Submission on Fixing Long-Term Care Act, 2021; Phase 1 Regulations
February 17, 2022

A. CONCERNED FRIENDS

For 40 years, Concerned Friends of Ontario Citizens in Care Facilities (Concerned Friends) has been advocating for a system where all long-term care (LTC) residents have access to services that meet their diverse medical, mental health, social, and emotional needs. They must be safe, cared for, and part of a vibrant community. The mission of Concerned Friends is to advance the health and well-being and enrich the experiences of those living in long- term care homes across Ontario (LTCHs). Our vision is to establish a system where individuals living in LTCHs have access to health and support services that best meet their diverse needs; where every person has a voice that is heard and rights that are respected.

The Pandemic has exposed and exacerbated serious system flaws in Ontario's LTCHs. Concerned Friends understands that these deficiencies were present before the pandemic and that a succession of governments have failed to hold operators to account for protecting those in their care. The public is now watching and expecting substantial improvement. The proposed regulations include some important steps in this direction, but more is needed.

We thank you for the opportunity to comment on Phase 1 Proposed Regulations (Regulation). Set out below are our comments and recommendations

B. COMMENTS/RECOMMENDATIONS ON PROPOSED REGULATION

(1) General

The information sheet accompanying the Regulation indicates that the estimated annual direct compliance costs for all LTCHs in Ontario are between \$20M to \$23.5M, or approximately \$36K for each LTCH per annum. However, some LTCHs have estimated that compliance with the new regulations could cost around \$500K per LTCH, especially for smaller, independent non-profit homes who do not have resources to draw on from a municipality or a corporate structure.

Recommendations:

1. **Each LTCH should be funded each year for compliance costs with the Regulation.**
2. **The estimated costs for compliance should be reviewed and increased to ensure that appropriate annualized compliance funding is provided to LTCHs. The estimate per LTCH is much too low to meet all of the new requirements.**

(2) Diversity and Discrimination

The Resident's Bill of Rights under Bill 37 has been amplified to recognize the rights of residents to be treated with respect and dignity, regardless of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Evidence from Canadian literature clearly demonstrates that health outcomes differ based on social and demographic factors such as sexual orientation, gender identity, language, race, immigration status, and ethnicity, as well as access to affordable housing, adequate income, social inclusion and other factors.[1] Existing literature within and beyond Canada has noted fears of needing to "go back into the closet" and/or receiving lower quality of care in long-term care settings because of their sexual orientation or gender identity.[2]

We applaud the recognition of diversity in the Bill of Rights. However, more is needed to ensure respect and dignity, regardless of the diverse characteristics of residents. These areas are not addressed in the Regulation.

Recommendation:

3. **The Regulation to require each licensee of a LTCH (licensee) to develop a policy and procedures to ensure that residents who come from diverse backgrounds, including gender identity and gender expression (such as 2SLGBTQI) are protected and recognized for their vulnerability to bias and prejudicial treatment. The policy to set out procedures to ensure that diverse residents are treated in a manner that respects their inherent dignity and procedures to be followed in the event of discrimination.**

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[1] Flanagan, A., Um, S., Sinha, S., Roche, B., Rosenburg, J., Nicin, M., McKenzie, K. (2021). Leaving no one behind in long-term care: Enhancing socio-demographic data collection in long-term care settings. Toronto, ON: National Institute on Ageing, Ryerson University and Wellesley Institute, at p. 6.

[2] 2 House of Commons Canada. 2019. Report of Standing Committee on Health of LGBTQIA2 Communities in Canada, 42nd Parl, 1st Sess, No 28. From: https://www.ourcommons.ca/ Content/Committee/421/HESA/Reports/ RP10574595/hesarp28/hesarp28-e.pdf

(3) Emergency Planning/Pandemic Preparedness

Clause 102 (4) (b) of the Regulation sets out the composition of the interdisciplinary infection prevention and control team, which is to include the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator.
However, there should be front-line staff mandated as part of the team, in order to have front-line expertise, investment in, and compliance with, the program.

