanding of the relationship between oral health and overall health. In many situations this misunderstanding could be alleviated by an explanation provided by a member of the oral health care team.

ODHA believes that one of the most fundamental personal care tasks is oral care. It is very clear from the reports we have received from our members that residents in long-term-care homes seldom receive basic oral health care assistance, let alone the twice-daily assistance mandated by the province.

Too many residents in long-term-care homes are suffering from rampant decay and periodontal disease. Excessive plaque left on the teeth day after day causes decay and periodontal disease. In addition, over time, as disease in the mouth increases, teeth are lost, nutrition declines and the individual's overall health and ability to fight disease declines and the burden on the health care system increases.

We have heard of situations where a resident had not had her dentures removed since admission because no one was familiar enough with the oral cavity to even recognize that her teeth were false and removable, and unfortunately the outcome was catastrophic. We have also heard of oral cancers that are undetected; of residents who have not been able to consume solid or semi-solid food for months who are back to eating solids after having a diseased tooth or teeth removed; that residents considered by staff to be uncooperative and violent became co-operative and friendly after having a diseased tooth or teeth removed and the pain relieved; residents whose partial dentures are loose due to decay and disease in the teeth required to support the dentures such that there are numerous abrasions and lesions in the mouth, often causing significant pain. We have also heard that staff in long-term-care homes report that a resident's general health improved once an oral health care routine and services had been established in the home.

If long-term-care homes are used as a measure of other areas of assisted living, then there is significant work to be done in educating all health care workers about the importance of oral health and the mechanics of assisting in daily oral health care.

Staff in long-term-care homes should be required to have standardized basic oral health education to enable them to assist clients with their oral health care and twice-daily routine, to understand that there are connections between oral health and overall health, to recognize when to seek assistance from dental hygienists and other oral health care professionals, and to understand the

role of, and request assistance from, dental hygienists in establishing oral health regimens.

With specific reference to Bill 140, oral health and oral hygiene should be explicitly included in the references to health care services and plans, and programs of care. Of particular note is the reference to a plan of care in subsection 6(4).

An admission oral health assessment should be performed by either a dental hygienist or a dentist and the results of this assessment should then be incorporated into the resident's initial and subsequent plans of care.

The program of personal support services referenced in subsection 7(2) should specifically include oral hygiene. Prescribed duties of the director of nursing in sections 69 and 70 should include oral health care co-ordination.

With respect to the provisions in section 22 of Bill 140, ODHA is concerned that there is no definition of "neglect" and yet there is a requirement to report it. In addition, the use of the words "improper treatment" is very subjective without a definition. "Abuse" is carefully defined by the legislation and yet "neglect" and "improper treatment," which have the same statutory mandatory reporting provisions, are not.

If improper treatment is captured by the concepts of malpractice, incompetence and incapacity on behalf of a practitioner, then the Regulated Health Professions Act has a well-articulated and well-established process for dealing with such matters. It needs to be clear that for regulated health professionals, the RHPA takes precedence over Bill 140; otherwise there may be some dispute or jurisdictional challenges, with the effect that the practitioner is not called to account.

The complaints process within Bill 140 provides for an alternative route for dealing with complaints such that the behaviour may never be brought to the attention of the regulatory college. In addition, in some situations, allegations may be very specific to the profession, making it all the more important that these issues be addressed by the regulatory colleges that have the expertise, experience and processes already in place. It is our view that any allegation of misconduct, including abuse, malpractice, or incapacity by a regulated health professional, must be referred to the regulatory college of the professional in question.

ODHA supports mandatory reporting of abuse, incompetence and incapacity, as such individuals should be removed from practice, allowing for due process, of course, as soon as possible and in the public interest. However, professional misconduct should not be included in the mandatory reporting requirements for the following reasons.

