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Monday 22 January 2007

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Lundi 22 janvier 2007

Standing committee on social policy

Comité permanent de la politique sociale

Long-Term Care
Homes Act, 2007

Loi de 2007 sur les foyers de
soins de longue durée

Chair: Ernie Parsons
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STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 22 January 2007

Lundi 22 janvier 2007

The committee met at 0906 in the Ambassador Conference Resort, Kingston.

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. Welcome to Kingston, Ontario. Welcome to the standing committee on social policy. We're in the third day of hearings on Bill 140, An Act respecting long-term care homes.

We have many presentations. They will take us all the way to 4 o'clock this afternoon.

FAIRMOUNT HOME

The Vice-Chair: We're going to start this morning with Fairmount Home. If they are here, they can come forward and start when they are ready.

I know that probably you know the procedure. You have 15 minutes. You can speak for all of the 15 minutes or you can divide it between presentation and questions from both sides of the table. You can start whenever you're ready.

Mrs. Julie Shillington: Thank you. Good morning, ladies and gentlemen. I'm Julie Shillington, administrator from Fairmount Home. With me today is Mary Lake, our director of resident care.

Fairmount is a 128-bed, accredited, non-profit municipal home dedicated to providing the best quality of life for those who live and work at Fairmount. Fairmount opened originally in 1968 as a 96-bed home. An expansion and renovation project was completed in 2004, allowing 32 additional residents the opportunity to live with us. Our Fairmount community fosters a creative and responsive environment in which all members—staff, families, volunteers, students, community partners and the residents themselves—respect and promote the strengths and abilities of each other, especially for those for whom Fairmount is home. All members of our community are advocates for all of those who live and work at Fairmount.

I feel it is important for you to note that the taxpayers in the county of Frontenac and the city of Kingston make a substantial financial contribution to our home over and above the contributions of government and residents. Only with this contribution can we meet current legislative requirements and standards and provide the quality of care which we feel our residents deserve.

Fairmount endorses the spirit of Bill 140, which appears to be intended to promote an accountable and resident-centred long-term-care system for Ontario. We agree with the fundamental principle that a home is a place where residents may live with dignity and in security, safety and comfort, and we understand the need for monitoring and continuous quality improvement. Through partnerships with our residents, family members, government and the Fairmount community, we've been successful in providing quality care for many years.

We're very concerned, both on a fundamental and practical level, about the way the government proposes to apply the provisions as set out in Bill 140. We welcome this opportunity to provide observations and specific concerns from Fairmount's perspective.

As a not-for-profit care provider, we're extremely disappointed that Bill 140 does not include clear statements of support for not-for-profit care delivery. The current government has been vocal in its support for not-for-profit health care and we feel it's important that this continue through this piece of legislation.

Not-for-profit long-term-care homes are respected and recognized not only for their dedication and commitment to quality of care and service delivery but also for the active and integral role they play as employers, supporters and contributors to their local communities. Being not-for-profit means that 100% of the resources are invested in the interests of the residents, and any surplus income is used to improve facilities or expand service.

We urge the government to amend the legislation to include a strong and explicit statement of support for the not-for-profit sector, a statement that commits the province to preserving and promoting not-for-profit long-term-care delivery.

Under Bill 140, a director or officer is guilty of an offence if he or she does not take "reasonable care" to ensure the corporation complies with all requirements under the act, and the penalties are harsher than those that apply to individuals sitting on hospital boards. A fine of

$25,000 or a 12-month jail term will prove to be a significant impediment to recruiting and retaining qualified board members.

We ask the government to consider the implications of this legislation on a home's ability to retain and recruit qualified and committed board members and amend it accordingly.

Mrs. Mary Lake: Fairmount has active resident and family councils, and we have worked hard together to ensure the collective needs of our residents are met. We are concerned that the proposed legislation may put the home and our residents in conflict by allowing individual families and residents the right to enforce individual rights even where such enforcement may infringe on the collective rights of all residents.

While we support provisions that minimize the use of restraints, we do not support the application of the same provisions to secure units. We have a secure dementia unit at Fairmount which provides for resident safety and special care where we can offer programs that meet the residents' unique needs and staff with the expertise to do so. The proposed amendment under Bill 140 to the Health Care Consent Act, section 42, refers to criteria for admissions to secure units by substitute decision-makers, one of which is that the admission allows the incapable person greater freedom or enjoyment. This is important. Admissions are not always due to the risk of serious bodily harm; in many cases, they are due to invasion of privacy of other residents, who then get angry, resulting in increased frustration and confusion for the resident with dementia. In a secure unit, the resident has the freedom to wander without upsetting other residents, which prevents catastrophic reactions for the residents themselves.

Bill 140 also requires placement coordinators to give the person being admitted to a secure unit written notice and to notify a rights adviser when he or she is being placed in a secure unit. The rights adviser must then meet with the person and explain the person's right to apply to the Consent and Capacity Board. Residents who are incompetent cannot understand the implications or risk. In many cases, the prospective resident does not want to come to the home, and the substitute decision-maker is suffering from extreme guilt. This process will exaggerate the situation, adding more stress to the caregivers, who are already overburdened and burned out.

We urge the government to consider these implications and amend the legislation accordingly.

We are also concerned that Bill 140 proposes a significant increase in regulation, which will mean less money available for actual resident care. We are concerned that without additional funding, we will spend more time on compliance and administration, which means less time at the bedsides of the residents. As an example, the requirements with respect to training and education are proposed to apply not only to staff but also to volunteers and contracted services. This introduces another level of compliance, which will be very onerous, given the broad range of people and third parties.

Bill 140 allows for written agreements to be voidable within 10 days. Fairmount has a waiting list of over 170 individuals, over 70% of whom are waiting for basic accommodation. We are very concerned that this clause will allow prospective residents the ability to manipulate the wait-lists and jump the queue by coming into the home agreeing to pay for a preferred accommodation bed and then voiding the written agreement within 10 days of signing. This would lead to a loss of preferred revenue and an increase in bad debts and would impact those in the community who are waiting for and can only afford basic accommodation.

We urge the government to consider the financial impact of this legislation on the homes and the burden on those with limited financial resources in the community, and to increase operating funding to assist homes in meeting the new requirements.

Mrs. Shillington: In closing, we are committed to providing quality care to our residents. We support measures to enhance standards and ensure accountability, but establishing new requirements and standards without providing the means to achieve them is only setting us all up for failure. The government's commitment to increase operating funding to $6,000 per resident has not been achieved, and this should be addressed before further pressure is exerted on our already thinly spread resources.

We ask the standing committee to consider our concerns and recommendations presented today. Only by revisions being made to both the proposed legislation and the funding scheme will we be able to maintain the level of care to which our residents have been accustomed.

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

Mrs. Elizabeth Witmer (Kitchener–Waterloo): Thank you very much for your presentation and thank you very much for the excellent care that I know that you personally deliver to your residents.

Certainly I share your concern about the directors and the liability. I have friends who sit on boards for municipal homes for the aged, and this is certainly a concern that they're already taking a look at. They're wondering if they're really going to want to continue to serve on those boards, with the liability that comes with it.

I guess one of the biggest problems that we're facing is the fact that the government hasn't lived up to its promise to provide an additional $6,000 per resident. I'm wondering, if the government were to give you the additional $4,000—it's about $4,000 that each resident is short—do you think this would help meet the requirements of this legislation? Has anybody done a costing as to the implications of this bill?

Mrs. Shillington: We haven't done a costing yet; we haven't seen the regulations yet. But anything that the government could provide would go a long way.

The Vice-Chair: Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you for your presentation this morning. You said that taxpayers

in the county of Frontenac and the city of Kingston already make a substantial contribution. Can you give us an idea of what that is on an annual basis?

Mrs. Shillington: It's close to $2.5 million.

Ms. Martel: Two and a half million dollars, over and above what you get from the government of Ontario. With that, you are able to provide additional staff that you wouldn't be able to otherwise. So that's what you're already getting from another source because of a shortfall.

It's clear that there are additional requirements in the bill, and it's also clear that the government is only providing about a third of what it promised. So what has to go hand in hand with this legislation is the rest of the money that was actually promised.

I want to ask you what your process is for admitting someone into a secure unit.

Mrs. Lake: Our process is that we look at the actual needs of each resident. Basically, it's the people who wander—not necessarily just those who would wander away from the building or out in the cold, like today, but also those happy wanderers who invade everyone else's space. They get yelled at, they get frustrated, and then they have catastrophic reactions. They just need that area where everyone else will let them be. We just go with the flow. There's no schedule; there are no routines. They can just be themselves and go where they want when they want.

The Vice-Chair: Parliamentary assistant.

Ms. Monique M. Smith (Nipissing): I'd like to join with Ms. Witmer in congratulating you because I have heard of the great care that you provide as well. We thank you for being here today.

I've heard a number of other presentations on some of your concerns around penalties in the not-for-profit sector, but I just wanted to home in for a moment on your—you support the provisions that minimize the use of restraints, but you don't support the application in the secure units. I'm just interested in hearing you elaborate on what concerns you have about the minimal-use-of-restraints policy with respect to secure units.

Mrs. Lake: Number one, there has to be permission from the substitute decision-maker. Then the incompetent person has to be told about the decision and why it's being made.