There is a requirement in the Regulation for emergency plans, including the identification of other agencies that may be involved. Given the partnerships between hospitals and homes that were essential for dealing with the COVID-19 pandemic, there should be a specific delineation of the partner hospital(s) in the Emergency Plan.

Residents in LTCHs comprise one of the most vulnerable populations in Canada. In Canada, LTC residents accounted for 3% of all COVID-19 cases and 43% of COVID-19 deaths.[3] They live in high risk congregate settings and everything possible must be done to protect them from disease and death.

Recommendations:

4. **Clause 102 (4) (b) of the Regulation be amended to include persons who provide direct care (front line staff) to be part of the interdisciplinary infection prevention and control team.**
5. **The Regulation to require that all persons providing services/entering LTCHs be fully screened and immunized (including boosters) for infectious diseases, including COVID-19.**

(4) Quality of Care

Palliative Care and MAiD

We agree with the requirement in Bill 37 (section 12) that all residents should be provided with care and services that integrate a palliative care philosophy. This should be done early on in a resident's admission to LTC. As our population ages, more people will develop terminal diseases and require skilled care, including palliative care. The average length of stay in a LTCH is 18 months. According to a 2018 study by the Canadian Institute on Health Information (CIHI), only 6% of residents in a LTCH have a record of receiving palliative care in the last year of life.[4]

[3] https://www.cihi.ca/en/covid-19-resources/impact-of-covid-19-on-canadas-health-care-systems/long-term-care
[4] cihi.ca/sites/default/files/document/access-palliative-care-2018-en-web.pdf

In order for residents to benefit from a palliative care approach, LTCHs must be adequately staffed and trained in palliative care. Residents must have access to palliative care specialists and resources, which support their physical and emotional needs.[5] That requires relying on a recognized definition and established standards for palliative care, such as those adopted by the World Health Organization.[6]

Section 34 of the Regulation permits 6 months for compliance with the palliative care requirement which is too long. LTCHs who deal with people who for the most part are dealing with end-of-life care, must integrate such philosophy upon the regulation coming into force. LTCHs should report publicly upon their steps in ensuring adoption of a palliative care program. In addition, there is no mention of MAiD (Medical Assistance in Dying) in the Regulation. MAiD is a treatment option at end of life and must be available at each LTCH so that residents can choose this treatment and have it administered at their home.

Recommendations:

6. **The Regulation to require that the adoption of a palliative care philosophy by licensees be upon passage of the Regulation and that LTCHs begin to publicly report on palliative care performance measures after six months of the regulation coming into force.**
7. **The Regulation to define the term "palliative care" such as that set out by the World Health Organization.**
8. **The Regulation to require that MAiD be available in each LTCH so that residents may choose to die at their home.**

Psychotropic Medication

It is well known that psychotropic medication is overused in LTCHs to deal with responsive behaviours of residents who do not suffer from mental illness. This constitutes chemical restraint, and the inappropriate use of psychotropic medications can have devastating effects upon residents, including severe side effects and death. A recent scientific study found a dramatic increase in prescribing psychotropic medications to older people in Ontario's care homes, including antipsychotics, antidepressants, and benzodiazepines such as Valium or Klonopin during the COVID-19 pandemic.[7]

Recommendations:

9. **The Regulation to address the minimization of use of chemical restraints for responsive behaviours and require that the Restraints Policy mandated by section 118 address the inappropriate use of psychotropic medication.**
10. **The Regulation to address the requirement for specialized behaviour and recreation therapists to assist in dealing with residents with responsive behaviours.**
11. **The Regulation to mandate training of LTCH staff in understanding and dealing with individuals with responsive behaviours.**

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[5] https://policyoptions.irpp.org/magazines/july-2020/palliative-care-has-been-lacking-for-decades-in-long-termcare/

[6] www.who.int/health-topics/palliative-care

[7] https://www.medrxiv.org/content/10.1101/2020.11.26.20239525v1.full.pdf

Care Plan

Residents upon entry into LTCHs are typically asked to sign medical directives. Section 87 of the Regulation specifically references directives. However, except in an emergency, all medical treatment decisions should be made and confirmed by the resident at the time and after informed consent, and if the resident does not have the capacity for treatment decisions, then the substitute decision maker for the resident should be approached for treatment decisions, after informed consent.