The definitions of professional misconduct or improper treatment may vary considerably among the regulatory colleges, and this requirement would essentially mean that a practitioner would have to be familiar with all of the professional misconduct provisions, including, for example, record-keeping and advertising. Unlike most incompetence and incapacity concerns, some

professional misconduct can be quite trivial in nature. Requiring interprofessional reporting of all professional misconduct will likely result in widespread non-compliance. The requirement will also likely be a great deterrent to interprofessional collaboration and practice. There may be an overwhelming number of frivolous, vexatious and retaliatory reports in the guise of "I have to report you." And the broadness of the reporting requirement demeans and trivializes the mandatory reporting requirements generally.

There may well be a place for generic professional misconduct provisions that are applicable for all health care practitioners that could be prescribed for the purposes of mandatory reporting, and such provisions should include situations where there is an obvious potential for harm or injury.

We do appreciate the opportunity to speak to you today. We are grateful that the government is willing to listen and work together with stakeholders and service providers seeking input and advice. We would be happy to take any questions that you have should there be time.

The Vice-Chair: Thank you very much. I guess we have three minutes left. We divide them equally among the three parties. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation today. Let me go to your recommendation that oral health be included in the plan of care that is listed in subsection 6(4), which would mean that the home would also be responsible for the costs associated with that, either a dental hygienist or a dentist coming into the home to do that for each client, correct?

Ms. Carter: I would suggest that would be a factor that would have to be included in it, and I think that's probably part of why oral health care is not recognized as part of overall health care.

Ms. Martel: All right. There's a cost there, but it's one that should be looked at and then a decision made. I think it's important enough that that should actually be considered and should be included as part of overall care.

I'm not sure that I clearly understood your concerns, however, around the manner of reporting. We would need, I gather, an amendment that would clearly say that the RHPA would take precedence over any other aspect of this bill with respect to reporting of abuse and neglect. You'd like to see that?

Ms. Carter: I think anything that triggered an allegation of incapacity, incompetence or malpractice should be referred to the regulatory college of the professional involved.

The Vice-Chair: Thank you very much. Parliamentary assistant.

Ms. Smith: Just to follow up on that question, with respect to improper care, your suggestion would be that it should be reported to the college and not reported within the home.

Ms. Carter: I still think there are provisions that it can be reported within the home, but our concern is that it doesn't go further than that. We do want to make sure that the public is protected by the processes that are

incorporated in the RHPA which deal with the professionals themselves.

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Ms. Smith: Right. But you, as a professional in the college, have a requirement to report inappropriate treatment or malpractice, for lack of another term. That's independent of the requirements that are in this legislation. Is there anything in this legislation that suggests to you that this legislation would supersede your college requirement to report?

Ms. Carter: I think wherever there are two pieces of legislation that have the same sort of outcome, i.e., there's a complaint being processed, there's always the potential for challenges of jurisdiction. I think that the one thing we don't want is to see someone not be held to account for their lack of care or a problem.

Ms. Smith: I'll sneak one more in. In the plan of care question that you've raised, you talk about the need for an initial assessment and that the dental or oral hygiene be included in the daily plan of care for the resident. So the role for the hygienist or the dentist would be to do that initial assessment. Do you foresee another role or a requirement that we have the hygienist coming into the home in any other—I'm trying to figure out how much money this could cost, so I'm just trying to find out, as part of that plan of care, do you foresee a hygienist or the dentist requiring further visits, further assessments, or is that on a case-by-case basis?

Ms. Margaret Detlor: It is on a case-by-case basis. However, as a dental hygienist working in long-term care, if I were able to be a part of that initial assessment and be a part of the care for that entire person, as opposed to just that one little portion, their health would be improved by adding dental hygiene into it.

The Vice-Chair: Mrs. Witmer.

Mrs. Witmer: Thank you very much, Margaret, for your presentation. I think you've raised a good point: Thus far, the whole issue of providing oral health care to the people in the long-term residence has been overlooked, and I think it's becoming much more important that it be included as we move to the future. So I appreciate the recommendations that you make here.