Ms. Smith: So your concern is more about the admissions to the secure unit than the actual minimal use of restraints in the secure unit?

Mrs. Lake: Definitely.

Ms. Smith: I wasn't clear on that from your presentation. That's why I was wondering.

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

0920

OMNI HEALTH CARE

The Vice-Chair: Now we'll move to the next presentation, by OMNI Health Care.

Welcome. You have 15 minutes. You can speak for the whole 15 minutes or you can divide it between the presentation and questions. You can start whenever you're ready.

Mr. Fraser Wilson: Good morning. I'm Fraser Wilson, chief executive officer of OMNI Health Care. I've been in long-term care for 20 years and served in many elected capacities at the Ontario Long Term Care Association, including president in 2002-03.

OMNI owns and operates 16 long-term-care homes in central and eastern Ontario. Most of our homes are in rural Ontario and have fewer than 80 beds. Our smallest home is 43 beds.

I thank you for the opportunity to present today on Bill 140. I am here to express my disappointment and disillusionment with the proposed new act. I had hoped that Bill 140 would move us forward to embrace the next 20 to 25 years, provide equality for all residents by introducing a capital renewal program for B and C homes, be responsive to current needs, and plan for the future.

I would ask that this standing committee incorporate the amendments proposed by the OLTCA and allow long-term care and those who work and live in it to embrace their potential.

When the Minister of Health and Long-Term Care introduced Bill 140 to operators, he stated that the proposed act will be the "cornerstone on which we build a long-term-care system that will be a model" for the rest of Canada. Nothing could be further from the truth. Ontario is the only province taking no action to replace three- and four-bed wards, and our staffing levels are amongst the lowest in Canada. Unless amended, Bill 140 will perpetuate Ontario's position in last place when it comes to the comfort, dignity and care of its residents.

I am disillusioned. All residents in Ontario pay the same amount for accommodation regardless of the home's structure and classification. In homes built to new standards, residents have the benefits of a maximum of two people to a room, smaller dining rooms and abundance of recreational and social space. In B and C homes, residents live in three- and four-bed wards, large dining rooms with 60 residents and limited social and recreational space.

Is this government sending the message that those living in B and C homes are not worthy of the same comfort, privacy and dignity as those in new homes? I had hoped that Bill 140 would recognize this inequality and outline a capital renewal and retrofit plan. Instead, Bill 140 did nothing to address the modernization of older homes or the equality of those residents living in them. Rather, the government introduced limited licences that will see C homes expire in 10 years and B homes in 12 years, with no plan for the future.

Residents, families, staff, communities and operators are especially concerned about the licensing uncertainty. Specifically, residents, families and staff are concerned whether their homes and jobs will be there in the future. They are worried that they will have to travel to new

communities to live and work. Smaller communities are concerned that they may lose employment opportunities and long-term-care services. Operators will struggle to finance their homes when there is no certainty regarding their licence renewal.

Current occupancy rates in Ontario are over 98%. Demographically, Ontario's population over 75 will increase 49% by 2016. At a time when there is an unprecedented demand for long-term-care, the licences of 263 homes accommodating 27,500 residents will expire. Is it good public policy to risk decreasing this much capacity at a time when all of it will be needed, and much more, to meet the long-term-care needs of people in communities across Ontario?

As recently as the fall of 2006, the government released an RFP for new homes in Kingston and Quinte West. Those RFPs included the provision for capital funding. Clearly this government acknowledges the need for capital assistance to construct new homes to the new design standards. It stands to reason that the same capital assistance is also needed for older homes to build to the new standards.

The previous government successfully rebuilt 16,000 D beds to new standards with a capital renewal program. In fact, members of all parties unanimously endorsed Elizabeth Witmer's private member's motion to rebuild and provide a capital renewal program for B and C homes.

The tone and authority limiting licences is even more disturbing. It states that the minister is not required to notify homes whether their licence will be renewed and the minister is not obligated to give any reason for not renewing a licence. In this age of transparency and accountability, it's astounding that such unilateral authority and secrecy would be written into proposed legislation. I ask that this draconian language be changed.

I will now focus my presentation on the care and services component of the bill. I am disappointed. I had hoped for a compliance system that focuses on outcomes and encourages initiatives. What Bill 140 proposes is more paper, process and regimentation. It is incredible to know that the rest of society and business recognize the need to embrace and empower people, lift their spirits, tap their talent and focus on what they do well, yet Bill 140 is authoritarian, disempowering, fault-finding and laced with micromanagement. Minister Smitherman and Parliamentary Assistant Monique Smith both acknowledge publicly that the majority of homes provide great care. Why is it, then, that there is a need to quash spirits, increase paperwork, over-regulate, zap flexibility and continue to stretch limited resources?

For example, as opposed to allowing homes to develop their own mission statement, there is now a prescribed process and a long list of people who have to be involved. Every home has developed and evolved its mission statements for years. Continue to trust our judgment. Take this requirement out of the legislation.

Our sector has been developing policies and documentation for decades. What message is the proposed legislation sending by now requiring a lawyer to certify these same documents? Are we now incompetent? Delete this provision. It is offensive, time-consuming and an unnecessary expense to the system.

Compliance inspectors, who were formerly called compliance advisers, are now required to document any non-compliance for anything that does not comply with the act. This could include documentation not being completed through the shift when the practice in the home is to do so at the end of the shift. This is the fault-finding regimen that focuses on process, not outcomes. Every time there is a non-compliance filed with a home, time has to be taken to develop a plan, write the plan and communicate it with the ministry. Is this an effective use of time? Change the wording from "shall" to "may," and train inspectors to be consistent in determining whether the non-compliance is trivial or adversely impacts on resident care.

I had hoped the new act would be attainable and fair. Instead, operators got absolute responsibility to protect residents from abuse from anyone at all times. How can we be responsible for financial abuse by family members or abuse that occurs when a resident has the right to visit privately with loved ones? The committee is asked to amend the act so that operators are responsible only for those things that they can control and influence.

In a similar manner, while we support the enhanced provisions for whistle-blower protection, operators should not have to bear the onus of proof on allegations filed by an employee. This clause assumes that the employer is guilty until proven innocent. How is this fair or even constitutional? We ask that this be deleted from the act.

The new act is an opportunity to create a stronger partnership with the Ministry of Health and Long-Term Care. Unfortunately, Bill 140 proposes a lack of responsiveness and an abdication of responsibility on behalf of the ministry. I had hoped for a commitment to more staffing, in recognition that our staff are run off their feet. Instead, we got no such recognition; we got a change in the spirit of the act from one of commitment to that of unilateral discretion and abdication of responsibility. Subsection 88(1) now reads that the minister "may provide funding" where it previously read "shall provide funding." Instead of more staff, we got more rules and regulations. Instead of a continued commitment to fund care and services, we got an exit strategy for the Liberal government. What is meant by this exit strategy? It brings into question the Liberal government's commitment to seniors.

Bill 140 will set the stage for the next 20 to 25 years. As the minister stated, the "proposed act will be the cornerstone on which we build the long-term-care home system that will be a model for the rest of the country." With this committee's help and the adoption of OLTCA's amendments, it can be.

I would be happy to take any questions.

0930

The Acting Chair (Mr. Jeff Leal): Thanks so much, Fraser, for your presentation.

On this rotation, I'd like to start with Ms. Martel. Ms. Martel, we have about five minutes for questions.

Ms. Martel: Thank you for your participation today. You said you have responsibility for 16 long-term-care homes. I would assume most of them are B and C?

Mr. Wilson: Yes, there are. There are 13 Cs, one B and two As.

Ms. Martel: Can you tell me if you've done a respective budget for what it would cost to bring those homes into compliance with the new standards?

Mr. Wilson: In accordance with the capital renewal program that's currently in place, although $10.35 in capital assistance was an appropriate amount for the past, we feel that we can reasonably rebuild or retrofit our homes to an amount that is indicative of that $10.35 with an inflationary adjustment. It was established in 1988.

Ms. Martel: You talked about the new RFP out for Kingston—I think it's for 96 beds—and you stated that it includes a provision for capital funding. Do you know what those provisions are?

Mr. Wilson: I believe it makes provision for $10.35 in capital assistance.

Ms. Martel: If I can ask, Mr. Chair, I wonder if research can get us a copy of that RFP. There's also an RFP out in Sudbury for 96 beds. I'd be interested to see what the provisions are around capital funding for that and actually if there are any others outside of Kingston and Sudbury that have been tendered.

The Acting Chair: Duly noted for research staff. Ms. Smith, please.

Ms. Smith: Thanks, Fraser. It's nice to see you. I understand you have some concerns around the licensing scheme, and you talk about uncertainty that it in the system creates and concerns around operators and their ability to finance their home.

I also understand that OMNI is actually being sold and that you haven't had a real problem in finding a purchaser, so I wonder about your concerns about certainty in the system when you've been able to find someone who obviously feels that there is a going concern in the business. Could you comment on that for me?

Mr. Wilson: Yes, I can. OMNI's predicament is different than that of smaller operators in rural Ontario that are independently owned and operated, where they have an act that will limit the licences. Their ability to renew their financing with a lending institution, when they know that there is no certainty at the end of that term, is going to be compromised.