The Residents' Bill of Rights (clause 3 (1) (12) of Bill 37) recognizes that every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity. However, this is not typically addressed in residents' care plans.

Recommendations:

12. **The Regulation to state that treatment decisions are to be made by the resident, after informed consent, or by the substitute decision maker, if the resident does not have capacity for treatment decisions. Directives are to be used only in the case of emergencies.**
13. **The Regulation to require that each resident's care plan address the resident being taken outside for recreation as per the Bill of Rights.**

Direct Care for Residents and Staffing

Bill 37 sets out "an average" of 4 hours of daily care as a ***target*** by 2025. Targets are not obligations and not enforceable, and 2025 is far too late, and beyond the mandate of this term of government. This timetable for improved staffing levels needs to be moved up to address urgent care needs, especially in the context of the ongoing COVID-19 pandemic.

Residents in LTCHs do not have appropriate access to physicians. Key findings show that the proportion of residents that received physician visits dropped by 16% in Wave 1 of the pandemic compared to normal years. Resident deaths in LTCHs due to COVID-19 were disproportionate compared to the general population during this period.[8]

Recommendations:

14. **The Regulation to require 4 hours of direct (hands-on) daily care for each resident to be in place upon passage of the Regulation. The "average" hours of care should be replaced with a minimum 4 hours of hands-on care per resident per day that recognizes the medical and care needs of the demographics of individual residents.**
15. **The Regulation to require that LTCHs report publicly on actual hours of daily hands-on care provided for each resident, and by which type of health care worker.**
16. **The Regulation to state that in addition to the Medical Director, there be an Attending Physician(s) or Attending Nurse Practitioner(s) (number based on # of beds) who is on site and accessible at all times and is responsible for managing and coordinating resident care in their respective LTCH.**

[8] https://rnao.ca/policy/nursing-home-basic-care-guarantee

(5) Resident Safety

Modernize Building Design and Accommodation to Meet Resident and Staff Needs
Almost half of the existing LTCHs (approximately 30,000 beds) do not meet the province's design standards (*Long Term Care Home Design Manual, 2015*), in terms of the amount of space per resident and the amenities being provided (e.g., 3 and 4 beds per room). Many of these homes are over 40 years old and need to be redeveloped by 2025 when their operating licenses expire.

Recommendations:

17. **The Regulation to require that building layouts enable effective workflow to support a safe, caring, and responsive living/working environment, e.g., dementia care, behaviour support.**
18. **The Government to provide dedicated long-term funding for on-going capital repair and maintenance of LTCHs to ensure that aging facilities are regularly assessed and updated or replaced as needed. Building maintenance supports livable and safe spaces for residents and staff.**
19. **The Regulation to address the need to ensure one person to a room with an ensuite bathroom for resident safety (other than couples who request to be together in a room).**

(6) Accountability, Enforcement, and Transparency

Administrative Monetary Penalties
The Regulation specifies the amounts and criteria for issuing administrative monetary penalties as deterrents for non-compliance with the Act. **However, there is no requirement to issue penalties.** Existing penalties (of up to $100,000 per home) have never been enforced.[9] The administration of penalties must be done if there is non-compliance. Otherwise, non-compliance will not be taken seriously. In addition, there is no delineation of how much non-compliance will result in a revocation of a license.

20. **The Regulation to specify that administrative penalties are mandatory if there is non-compliance.**
21. **The Regulation to address how much non-compliance will result in a revocation of the licensee's license.**
22. **The Regulation to stipulate that any administrative penalties issued against a LTCH and whether the penalties have been paid or are in arrears, to be published on the Ministry website for LTCHs, as well as the website of the LTCH.**

Inspections
The Regulation contemplates annual inspections, which is critical. However, these inspections need to be unannounced and full quality and compliance inspections. The Regulation indicates in sub-section 353 (8) that a LTCH that has been inspected at least once in the 2022 calendar year under the *Long-Term Care Homes Act, 2007* is deemed to have met the inspection requirement

[9] Executive Director of Ontario Health Coalition in a Global Radio AM 640 Interview (October 29, 2021).

under section 146 of the *Fixing Long-Term Care Act, 2021* in respect of the 2022 calendar year. This means that *any* kind of inspection, such as a complaint inspection, suffices for 2022. This does not constitute a full and unanticipated inspection. **There must be full annual inspections done without notice for all LTCHs for 2022.** LTCHs must be in compliance with all legislation and other requirements, and provide a safe and quality home for residents.