I think the whole issue of the fact that there's going to be some duplication with the Bill 140 reporting and also the Regulated Health Professions Act obligations is something that the government needs to take a look at, because I would agree with you: It does take precedence over Bill 140 and there are issues that obviously more appropriately should be dealt with by the professional body. So I would even ask, Mr. Chair, for the people to do a little bit of research and just share with us, what is the intent of Bill 140 when it comes to complaints that would normally be dealt with by the professional college? There seems to be some conflict here. If we could maybe get some understanding—

The Vice-Chair: Are you asking the research department to do this stuff? Can you give specific questions?

Mrs. Witmer: Yes. I'd like to know what is going to happen in accordance with Bill 140 when a health

professional has an allegation, if there's an allegation. What's the possible conflict with the RHPA? Because it is supposed to take precedence, and I think we need to be very clear on who looks after what. I think it is an issue. We had the nurses here today and they just assumed, I think, that the college would take precedence. I asked them about the whole issue of abuse and they said, "Once action was taken, obviously the individual would probably lose their licence and not be allowed to return to the long-term-care home." So I think we need to take a look at that.

The Vice-Chair: Okay, the researchers are going to do their best to find out—

Mrs. Witmer: Okay. We need some clarification as to what's meant by Bill 140 and what the normal role of the RHPA would be, because normally the precedents would be there in that legislation.

The Vice-Chair: Mrs. Witmer, I guess the researcher is going to do their best in conjunction with the ministry staff, the legal department, so we'll see what's going to happen. When they get that information, it will be shared between all the parties.

Mrs. Witmer: All the parties, yes. Thank you.

The Vice-Chair: Thank you for your presentation.

ONTARIO FEDERATION OF LABOUR

The Vice-Chair: We now move to our next presentation. It will be by the Ontario Federation of Labour. Welcome. You can start whenever you are ready. Please, before you start, state your name. You've been here many different times, so you know the procedure.

Ms. Terry Downey: Thank you. Good afternoon. My name is Terry Downey. I'm the executive vice-president at the Ontario Federation of Labour. With me today as well from our federation is the director of health care, Duncan MacDonald. I'll be making our presentation on behalf of the federation.

We welcome this opportunity of appearing before the standing committee on social policy to discuss the Long-Term Care Homes Act, Bill 140.

The sad state of long-term care in our province has been noted by many. For example, the long-term-care facilities section of our October 2005 report, *Understaffed and Under Pressure: A Reality Check* by Ontario Health Care Workers, which I believe you're being handed now—I hope you get an opportunity to read it at length later on—found many examples of concern with respect to health care workers. I would like to read a couple of examples to you.

In terms of the understaffing issue, "Why isn't there more staff? We're exhausted. We're all working doubles and this employer is so cheap they won't hire any more people."

Another health care worker indicated, "I'm getting bladder infections because there is no time to pee. We have big trouble getting to the bathroom. I'm running all day. If you are on a water pill, if you have to hold it,

you're much more prone to bladder infections. It's not just me."

As a last example, I want to show you a flavour of what folks are saying: "Residents in these retirement homes, well, it's not a good situation. People off the street, call them Bobby or Sally, are now giving you shots and meds. Legally they are required to work under the guidance of a registered staff, but dream on. There is no RN on nights and so they are forced to do this. I mean, anyone and their dog can be pressed into duties in Ontario retirement homes, no matter how untrained they are."

So for our members, Bill 140 is a flawed piece of legislation reflecting the betrayal of Ontarians by this government, in our view. It's a betrayal of the wishes and needs of our seniors. It's a betrayal of Ontarians who provide quality care in facilities across this province. It's a betrayal of Ontario families who have members in these facilities. And it's a betrayal of the wider community of Ontarians who believe that quality care for those in need is both desirable and attainable.

The government knows the state of long-term care in our province. Bill 140 reflects the attitudes and actions of a government that does not listen to Ontarians.