I'll give you a good example. Ordinarily, mortgages are amortized over 25 years. If their mortgage was to renew two years from now and only have eight left, that amortization would be over a far shorter time period, and the principal and interest payments would go up exponentially and I would actually say would compromise the viability of the operation.

Ms. Smith: Right, but OMNI hasn't actually been negatively impacted.

Mr. Wilson: Not in our case.

Ms. Smith: I was interested in your view that the mission statement shouldn't include the involvement of family members and residents, which is what the legislation provides, because you say that every home has developed and evolved their mission statements for years. It's my understanding that some of the larger chains—I'm not sure yours—actually just implement the chain-wide mission statement. Bill 140 is attempting to be resident-focused. It's our perspective that every home should reflect the needs and values of its residents. That's why we're looking at involving these individuals in the development of mission statements.

I know that you're very involved in your residents' lives;I read your newsletter. In your view, the mission statement shouldn't include their involvement.

Mr. Wilson: It's a matter of time and process. To put it into legislation today would make the assumption that our current mission statements are not responsive, that they're not current and that they don't meet the needs or the culture within homes. This adds time, involvement of a whole lot of other people; it will take their time off the floor in order to make these things happen. It was simply an example: Is our time better served providing care on the floor or developing the mission statement with a whole façade of people?

The Acting Chair: Mrs. Witmer, please.

Mrs. Witmer: Thank you very much, Fraser, for your presentation. I certainly share your concern that, despite the fact that all members of the government did support my call for a capital renewal program for B and C beds, unfortunately we haven't seen any plan on behalf of the government to do so. When you go into a B and C home and you take a look at the difference between that and an A home, where people are in two-bed wards and have a washroom and private space, there's a big difference, and it's hard to believe that everybody pays the same price.

Your association did offer, certainly, a compromise position on the limited-term licensing, which I know is of concern. Have you had any response from the government on whether or not they're prepared to take a look at the compromise that you've suggested to give more certainty to residents?

Mr. Wilson: To my knowledge, we have not received any comprehensive response to the proposal that has been tabled by OLTCA.

Mrs. Witmer: I know Sid Ryan appeared before us last week, and he told us that certainly he was in dialogue with the government regarding some areas of concern. So I wondered if they had been talking to you and working with you to prepare amendments to alleviate some of the concern of residents, staff and owners. I hear you saying no, not to your knowledge.

Mr. Wilson: Which actually surprises us, because we are representative of the long-term-care sector, between OLTCA and OANHSS, which represents the not-for-profit sector. Nobody knows the sector like we do, yet we have not had the appropriate opportunity to interface with government. In fact, I would say that we've been pretty much shut out, which is disappointing.

The Acting Chair: Fraser, I just want to thank you. You've always been very kind when you've offered me the opportunity to visit your fine facilities in Peterborough. I've always appreciated your kind courtesy and your hospitality.

MAXVILLE MANOR

The Acting Chair: Next I would ask Mr. Munro to come forward, please, from Maxville Manor. You have 15 minutes, sir. Any time you don't take, we'll allocate for questions from members of the committee. Welcome this morning, sir.

Mr. Craig Munro: Good morning, honourable members of the Legislature, ladies and gentlemen. I wish to thank this committee for the opportunity to address some of our concerns over Bill 140. My name is Craig Munro. I am the executive director of Maxville Manor, a not-for-profit organization located in the village of Maxville, approximately 25 miles north of Cornwall. I've been the senior executive of this organization since 1977. I am a past president of our provincial association, now called the Ontario Association of Non-Profit Homes and Services for Seniors. I sat on that board for a period of years, which afforded me the opportunity to visit other communities and facilities across this province, other Canadian provinces and some facilities in the United States. As well in that capacity, I had the privilege of frequently meeting with many political and bureaucratic representatives of the various government ministries involved in the care of our seniors.

The organization I represent, Maxville Manor, originally opened in 1968 and has evolved from a 90-bed home for the aged to a full-service community seniors' organization. Our 122-bed long-term-care facility saw a $9-million rebuild in 1994. We provide outreach services to over 300 clients in three townships located in two eastern counties. We own and operate a life-lease apartment development next door to the care facility. I ask for your indulgence in receiving our presentation.

On October 3, 2006, the Minister of Health and Long-Term Care introduced the Long-Term Care Homes Act, 2006. If it becomes law, the bill will repeal the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act and replace them with a single statute.

The Ministry of Health and Long-Term Care, under different governments, has spent several years trying to wrestle with the current three pieces of legislation by amalgamating many of the regulations under all three pieces of legislation. This current government now believes it can push through this new Long-Term Care Homes Act, Bill 140, and in so doing will reduce the amount of time available to care for residents.

We wish to address this presentation to the following main areas of concern.

Philosophy: Long-term care for our seniors in this province has its genesis in the not-for-profit sector and in fact was started by a few Roman Catholic religious orders. Their efforts virtually forced the public and political representatives to take action in improving care and services for seniors. The system that evolved included the not-for-profit facilities, which were made up of municipal and charitable homes for the aged, and a host of privately owned nursing homes.

0940

Typically, the not-for-profit sector operated under two pieces of legislation through the Ministry of Community and Social Services. Their goals were mutual: provide our seniors with the best care possible within a set or negotiated financial scope.

While municipalities were required to provide a home for the aged, charitable organizations, such as Maxville Manor, came into the field with the same mutual understanding; that is, provide our seniors with the best care possible within your financial means. These facilities were supported through a consultation process with various program supervisors from the ministry. It was understood that the province, the municipalities and the charitable organizations shared a responsibility to look after our seniors in the best way possible.

Meanwhile, a number of privately owned nursing homes proliferated and were regulated under the Nursing Homes Act, administered by the Ministry of Health, to provide a minimum of service to their residents. This legislation brought inspection teams from the ministry to ensure that private operators were providing the bare minimums. Failure to do so could bring costly sanctions. Fair game, if they could provide the service and make a profit, but note the essential differences.

Our organization, Maxville Manor, a not-for-profit community-based charity, was originally conceived 40 years ago by a number of people in the community—a village of 850, I should add—concerned about caring for a growing seniors population in the area. Many of these community leaders formed the first board of directors, which was and still is composed of people from virtually every organization in the community, including voting members from each of the five area churches, two municipal entities, the local Lions Club, the Kenyon Agricultural Society—which is famous for the renowned Glengarry Highland Games, a volunteer organization of some 400 souls—and the Glengarry Old Time Fiddlers.

The development of Maxville Manor was a total community effort, drawing on the volunteer time of many of the area citizens and the generous donations of over 3,000 people from the surrounding area.

Some historical operational highlights that I would like to mention include:

We were the second long-term-care facility in eastern Ontario and 10th in the province to receive accreditation status.

We started the first life-lease development seen between Toronto and the east coast.

In 1978, we initiated the first involvement of the area psychiatrists in addressing dementias and other seniors' mental impairments. This work became the engine for the creation of the geriatric assessment team for the three united counties.

We were the first facility in the province to arrange for regular dental services through the local public health office.

We provided the first wheelchair-accessible transportation for seniors in the three united counties.

While it is always self-satisfying to be able to relate firsts and notable achievements, our motivation for pointing out the above is to demonstrate that, after 40 years of successful operation, we are not neophytes to the health system, and we do not operate in isolation.

Bill 140, in its present form, provides no sense of a shared responsibility, but rather the heavy hand of controls, sanctions, penalties and possibly even jail terms. This bill places a bureaucratic stranglehold on the delivery of care. Bill 140 proposes a significant increase in regulation that will require our staff to spend more time and resources on ensuring administration and compliance. An example is that the section of the bill dealing with training and orientation of staff takes up a full three pages of the bill.

There is no mention of the province providing any additional funding to cover any of the compliance requirements. Bill 140 makes extensive references and demands on operators to provide for all care requirements of their residents, yet this bill, as with all existing legislation, makes no mention of a minimum standard of care, hours of care or even funding associated with any care to be provided. As this ministry learned in the study carried out by the Pricewaterhouse group and funded by this ministry, even the state of Mississippi provides for some minimum level of care for its seniors, well beyond anything being funded in this province.

We appreciate the need for ongoing upgrading of homes to meet the changing needs of residents, yet there is no mention of any capital renewal funding tied to structural compliance and ultimately licensing of facilities.

Under the bill, not-for-profits will be allowed to sell or transfer beds only to other not-for-profits. There is no such restriction placed on for-profit facilities. This has the potential to devalue the equity interest of the not-for-profits and could seriously affect their borrowing capacity. The mere idea that this province now pays for-profit corporations taxpayers' money to build facilities is one that is totally foreign to and misunderstood by most people in this province.

While it may be good politics and gain good press to hammer away at residents' rights, we are concerned that the legislated individual rights of residents and families might infringe on the collective rights of all of our residents.

In the not-for-profit sector, elected municipal officials and volunteer community board members ensure that our residents' rights are protected, without the need to enshrine these in legislation.

The issue around placement of residents in our special care area, designated for those with moderate to severe dementias, should remain totally within the realm of the facility's own staff. What would anyone in a regional or provincial ministry office know of the daily care needs of any of our residents?