Recommendation:

23. Delete subsection 353 (8) from the Regulation.

(7) Definition of Not-for-Profit Homes

The Regulation continues to deem for-profit entities to be a non-profit long-term care home, provided that the equity shares are owned by a non-profit corporation or other specified organizations (clause 318 1. iv of the Regulation).

A for-profit corporation is a corporation that seeks to generate profits for its shareholders, regardless of who those shareholders are. The mission of the equity owner is not the mission of the for-profit corporation. Even if a corporation has equity shares owned by a non-profit corporation, there are preference shares that can be held by other persons/entities that are for-profit. Furthermore, there is provision in the Regulation for for-profit entities to assume ownership of the not-for profit's shares if the shares have been provided as security and there is default. Hence, the deemed not-for profit home could be a for-profit LTCH totally owned by for-profit entities.

A LTCH must do everything in its power to meet all regulatory requirements and to provide a safe and quality environment for its residents, all of whom are vulnerable and dependent upon the home for their entire care. Should any revenue be generated by a LTCH, this must be used to augment the functioning of the home, not flowed to shareholders. Deeming a for-profit corporation to be a non-profit long-term care home is misleading and hides the fact that such corporation has a mandate to generate profit to be flowed to shareholders. Clause 318 1. iv opens the door to many for-profit corporations being deemed to be non-profit long-term care homes.

Recommendations:

24. **Delete clause 318 1. iv of the Regulation. For profit corporations should not be deemed to be non-profit long-term care homes.**
25. **The Regulation should state the government's intention is to develop and grow the not-for-profit and public component of the LTCH system.**

(8) Whistle-Blowing

The provisions regarding whistle-blowing are set out in section 30 of Bill 37 and they have not been augmented. In order to encourage whistle-blowing when required, and to provide assurance to those who choose to report, it is important that each licensee develop a robust policy and series of protections on whistle-blowing. Residents are in a very vulnerable position given that they rely upon the LTCH for the necessaries of life. All persons, including staff, residents and families of residents must be able to report wrongdoing, without fear of reprisals.

Recommendation:

26. **The Regulation to require that each licensee develop a policy on whistle-blowing that addresses staff training on the policy, anonymous reporting, protections to ensure no reprisals and procedures to be followed in the event that reprisals are done.**

C. Summary of Recommendations

1. **Each LTCH should be funded each year for compliance costs with the Regulation.**
2. **The estimated costs for compliance should be reviewed and increased to ensure that appropriate annualized compliance funding is provided to LTCHs. The estimate per LTCH is much too low to meet all of the new requirements.**
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4. **Clause 102 (4) (b) of the Regulation be amended to include persons who provide direct care (front line staff) to be part of the interdisciplinary infection prevention and control team.**
5. **The Regulation to require that all persons providing services/entering LTCHs be fully screened and immunized (including boosters) for infectious diseases, including COVID-19.**
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14. **The Regulation to <u>require</u> 4 hours of direct (hands-on) daily care <u>for each resident</u> to be in place <u>upon passage of the Regulation</u>. The "average" hours of care should be replaced with a minimum 4 hours of hands-on care per resident that recognizes the medical and care needs of the demographics of residents.**
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26. **The Regulation to require that each licensee develop a policy on whistle-blowing that addresses staff training on the policy, anonymous reporting, protections to ensure no reprisals and procedures to be followed in the event that reprisals are done**.

Concerned Friends, through its advocacy work with residents and families is in a unique position to offer new perspectives on the challenges and opportunities for improvement in LTC. We are pleased to clarify any of our comments/recommendations and to work with the Government in ensuring a long-term care system that is robust and provides quality care for Ontarians.

Thank you for the opportunity to provide comments.

Yours truly,

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