I want to talk to you about our vision for long-term care. The Ontario Federation of Labour constitutes the largest provincial labour federation in Canada. The 700,000 members of the OFL are drawn from more than 1,500 locals of 40 different unions. Our members work in all economic sectors and live in communities across Ontario, from Kenora to Cornwall and from Moosonee to Windsor.

Since our founding convention in March 1957, the OFL has consistently advocated for our vision of a universally accessible public health care system for all Ontarians. Our vision for health care draws on the experiences of, firstly, dedicated health care workers who provide needed services and who are profoundly troubled by the misdirection of public policy and the failures of the institutions which employ them; and also workers and their families who in the past used or continue to use the services of Ontario's health care system.

Our vision for health care is outlined in two recent documents, one of which we have provided for you, which is the *Understaffed and Under Pressure* report. The other is our major policy paper entitled *Rebuilding Health Care*, which is available on our website. It was developed with the valuable assistance of our affiliate unions in health care—I'm sure you've heard from many of them over the last two days—and discussed and endorsed by delegates to our last convention in November 2005.

In May and June 2005 the federation, working in conjunction with affiliated health care unions, sponsored meetings in 15 communities to examine the consequences of understaffing. The report is a record of first-ever meetings of health care workers from all sectors and unions. They came to a mutual conclusion: that all sectors and workplaces have been hard hit by under-

staffing and that the problems associated with understaffing and its consequences are systemic and serious.

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On the issue of long-term care, we have worked closely with our affiliated unions in health care. These unions have thousands of members who are dedicated workers who provide quality services in this sector across Ontario. We have also worked closely with our community allies through organizations such as the Ontario Health Coalition, which I know has presented to you already as well.

Our policy paper on rebuilding health care called for specific actions which the McGuinty government could begin to implement immediately in the long-term-care sector. We are asking for:

- a required minimum standard of 3.5 hours per day of nursing and personal care for residents;

- staffing levels that reflect not only the number of staff but also the appropriate classification and qualification of staff to ensure residents receive care that is appropriate to their needs;

- soliciting of ongoing input into long-term-care policies by workers through their unions, residents and their families;

- increased capacity of workers to have a say in what is happening in their facilities by instituting regular, unannounced inspections and mandating inspectors to speak with residents, family and workers about conditions; whistle-blower protection to be implemented for workers who complain about conditions and for the protection of residents;

- mandatory reporting and monitoring of staff levels instead of the Liberals' voluntary compliance. This will ensure that there is proper use of government monies.

There are a number of broad areas of concern that we have with Bill 140. They include (1) the lack of staffing standards; (2) identification of the needs and solutions; (3) undermining of the non-profit sector; and (4) geographic differences in standards.

Let me first address the lack of staffing standards. The most fundamental flaw of Bill 140 is that it does not address the chronic and critical understaffing issues in long-term care. We believe that the legislated province-wide staffing standard is necessary if we, as a society, are serious about addressing the needs of this sector. This is an action we expect our government to take on behalf of all Ontarians whether or not they are now, or will become, residents or workers in long-term-care facilities.

There was a staffing standard previously of 2.25 hours of minimum nursing and personal care per patient per day until it was eliminated by the previous Conservative government under Mike Harris in 1996. Ontarians became aware of the implications of this action. In 2001, a PricewaterhouseCoopers study reported that Ontario had the lowest amount of total care hours per nursing home resident per day in a sample comparing Canadian provinces, a number of American states and a European country—the Netherlands.

The Ontario Liberal Party joined with others at that time who sought the reintroduction of staffing standards. On November 7, 2002, the Liberal Party introduced a resolution in the Legislature stating “that, in the opinion of this House, the Ernie Eves government should immediately establish minimum standards of care for nursing homes and homes for the aged, including the reintroduction of minimum hours of nursing care and the requirement for a minimum of at least one bath a week.” Many of the Liberals who spoke in favour of this resolution in 2002 are now playing a variety of roles in the Liberal government of Dalton McGuinty.