Bill 140 imposes personal liability on directors for failing to take all reasonable care to ensure their homes meet all requirements of the act. Directors could conceivably go to jail for such a breach. We are concerned that this may present a significant barrier to recruiting and retaining our volunteer directors. We find it curious that the penalties in Bill 140 are significantly harsher than those affecting directors on hospital boards. Penalties under Bill 140 are up to $25,000, compared to a maximum of $1,000 for hospital directors. Is this type of penalty really meant to serve as a warning to the for-profit corporations making large profits in their attempt to provide the minimum service allowable?

In summary, in this government's hurry to rationalize the legislation around long-term care, Bill 140 removes any suggestion of a shared responsibility with the not-for-profit sector.

As it needs to protect the public under the for-profit system, the ministry sees it as efficient to lump us together and allow us to be tarred with the same brush.

This bill is unfair and heavy-handed, it sends a clear signal of distrust, micro-management and intimidation to the thousands of caring staff in all long-term care, and is a breach of a long-standing trust with our volunteer board members in the not-for-profit sector.

We cannot stress enough our despair at this government's desire to homogenize all long-term care so that even our community-based, not-for-profit organizations will be expected to provide only the minimum. Bill 140, while perhaps more palatable in its conception, has become a testament to a government that seems incapable of understanding what is involved in caring for our seniors.

Accountability costs, in both money and opportunity. Given the limited availability of nurses in this province, why would you want them at a computer instead of taking care of residents?

This bill should be discarded and a new direction mandated that recognizes that real caring for our seniors belongs in the hands of our communities and that at least a minimum of service should be defined and adequately funded.

The Vice-Chair: Thank you very much for your presentation. We have a few minutes left; we can divide it equally. One minute, Parliamentary Assistant.

Ms. Smith: Thank you for coming before the committee today to discuss your views on Bill 140. I was interested in one particular aspect where you talked about the fact that the bill requires that not-for-profits only be allowed to transfer beds to a not-for-profit. This was actually something that OANHSS had requested because they wanted to protect the share of not-for-profits in the system. We're now hearing from not-for-profits that they don't like that provision. So I just wanted to hear your views on that a little more clearly, please.

Mr. Munro: I'm not clear if the association specifically asked for that type of wording. I understand that

the bill was changed in anticipation that this might appear or be of some benefit to the not-for-profit sector. In fact, it's a detriment.

I'll use the example: If our organization, which is a local community charity, wanted to get out of the long-term-care business but continue providing services to seniors, as we do with life-lease units and outreach and so on, we would only be able to sell our licence, if you will, to another not-for-profit facility, as opposed to some other private corporation that might come down the road. That's going to be a detriment to our ability to—

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

Mr. John Yakabuski (Renfrew–Nipissing–Pembroke): Thank you very much, Mr. Munro, for joining us this morning. You've made some excellent points, and I just want to touch on a couple.

Clearly, you believe that this bill, as it's presently written, without proper funding, will lead to less care for residents, not more, as opposed to what the government believes. It looks like your concern is that you could lose board members—good-quality, volunteer board members. Would it be fair to say that the government is scapegoating long-term-care operators and declaring war on them because it's good politics to spread this message that they're out to protect residents, and using your industry as a scapegoat?

0950

Mr. Munro: I think the government is coming down very hard on long-term care in their haste to rationalize the three pieces of legislation. They have to protect the public in the for-profit system, and I can understand that. They are operating for profit. They are not there for any other reason. Our not-for-profit facilities exist only to care for people. That's our only motivation; it's not to make a profit.

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

Ms. Martel: Thank you for your presentation and for a long and very noble history in the community.

You mentioned your concerns about the penalties, and I note how diverse your board of directors is. Has the board of directors itself taken a look at the provisions around penalties, and, if they have, what are their concerns or comments in that regard?

Mr. Munro: As with any volunteer board, they are going to turn to their professional staff and say, "What kind of reporting do we have to have in order to ensure that every piece of this act is being looked after?" You can imagine the kind of reporting requirements that's going to create for the paid staff and how long our board meetings are going to become to make sure we're presenting the kind of documentation that's going to be necessary for them to review to make sure that we're meeting every care need of every resident.

Ms. Martel: Have you any sense of the time that it will take to do that?

Mr. Munro: No. I couldn't even venture a guess.

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

ROSEBRIDGE MANOR

The Vice-Chair: The next presentation will be by Rosebridge Manor. I also want to remind the audience that we have a lot of coffee and tea, if you want to help yourself, and juice too. It's open for anyone who wants to have a coffee or tea.

Welcome. Please, before you start, can you state your name for Hansard.

Mrs. Nelly Hobbs: Good morning. My name is Nelly Hobbs. I'm the administrator of Rosebridge Manor in Easton's Corners. I've been a care provider and advocate for residents, families and staff in long-term care for over 20 years, and I proudly say that we are for-profit, but we certainly have endeavoured to and do provide more than the minimum standard.

I would like to introduce David Kent, who is the chairperson of our family council. He has agreed to represent residents and families by addressing their concerns with Bill 140 to this committee.

Mr. David Kent: Good morning. Just a brief mention about myself. I'm a retired federal government worker who spent 30 years doing policy and legislation for the federal government on a national basis, so I have some idea of what it takes to put a bill through. I have no political or business reasons for being here. My reason is strictly for my father and other people who are residents of the homes.

My father has been a resident at Rosebridge Manor for three and a half years now. He is a World War II—

The Vice-Chair: You're David Kent, right?

Mr. Kent: Yes, I'm David Kent. Sorry; I didn't say my name, did I?

The Vice-Chair: Just to make sure. No problem.

Mr. Kent: He is a veteran of World War II and contributed to Canada and the Canadian economy all his life, not only through his service in the community but also through charitable endeavours and through all his work life. I have agreed to speak before the committee because I am concerned that parts of Bill 140 will have a negative impact on care and the home environment, to ask the committee to amend the bill to support our home in providing the care that our loved ones need and deserve, and to support the staff in ensuring that they are able to sustain and improve the home-like environment. I know, through frequent interaction with the staff at our home, that they are dedicated to providing the best care and support for our loved ones. Without your support to make changes to this bill, however, their job will become even more difficult than it is today.

Rosebridge Manor is a relatively small rural home located in Easton's Corners. It has provided services to residents of Leeds, Grenville and Lanark since 1977. Statistics show that demands for this service will not only continue, but will increase in the future.

The home has established strong linkages and partnerships with the community over the years to improve and enhance care and services to the residents. This includes services for the residents provided by a strong volunteer

program and a long-term relationship with the BPH gero-psychiatry team, as well as relationships with contractors and other service providers to ensure the safety and comfort of our loved ones.

In addition, the home is a major employer in this rural community, employing approximately 80 direct staff, as well as providing employment for other services such as foot care, hairdressing and physiotherapy.

Although Rosebridge Manor strives to provide an excellent level of care and has become the extended family for many residents, there are serious inequities in the funding and structural amenities of homes such as ours across Ontario which make this effort much more difficult. We pay the same as families in newer homes, yet we still have four-bed wards and large dining rooms with 50 or 60 residents. Should our loved ones not expect the same level of comfort, privacy and dignity as those in newer homes? Our home represents 78 out of 35,000 residents in Ontario who get noticeably less money for their efforts. This standard is not just and is certainly not equitable, or acceptable either.

Not only have we been overlooked with funding and capital improvement initiatives, but now, because of the wording of Bill 140, we are uncertain about the future of our home and the services it provides to the community. The ambiguity of the language around licence renewal and criteria for renewal of the licence is disconcerting. This ambiguity and the uncertainty create extra stress on residents, families and staff. How can a home attract and retain competent leaders and staff when the very existence of the home is uncertain? How can financing for mortgages and improvements be arranged when owners will not be able to say with any degree of certainty how long their home will be able to operate? How can homes maintain their occupancy when they are not able to assure the community that they are viable for the future? If the government asks us to rebuild Rosebridge Manor to meet new standards, how is it possible without a capital renewal program and financing—capital and financing that have been and are being provided to other homes but withheld, we feel, from ours? What assurances are there that the home will remain in the community that it currently serves?

Why are residents in our home treated differently from those in newer homes? My father fought to preserve our way of life and to ensure that all Canadian citizens would be treated equally, provided the same opportunity to live their lives with dignity and respect. This bill seems to fly in the face of this by giving some homes more support than others. Is the government saying that my father has become a second-class citizen? I certainly hope not. The age of our home does not make it a less desirable place to live. In fact, with support equal to that given to newer homes, it would continue to be a place where my father and the loved ones of others could spend their days in peace, surrounded by fresh air, in a country setting similar to what most of the residents grew up in.

Our residents, families, staff and communities need more than Bill 140—I always want to put a "C" in front of that from the old federal thing—currently provides. We ask this committee to address our concerns. Remove the uncertainty that Bill 140 creates about the future of Rosebridge Manor. The people in our home are the working people who grew this country into what it is today. Ensure that our 78 residents benefit from equal funding and capital renewal programs that are now available to newer homes.

In addition, on a personal note, Bill 140 currently provides 195 places to introduce new regulations. More rules and regulations imply more paperwork and more processes. This results in less time for staff to care for residents. Does the government want more paperwork or more care? Please take a look at the total picture when you are thinking about more regulations and assess what you are asking of the staff that we count on to look after our loved ones. One thing that I always found in the federal public service was that when we put out regulations from headquarters, from the central body, and we asked the regional people to do newer, different or more things, we had to make sure first of all that there was the staff there to do it and that they could actually accomplish this within the time we wanted them to do it. I'm not sure that with this many regulations we can put the thought into that. We have to proceed very carefully, I feel, with those kinds of things.

Provide assurance to the public that they will have access to long-term care in their community in the future.

Bring our forefathers into the forefront. It is what they need from you and is surely what they deserve.

1000

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

Mrs. Witmer: Thank you very much for your presentation. I think you've articulated very well the concern that many people in small communities throughout the province of Ontario have, and that is the uncertainty as to whether that small home will actually survive into the future, because there is no capital or renewal plan to improve those C and B beds, and obviously, with the limited licensing, you don't know whether you're going to be here seven or 10 years from now. So I hope the government does hear you; I hope they hear others. I have heard from people in small communities—I grew up in one. They're afraid that home might not be there and maybe they'll have to go to Kingston or Brockville or London or what have you. There is that level of uncertainty here.

I think you've made a really good point: When you introduce regulations, you also need to take into consideration the additional time that is going to be required to implement them and the impact on staff, and that's not here. We know there already is not enough money to provide the level of care that's needed for the people in the homes, so the government does need to step up to the plate.

I really do thank you for your presentation. You've made a good point: How do you feel paying the same

amount of money for your bed and your home as someone who's in a new home, an A-bed level of care? How does that make you feel? It does create two levels of people.

Mr. Kent: That's why I'm here. When we first brought my father to Rosebridge, three and a half years ago, it was on an interim basis because we wanted to get him into a larger place in town. Once he was there for a couple of months, because the care is so exceptional and because of the setting of the home and this type of thing, we decided we just couldn't move him away from there because we were so happy with the home itself. So it's a bit of a trip for us, a 40-minute trip, to go to Rosebridge, but when you have these smaller homes in a country setting like that, I think they deserve to have the same kind of funding levels as all the other homes. We're not creating different levels of residents, I hope, in this thing, that because you're in a newer home, you're a different class of person than somebody who's in an older home.

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

Ms. Martel: Thank you for your presentation here today. Mr. Kent, thank you for your many years of public service.

I wanted to actually talk about licences. I note that you've got four-bed wards and a large dining room, so sooner or later you're going to be asked to make some changes and to move to two-beds and perhaps a change in the dining room. Explain to me again what your concern is with respect to having a fixed licence and, within that fixed licence, conditions around a redevelopment, going to the bank or credit union and trying to borrow money with the knowledge that there is no capital program in place to support what you want to do. Express to me your concerns, in terms of uncertainty but also financing and costs.

Mrs. Hobbs: I think Fraser Wilson explained that fairly well, and I would defer to his answer. I think it is related to, if we can't say that we are going to be operating for sure in 10 years, we will not be able to get any sort of renewal on our mortgages. I don't believe that any financial institution is going to loan money for improvements or anything else if our licence is not firm. Right now, our licence is based on performance: how we meet standards, that sort of thing. There is not that sort of guarantee in the new bill for licensing. We don't know how our licence is going to be determined. That's the concern.

The Vice-Chair: Thank you. Parliamentary assistant.

Ms. Smith: Thank you for being here. Thank you for donating your time to the family council. We really appreciate the work that family councils do and we've tried to give them as much support as we can through this legislation.

Rosebridge Manor is part of the OMNI chain, so you haven't actually been impacted by the licensing scheme in the sale process that's going on; I think Fraser spoke to that earlier.

I just wanted to ask Mr. Kent, with his past experience on drafting legislation at the federal level, it would be unusual to include a redevelopment plan in legislation that was a timely—as the previous government did in their D-redevelopment plan, that was not in legislation. That would be more of a budgetary question, would it not?

Mr. Kent: It's a bit hard for me to comment on that. All my legislation was centred around customs and enforcement-type legislation. I really couldn't comment fairly on that.

Ms. Smith: But if in the customs area you were looking at refurbishing the customs offices across the country, that wouldn't be in legislation; that would be a budgetary question and a policy question for your department, right?

Mr. Kent: That's correct, yes.

Ms. Smith: So it would be unusual to put a redevelopment plan in legislation because usually it's a fairly time-sensitive, one-time deal. The legislation, we hope, will be around for some time to come.

Mr. Kent: Yes. If we put funding out to all the regional offices, there would be some regional offices who would really complain if they got a lot less funding than some others.

Ms. Smith: And if that was locked in legislation, they'd be complaining for a long time.

Mr. Kent: Yes, they would. I'm very sure of it.

The Vice-Chair: Thank you.

PROVIDENCE CONTINUING CARE CENTRE

The Vice-Chair: The next presentation will be by Providence Continuing Care Centre. Welcome. You can start when you're ready.

Mr. Larry Norman: Good morning. I want to thank you for the opportunity for coming here and speaking to you this morning. I'm Larry Norman; I'm chair of the board of the Providence Continuing Care Centre. I have with me Shelagh Nowlan, who's the administrator for Providence Manor.

Let me start by saying that Providence Manor is part of the Providence Continuing Care Centre, which constitutes St. Mary's, a rehab chronic care hospital, and also Mental Health Services, which is the former provincial psychiatric hospital. We run those facilities, so I might come at this from a slightly different perspective.

Providence Manor is a charitable home for the aged. Of the 243 residents we have at the moment, five are designated veterans' beds. It's the only Roman Catholic-designated home in southeastern Ontario, but I want to stress that it's open to all faiths. It has 150 years of history of administering to those who are vulnerable in the community and often disadvantaged.

I want to say, first of all, that we are not against Bill 140, and we welcome many of the aspects of that. But like any legislation, it can always be improved by talking to those people who are engaged in the system and who see the issues day in and day out. We speak from the perspective of the non-profit sector, and I'll focus on a few issues.

But before I do that, I want to talk generically about a few issues. First of all, this is part of a holistic, integrated system. It is not independent by itself. We live in the province of Ontario, where many of us will be borne into the health care system through a hospital or something, and we'll spend our last days being supported by this province in our homes or in a long-term-care facility or in a hospital. In between, we'll use the facilities as needed. I say that because it's important that we don't look at legislation as separate from the whole. It is very much an integrated system. If you don't believe that, all you had to do was listen to the CBC or read the newspapers last week about our friends at KGH, who have no beds for those who need them because there is no long-term-care facility. So I ask you to think about the holistic nature of this system in which we are engaged.

The second thing generically I want to say is about funding—and I'll speak more specifically later—but just having the absolute money at some point in time through the calendar year is insufficient. We lobbied hard for multi-year funding commitments in the hospital system, and the benefits of that are enormous. I speak as the chair of the board for hospitals. They must move to the same kind of thing for long-term-care facilities. My background, I guess, is in business. I don't know how you can run a business—and this is a business, although it is a not-for-profit business—without having the ability to plan in more than a one-year or six-month time frame.

With that being said, let me move on to some specifics about the bill. First of all, not-for-profit care delivery: I believe that we must, in this legislation, enshrine the rights and specifically the notion of "Not-for-profit is here to stay." I have a concern about that because it is eroding, and I'll give you a specific example of that. As you know, we have a shortage of long-term-care beds in this community and we recently had an RFP to make a proposal. We have chosen not to submit. There is no way that we could fund a new facility. We have no profits; we'd have to borrow the money and then have to get it back some way by saving here and saving there. Sometimes I feel like master of the house in Les Miz: You save a little here and a little there and a little somewhere else and maybe you can make this thing come together. But that's really being facetious, and I don't think I want to go there.

1010

So it's important that we do enshrine this in the legislation. It is in other parts of legislation in the health care system; why not here? I think it's important because we as a non-profit organization, and being a religious organization, have a long history of care in this area. As a matter of fact, our waiting list of people who would like to get into our home exceeds what we could ever, I suppose, look after in the next 10 years.

Let me now move to the fixed-term licensing. I sometimes wonder when I read this if this not a pipe dream, in a way. Let me ask you this: If you were to come to me today and say, "We're not going to renew your licence"—I have 250 beds approximately—where would these people go? What would you do? We already don't have enough, so I wonder how you really would make something like this work. Maybe what we need to do is put more emphasis into making sure we never reach that point and put the energy into that place where we'll have good, viable institutions so that we will never have to face a renewal of licence.

There's another aspect of the renewal of licence I do want to talk about and that is, there are two aspects to a facility. One is the operating side of the coin; the other, though, is the maintaining side of the coin. To keep the facilities renewed and vigorous and right for the residents that we have in these institutions, we have no means of capital money except what we can find somewhere to keep these systems—as an example, we just borrowed $1 million from the bank to make sure the windows were renewed, the roof was renewed and all that. We'll pay that back somehow, some way; maybe through our local foundation, maybe by saving a little here and a little there. But is that really what we want? We need to have some kind of a capital, as we do in the other aspects of the hospital system. When I go to St. Mary's, I've now got monies. They may or may not be adequate, and we can debate that, but at least there's money every year that I know I can use for this kind of thing—absolutely critical to do that.