Dalton McGuinty, in his April 4, 2003, response to a question from the Ontario Federation of Labour, stated, “We have a comprehensive plan to improve the quality of life for residents of long-term-care facilities. Our plan includes restoring standards and providing the necessary funding to increase the level of nursing care that long-term-care residents receive. Inspectors will be required to audit the staff-to-resident ratios, the number of nursing hours per patient, the mix of staffing and number of staff who have taken a course in the care of seniors.”

In December 2003, in response to a series of investigative articles into the long-term-care sector in the Toronto Star, as you know, the Minister of Health and Long-Term Care, George Smitherman, promised a “revolution,” and that fixing this problem would be his “top priority.” But by October 5, 2004, in a meeting of the standing committee on estimates, the same minister had changed his tune and said that he would not be reinstating the 2.25 hours staffing standard. Even an April 2005 coroner’s jury report into the deaths of two residents in a Toronto nursing home in 2001, which made 85 recommendations, including the need for staffing standards, has not moved this government.

So through Bill 140, the government did not see fit to bring in staffing standards and to implement what had been so recently their party policy. There is even some talk that while staffing standards were not addressed in Bill 140, a section of this bill, section 36, dealing with regulations, could be used to bring in staffing standards.

A staffing standard of 3.5 hours per day of nursing and personal care per resident has broad support among Ontarians. It is supported by our members who work every day in this sector. They know what human resources must be in place in order to provide for the needs of Ontarians in the long-term-care sector. It is obvious to us that a dedicated, stable workforce with expertise and experience is vital in providing for the needs of Ontarians in the long-term-care sector. This can be attained if the government implements a staffing standard of 3.5 hours, at a minimum, per day of nursing and personal care per resident.

I want to speak now about the identification of needs and solutions. Many Ontarians have been involved in identifying both the problems and the solutions for our long-term-care sector. The government could have used this public interest in order to develop a vision of and a legislative framework for an effective long-term-care

sector in our province. This would have provided the opportunity for Ontarians to see clearly what the government is suggesting, as well as giving them the opportunity through public hearings, much more expanded ones than this current schedule, to suggest improvements.

Perhaps this government lacks a complete vision of what we see as the role for the long-term-care sector. Section 1 of Bill 140 states, "The fundamental principle to be applied in the interpretation of this act ... is 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."

A more inclusive and fundamental principle is found, however, in the Nursing Homes Act, one of the three pieces of legislation which will be repealed and replaced by Bill 140. It states that "a nursing home is primarily the home of its residents and as such it is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met and that its residents are given the opportunity to contribute, in accordance with their ability, to the physical, psychological, social, cultural and spiritual needs of others."

The Vice-Chair: Excuse me, you have one minute left.

Ms. Downey: We think this is a clearer picture, and this should be put into the bill as opposed to what's currently there.

We also talk about issues around training and the undermining of the non-profit sector. We really believe that a public and non-profit provision of long-term care is

better suited to identify and serve the needs of Ontarians than a for-profit system geared to serve the needs of corporations that seek to improve their financial bottom line.

In conclusion, we think that the sad state of long-term care in our province is of concern to Ontarians, and that the government has an obligation to show leadership in dealing with the issues that we have laid out, verbally now and also within our presentation. Our members believe that you cannot have quality care without people. To this end, a staffing standard is a necessary first step. The second step is for the provincial government to commit itself to a non-profit model for long-term care. Taken together, this will ensure that we have access in the communities—

The Vice-Chair: Thank you. The time has expired.

Ms. Downey:—and the kind of service that will serve the needs of the long-term-care sector in our communities. Thank you.

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

Before we adjourn, we have an announcement. To my understanding, the three parties have talked about the space on the plane that will be available for the staff on a chargeback basis. Is this agreed? Agreed.

Now we are adjourned until the 22nd of this month. The meeting will be in Kingston, Ontario, at 9 o'clock. We'll see you then. Thank you very much.

The committee adjourned at 1600.

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