Let me talk about regulations and cost, and I want to come at this from the point of view of, how much money do we have to do this kind of thing? Being part of a larger hospital system, we have scorecards in place, we have many of these standards in place, but I would bet you this morning that they would not meet what you will put in place in terms of how they're formatted, the right computer programs and all of that. But they do exist, and the question is, how much are we prepared to spend to do that? And with the absence of long-term funding and adequate funding, they will take away from patient care. You've heard that many times this morning, and I heard that as I sat there too. So it's an important thing to think about how we implement this. I don't discount the importance of standards in the system. We all have those in our lives and they need to be there. But what's the cost and how do we cover the cost of that and do that?

Let me talk a little bit about the personal liability of directors, because I guess I'm sensitive to that. I'm not sure anymore which one I now come under in this act, because for me personally, what I'm entitled to or not entitled to under this act is different than if I was at St. Mary's or Mental Health Services. So we need to be thoughtful, and that gets back to my point about the integration. These things should not stand alone. Should they not be part of a bigger whole and should we not be consistent? I wish I was working for Ontario Hydro, where if I screwed up I might be able to walk away with a little more money than I would as a director. But I have to tell you this: I spend time every day in this health care system. As a volunteer, I get nothing out of this except that I'm doing some good in this community and making a difference, and that's important. And it's important to

me. But to come out and then jeopardize people like me who are prepared to give time to do this I think is inexcusable. There has to be a better way of doing this than what is currently proposed.

Because I'm sure you have some questions, let me conclude by saying thank you. I hope you can make some changes.

I've been involved in this health care system for some 30 years as a volunteer and maybe 25 in the long-term-care field. This is a very, very dynamic and changing world we live it. It's important that we don't enshrine in legislation a whole bunch of detail and standards and so on which will be different two years or five years from now. Legislation changes but slowly and rarely. I ask you and plead with you not to do too much of this kind of thing. It is important to have standards, but every home is different. The residents we have today will be different than they are five years from now. Those standards put in place today, will they be the same five years from now? I very much doubt it.

When I was first involved with Providence Manor, people who came to that community could walk downtown; they could do things. Sure, they needed help and needed care. Today, there's nobody who can walk downtown and there's nobody who doesn't need extensive care, and that will be different five and 10 years from now. So I plead with you, whatever you do, take the future into account. It is not a today issue; it's a longer-term issue than that. Somehow we got mixed up: "Because we have a bit of a problem today, we'll put in legislation that's only good for today but not good five or 10 years from now."

I close with that note: Please think carefully about what you do. Thank you.

[*Interruption.*]

The Vice-Chair: Thank you very much. We have about three minutes left. We can divide them equally between the three parties. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation and frankly for your commitment to the health care system.

I want to focus on your concerns about licence renewal because you said that you have existing financial obligations that extend beyond what would probably be a 15-year licence under the provisions and also that indications from the lending community are that this would increase the cost. Have you had those discussions with your financer? Is that what you're being told directly about the implications for you if the bill is passed in its current state?

Ms. Shelagh Nowlan: At this point, not directly. We haven't had to go to seek further financing. We have just recently acquired a loan through the existing options. But the indication is that shorter-term licences, as I think shorter-term mortgages do, have increased repayment schedules. That's the focus that we were bringing to this discussion.

The Vice-Chair: The parliamentary assistant.

Ms. Smith: Thank you for your contribution to health care in the community and your personal contribution over the years. I know that Providence does a great job. My brother was a med student here; he did geriatric care and spent some time with you a while back.

I wanted to ask you about your concerns around the regulation and the documentation. We've asked this a couple of times of providers, and this may be more a question for Shelagh. Can you point out to me which sections of the act you feel will be requiring more time than what is already in the policy manual, in your practice manual, in the regulations and in the legislation as they exist now?

Ms. Nowlan: Certainly. The documentation that I am referring to specifically refers to some of the added frequency and description of what a complaint is. There is an increased burden to not just look at the written complaint but to look at complaint processes, which often are managed within the home itself—the resolution of issues is best dealt with promptly, working with the resident and family. What this does is add a layer to the reporting structure. At Providence Manor, we also currently report to the board through, as Larry had mentioned, reporting schedules on risk issues—

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

Mrs. Witmer: Thank you very much, Mr. Norman. What an incredible record of service. I would have to say, your presentation just made a lot of good common sense. I think the audience recognized that and applauded it. I do thank you very much.

You said that the RFP process for the new beds here in Kingston—which I know are desperately needed and I understand now they aren't going to be ready until 2009 or beyond—was a disadvantage to you. You couldn't even participate. Can you just expand on why you couldn't?

Mr. Norman: Two reasons: One is that we have no capital available, so we would have to borrow the monies. That's the first thing. Second, we did do some work, and we could not build for the dollar-per-square-foot value that was given to us. We checked that with a couple of architects and so on. We could not do that. However, we have agreed to work with some others who might have an interest in helping because we do have a lot of expertise in this field. We are prepared to work with others to do that, and we've made that commitment.

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

1020

SHERWOOD PARK MANOR

The Vice-Chair: Now we'll move to the next presentation, which will be by Sherwood Park Manor.

Welcome, sir. You can start whenever you're ready, but before you do, please state your name and the name of your company.

Mr. Jack Butt: Thank you, Mr. Chair. My name is Jack Butt. I'm the chairman of the foundation at Sherwood Park Manor. I'm pleased to be joined by two of my colleagues: Ms. Joan Bennett, our administrator, and Dr.

John Southin, who was a former chair of our board and is currently the chair of our public relations committee.

Sherwood Park Manor is a full-service, accredited, non-profit nursing home. We opened our doors in 1976, and today the manor is one of a few fully accredited nursing homes in our area. We have 107 beds and 106 staff. We strive to ensure that the atmosphere is conducive to the dignity and well-being of our residents. We pay careful attention to each and every aspect of our residents' daily lives so that they can truly say, "This is my home."

As a not-for-profit charitable organization, we rely on private donations, our foundation and in-memoriam gifts to fund the replacement of furnishings and equipment. This differs from municipal homes that can access levies from municipalities and, similarly, private homes where profits could be redirected towards immediate needs.

Our board supports many of the aspects of this legislation, and both our administrator and director of nursing can attest that they have struggled to achieve much of what is being contemplated in Bill 140. Our staff and our board very clearly endorse the notion of building a strong and safe long-term-care system, and we understand and support the need for constant monitoring, the need for high standards and the need to strive for improvement. That notwithstanding, our board is concerned that this legislation in its present format will not encourage partnerships, is prescriptive and will have a serious impact upon the delivery of our care.

We hope that you all take time to re-evaluate this legislation and once again affirm the government's "commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all ... residents."

At Sherwood Park, we value the input and advice we receive from our residents' council and our family council. You should know that we have worked hard to create this positive climate that fosters open dialogue and nurtures good relationships with our residents and their families. In fact, we actively engage all our residents and our families in their plan of care and the overall activities of the manor.

We believe that the current balanced approach that we have developed will, with this legislation, place us in conflict with our residents. Our director of nursing asks the following: "How do I now deal with a resident who refuses infection control and then puts others at risk?" Further, she asks us, "What about a resident who refuses baths and refuses to participate in normal personal hygiene, yet asks to be seated at a dining room table with others?" We are also concerned about this contract between the resident and the home which allows these individual rights to be enforced at the risk of infringing on the collective rights of others.

Further, we suggest that if members of our community at large have access to all our budget information, then the process of collective bargaining would be fatally compromised.

We do support the provisions of the act that minimize restraints. However, once again the act requires documentation by registered staff, as those impacted have to be monitored every two hours; once again, a funding issue.

Our director of nursing has significant concerns around psycho-geriatric transfers in our community as beds are being downsized at another facility and those residents or clients then being intermingled with our other residents who are frail and elderly.

Our director of nursing also tells us that we are more regulated than any other sector, particularly the hospitals. She tells me that this new legislation already makes significant impediments to her ability to recruit and retain staff. The complexity of care required in our sector requires special expertise, and the increased workload under this bill, without increased funding, means heavier workloads. It means more resignations and greater challenges in recruitment. It follows that her staff will be unable to measure outcomes and therefore provide effective service delivery, as we believe what gets measured gets done. A law of nature suggests that resident care will suffer as our staff devote their time and resources to the preparation of reports and other documentation.

Certainly we endorse the concept of the enforcement of standards and accountability. However, once again we suggest to you that funding must be increased to ensure that compliance documentation is not only completed thoroughly, but is taken seriously.

As well, our board is very concerned about the added obligations and the penalty provisions under this act. We have been advised that our directors' and liability insurance will not cover anything we have to do by law. For example, it will not cover fines levied under the act, and we suspect that it will be difficult for us not only to retain but to recruit board members. In fact, one of our board members who is a lawyer has already written Minister Smitherman in this regard, and I suspect that in his concerns and his articulation of them, he is speaking for every board member in Ontario.

In preparing and reviewing our comments for this act, we had access to a 2001 report from PricewaterhouseCoopers and also a recently released coroner's report that made some 85 recommendations. Both of those included an articulation of the need for increased funding and minimum standards. We have since learned that that position is also supported by CUPE and OPSEU.

Sherwood Park Manor, along with other homes, has a long history—and a proud history, I might add—of going that extra mile for residents, often providing more than is required by topping up provincial funding with donations from our foundation, by creating home-like environments, by serving the distinct needs of our communities and working with a cadre of volunteers. We recognize the need to continue to play a leadership role by providing quality care, and we wish to continue our partnership with the government to make important and lasting improvements. Unfortunately, we perceive this bill to be adversarial in nature, as it will impose addi-

tional and substantial hardships due to new requirements which we'll have to meet.

1030

We perceive that many of the sections of this act are flawed and need to be revised. Our board has asked me to tell you that they would be supportive of the creation of a task force which would be representative of all our stakeholders. They suggest that this task force be assigned the challenge and responsibility of developing practical, workable and palatable compromises and solutions which would result in not only achieving the government's objective of higher standards but would also have the commitment and support of all the stakeholders.

We agree that we can't erode the current level of care. We agree that we must be accountable and responsible. We believe in partnerships. We believe that bad apples must be punished. We also agree that good performance must be rewarded.

I think it was Mark Twain who said, "If your only tool is a hammer, then all your problems are nails."

Thank you for the opportunity to talk to you.

The Vice-Chair: We have a few minutes left. We can divide the time equally among the three parties. We'll start with the parliamentary assistant.

Ms. Smith: Thank you, Mr. Butt, and all of you, for being here from Sherwood Park Manor. We appreciate hearing your views.

I've heard concerns around the involvement of community members on family councils, so I appreciate you raising that with us again today.

I wanted to ask you a quick question about removing secure units from the more intense monitoring and documentation around the use of restraints. Why would you feel that residents who are living in secure units would require less monitoring with the use of restraints than those living in the rest of the home?

Mrs. Joan Bennett: Perhaps I could respond to that. It's rather a broad issue, so I'll answer it in a broad way. There's quite a lot of pressure right now for us to accept residents who have a psychiatric diagnosis, and there are a lot of reasons for that. The access to chronic psychiatric beds in our community has decreased, so there's a lot of pressure to take people who have a psychiatric diagnosis. Very often their behaviour is difficult to control and they're a danger to other residents. But we do take them. We have a lot of expertise in that area. We've found that 92% of our residents have psychiatric diagnoses. To a large extent, we're able to manage them, but fairly frequently we have residents who develop violent behaviours, who are a danger to other residents, so then what do we do? We try to have them transferred to the psychiatric hospital, but they don't have chronic psychiatric beds. So what we have done in the past is transferred them to the secure units, but now that's very hard. Under this bill, they can only be transferred to the secure unit if that person's decision-maker agrees. That's my understanding from the Ontario Association of Non-Profit Homes and Services for Seniors.

The Vice-Chair: Thank you.

Ms. Smith: We can talk about that after, because I don't want to take any more time.

The Vice-Chair: Mr. Yakabuski.

Mr. Yakabuski: Thank you very much for your excellent presentation.

Picking up on your Mark Twain story, I'm sure everybody here has seen the OLG ad—it used to be OLGC, but they changed that for $6 million—because the government spends a lot of money on advertising, where this hockey team is sent out to play a game of hockey in all this retro equipment and they get quite a shellacking. It's somewhat entertaining. Would you say that that's a fair analogy of what we're expecting our long-term-care homes to accomplish under this bill? We're giving them all kinds of responsibilities and regulations to work under, but we're equipping them like this hockey team that was equipped out of the 1920s to go play against a modern-day team. Are we setting this whole thing up for failure simply because the government wants to send a good political message out there?

Mr. Butt: It's our board's position, clearly, that if we impose increased documentation and increased standards and don't provide the corresponding increase in funding, then our staff are going to concentrate not on providing the bedside care that we demand but in filling out forms and documentation, which we think is unacceptable.

Mr. Yakabuski: And ultimately that would be bad for our residents.

The Vice-Chair: Thank you. Ms. Martel

Ms. Martel: Thank you, all of you, for being here. It's nice to see you again, Mr. Butt, albeit in a different capacity this morning.

I want to focus on minimum standards, because my concern has been the fact that there are no minimum standards in this bill, despite the fact that the Liberals promised to reinstate minimum standards in the last election. They said 2.25 hours at that time, but I think it should be closer to 3.5, and there are many others who are in support of that view. Of course, that requires more staff, but if the government also lived up to the second promise that it made in the election, to fund $6,000 more per resident, then there would be the money available to provide the staff to increase that level of care.

Can you give me a sense of what your level of care is per resident at your current funding levels?

Mrs. Bennett: I can answer that. Actually, sadly, this year we've had to cut the hours for health care aides. We've had to cut our hours 10 per day going into this year, because the track of funding in the last three years has been really poor. In nursing, this last year our funding increase was 1.71%; in programs, 2.5%; for raw food, 1.12%; and in other accommodations, which is dietary, maintenance, housekeeping, utilities, insurance, auditing, legal, bank fees, postage, office supplies and mortgage payments, we got 0.88%. Our union—

The Vice-Chair: Thank you very much.

Mrs. Bennett: Oh, I couldn't answer you. Sorry.

The Vice-Chair: Thank you very much.

Mr. Butt: Thank you.

JEAN BERTRAND

The Vice-Chair: We'll move to our next presentation, by Caressant Care Nursing Home. You can start whenever you are ready.

Ms. Jean Bertrand: Good morning. My name is Jean Bertrand. I am a member of Service Employees International Union. I welcome this opportunity of appearing before Mr. Chair and the standing committee on social policy to discuss the Long-Term Care Homes Act, 2006, Bill 140.

I have been employed for 20 years at Caressant Care Nursing Home, Marmora, Ontario. Caressant Care Nursing Home has a total of 84 long-term-care residents.

Staffing hours for a 24-hour period:

—Day shift: one RN, seven hours; one RPN, seven hours; eight PSWs or health care aides at seven hours, equalling 56 hours;

—Bath shift: one PSW, seven hours;

—Evening shift: one RPN, seven hours; one RN, seven hours; seven PSWs at seven hours, meaning 49 hours;

—Night shift: one RN, seven hours; three PSWs at seven hours, equalling 21 hours.

Total care hours are 168. We have 84 residents, so 168/84 equals two hours of care per resident.

The long-term-care homes in Ontario are understaffed and under pressure. This is why we need a minimum standard of 3.5 hours per day of nursing and personal care for residents. These people are human beings, with the right to be treated as such. We are not factory workers and they are not machines, but this is how both nurses and residents feel. These residents in long-term care built this country. They are our parents or our grandparents. They have had enough hardship in their lifetimes already. Residents have the right to be respected and have dignity. They have the right to live out their golden years in a safe and comfortable environment. Their needs are few, and yet we continue to fail to meet them. Some residents without families need more care time. We are their loved ones or family.

1040

Understaffing is a chronic problem in Ontario nursing homes. Understaffing translates into poor resident care. Most of the time, if some employees call in sick or are absent, we work short. Overtime to remaining staff, some RNs, is for one hour. The home claims that it is not in the nursing budget. One personal support worker takes care of 12 residents at a time. If you are short, then you pick up the other short-staffed residents. In a seven-hour day, a personal support worker helps to feed morning nutrition, to deliver laundry to residents' rooms, full periodontal care, toileting, bathing, grooming, suppository days, shaving etc., making beds, tidying dressers and closets, and making sure that everything is marked with names. The nursing home demands that a resident's diaper be 80% wet before we change one diaper in a seven-hour period. Staff need to cope with ringing call bells, wandering residents, doctors' days, blood days and lab days, and sick residents take even more attention.

To get CMI, you have to chart. Who has the time? We work understaffed with full-time staff, and when we work short, then there's stress, sickness, WSIB, loss of time. That is why we have to put the staffing standard at 3.5 hours per day of nursing and personal care per resident. I have been employed in this sector for 20 years, and these residents need these hours for living in dignity and with respect, safely and comfortably.

Bill 140 is a flawed piece of legislation reflecting the betrayal by this government of the people of Ontario, betrayal of the wishes and needs of our seniors and the people who provide quality care in facilities across this province. The sad state of long-term care in our province is that the provincial Liberal government has an obligation to show leadership in dealing with this situation. You cannot have quality care without people. To this end, a staffing standard is a necessary first step. A necessary second step is for the Liberal government to commit itself to the non-profit model, then to the state of long-term care. Taken together, these will ensure that people living in this province will have access in their communities to the kinds of services they need now and in the future, services provided for them by dedicated, qualified staff who themselves are members of the same communities.

If Bill 140 is not amended by this government to deal with a staffing standard of 3.5 hours per resident per day and a non-profit model, then the state of long-term care in our province will not improve. We urge the Dalton McGuinty government to address the issues I have raised in my presentation. We further urge them to listen to the concerns of the people in Ontario and act upon them.

Thank you for the opportunity of appearing before the standing committee on social policy to share my thoughts regarding the Long-Term Care Homes Act, Bill 140.

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

Mrs. Witmer: It's always very refreshing to hear from someone who's personally working with the residents on a day-to-day basis. Certainly when I visit homes I do see the tremendous pressure and stress on the health care providers such as yourself, with the lack of resources.

The Liberals did promise an additional $6,000 for each resident to provide for personal care. That hasn't been delivered. Now we see a bill that introduces more paperwork and that really, again, is going to lead to a decline.

We've been hearing today that the residents in the long-term-care homes today have much more complex needs than in the past, and I suspect that this is only going to increase. You've said that, for example, a minimum level of 3.5 hours of personal care needs to be provided, as opposed to the current two hours. What is it that you could do for residents with the additional care that you really feel is impacting them negatively today?

Ms. Bertrand: My feeling and the feeling, I'm sure, of all nursing staff, PSWs, health care aides and hands-on care people is that we really need to have a little bit more time so the residents don't feel that they're being treated like a machine. You go in there, you say, "Good morning," and that's about it. You have so little time, because you start at 6 a.m. and you have to be in the dining room for 8 o'clock. That's unfeasible. You have 14 residents to wash or bathe and care for before breakfast.

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

Ms. Martel: Thank you for your presentation and for your work in this sector over many years caring for the frail and elderly. Tell me, in those 20 years, what has been the change in the health of those residents who are coming into your home now?

Ms. Bertrand: I find that the thing with CMI is you get more points, you get more hours, for your hands-on care, but if you don't have time to document—which we don't, because we're so overworked. We don't have time to document to improve our hours.

Ms. Martel: If someone calls in sick, if someone gets ill or gets hurt and has to go home, is the home replacing the staff? Or is the first line, essentially, to just ask others to do more?

Ms. Bertrand: Because the workload is so heavy in the nursing home, it is very hard to keep new staff. They just can't cope with the hours and what you have to do in a short period of time.

The Vice-Chair: Thank you very much. Parliamentary assistant.

Ms. Smith: Thanks for being here today. In my tour of a variety of homes a couple of years ago, I didn't get to Cobden, but I did get to Marianhill and Bonnechere Manor and Deep River—so a few in your neck of the woods. I appreciate the great care that you're giving to the residents in your area.

I wanted to ask you a bit about the staffing standard that you've been talking about and the 3.5. There's a lot of discussion around that issue and a lot of discussion about what is included in that 3.5. Would you include in the number the hands-on caregivers, would you include dietary and restorative care, and would you include people who are doing activities with the residents?

Ms. Bertrand: No, just hands-on care.

Ms. Smith: How do you define hands-on care?

Ms. Bertrand: Hands-on care is somebody who really takes care of you completely—total nursing care.

Ms. Smith: So the nursing aides, the personal support workers, the RNs and RPNs?

Ms. Bertrand: Yes.

Ms. Smith: What about people who come in to provide physiotherapy or occupational therapy? Would those be included?

Ms. Bertrand: Definitely not. I'm just speaking about the hands-on care, because these people really do need it—and not to be washed in a matter of seven seconds.

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

1050

ST. PATRICK'S HOME OF OTTAWA INC.

The Vice-Chair: We'll move to the next presentation by St. Patrick's Home of Ottawa Inc. Welcome to the standing committee on social policy. If you don't mind, before you start, please state your name and your colleague's name.

Ms. Linda Chaplin: Good morning, Mr. Chairman and ladies and gentlemen. My name is Linda Chaplin. I'm the executive director at St. Patrick's Home in Ottawa, and with me is our board chair, Mary Whelan.

St. Patrick's Home in Ottawa was founded as a children's orphanage and a house of refuge for the elderly in 1865, which was two years before Confederation, of course. It's one of the oldest in Ontario. Our current site was built in 1964, with an addition in 1985. The Grey Sisters of the Immaculate Conception operated St. Patrick's from 1933 until 1996. At that point, the home was incorporated as an independent entity. In the year 2000, the Grey Sisters transferred sponsorship to the Catholic Health Corp. of Ontario. Pending Bill 140's proclamation, we are currently regulated under the Charitable Institutions Act and well served by a voluntary board of directors, who certainly exercise due diligence and care in their governance.

In addition to our 202 long-stay beds, we have an on-site day program and four independent-living suites, supply Meals on Wheels to a community group and are home to 16 Grey Sisters, who have a convent on our fourth floor. Their culture of caring and compassion is perpetuated by their presence, and they make daily contributions to the lives of our residents. We also have over 250 volunteers, who offer much-needed support, companionship and links to our community. The administrator in me calculates their actual contribution as amounting to about 16 or 17 full-time positions.

I welcome the opportunity to present to you today on Bill 140. We appreciate that it intends the assurance of a safe and healthy long-term-care environment and consolidates the statutes that currently govern us. The perspective that I bring today comes partly from being part of a faith-based organization that is known and respected for its long history of loving and compassionate care. We live our core values on a daily basis: sacredness of life, growth and vision, spirituality, hospitality and social justice.

In moving forward with the legislation, we hope the committee will consider our concerns, our comments and also some suggestions that we'll bring forward. Our concerns are driven by the following long-term-care realities, and a number of my colleagues who have spoken have brought these forward as well:

—Our resident profile in long-term care has changed markedly even over the past decade. People coming to us are older, they are more frail, they are much more likely to have cognitive impairments, and overall they have much more complex and heavier care needs.

—More than 50% of our residents suffer from varying forms and degrees of dementia.

—Residents and their families have escalating consumer expectations around care and services.

—The increasingly complex residents in our care, on average, have five or more medical diagnoses, and they receive at least nine medications throughout the day.

—Most aspects of daily care, such as bathing, toileting and dining, require the assistance of one or more caregivers as well as lifting and transfer devices.

—Some residents are resistive to care, and some residents are openly combative.

—It is fair to state that all are fragile and all are in a state of decline.

Bill 140 only marginally recognizes the implications of this reality in our daily interactions with residents, and often their family dynamics are quite complex.

I'll address our concerns under 10 major headings.

Our first comment is on the mission statement. Bill 140 requires that a new mission statement be developed consistent with the resident bill of rights and in concert with resident and family council, staff and volunteers. Our concern is that the membership in councils, staff and volunteers change over time, and each person brings individual belief systems, values, motivations and agendas. Faith-based organizations have a long-standing history of operating within mission statements that are time-tested and reflect their teachings, and they are regularly revisited for currency and relevance.

We are proposing that the legislation include a clear indication that organizations need not include provisions that are contrary to their spiritual foundations and religious teachings.

With respect to boards of directors, Bill 140 gives the impression that voluntary boards of directors have lacked accountability. If implemented as scripted, the bill will represent an onerous, if not impossible, challenge for recruitment and retention of voluntary directors. The possibility of personal liability and individual directors being held accountable if they "fail to take all reasonable care to ensure their homes meet all the requirements of the act" with fines of up to $25,000 or 12 months in jail is a significant deterrent. This leads to the high probability of insurance premiums increasing and that, potentially, policies will be more difficult to obtain. Without considerable increased funding to implement Bill 140, we will experience a negative impact on an already strained capacity for front-line care delivery as further resources will be redirected to meet the new standards and avoid repercussions and penalties.

We propose that the framework in place within the Public Hospitals Act be utilized as a reasonable guideline for expectations of our voluntary boards. There are certainly general offence provisions within the Public Hospitals Act, but the penalties range from $50 to not more than $1,000 on conviction—significantly different from $25,000 and 12-month jail terms.

With respect to the plan of care—this has to do with the documentation issue that a number of my colleagues have spoken to. We certainly are respectful of the fact that each resident deserves individualized care. Certainly, both the sector and our residents have benefited from the standardization that was implemented in 1993. However, on surveying both our medical director and attending physicians, they feel that the documentation burden will become prohibitive due to the significant opportunities for inspections outlined in Bill 140. We are already highly regulated, inspected and legislated, and a further increase is likely to lead to a regretful exit of our current capable and committed physicians.

The documentation burden, however, applies to all professionals in the sector. We work closely with and develop trusting relationships and very solid communications with our families and residents, and we do develop comprehensive, dynamic care plans that are modified as care needs change. The documentation and administrative burden of Bill 140 without resources to deal with it will mean a reduction in front-line care and services. Long-term care in Ontario is already a resource-constrained health environment, with among the lowest funded hours in Canada. Funding has simply not kept up to increasing care levels and escalating consumer expectations. Our priority is hands-on care, and diversion of energies for documentation will compromise care further.

We recommend that a detailed analysis be undertaken to assess the impact of and the need for increased documentation prior to implementation, and ministry commitment to fund the implementation of Bill 140 is essential. We believe ministry funding for the long-term-care sector needs to reflect the actual care requirements and demands.

With respect to consent, Ottawa is one of the areas in the province identified as underserviced for long-stay beds, and thus we frequently have alternate-level-of-care transfers from acute-care for whom we are not the first choice. On any one day in the city of Ottawa, there are at least 110 acute-care beds being occupied by individuals awaiting placement in long-term care. There are reports in the province of applicants being dispatched to placements almost 100 kilometres away from family in a facility not of their choice. We believe this must stop. Therefore, we applaud section 42, requiring consent for admission to a specific home.

The area that causes us concern is the requirement for consent for admission to a secure unit. Admission to a secure unit is certainly an emotionally charged decision. The requirement for formal consent is problematic, however, from a risk management perspective, as it can cause delays and resultant risks. We already assess residents' condition and behaviours, and our well-trained staff assess capacity and competence. Families also have access to an external assessment on request.

1100

Because we live in congregate living environments, we must take absolute care for the safety of all residents and all staff. If we have an additional layer of bureaucracy, in the person of a rights adviser, for example, the

timeliness of transfer and safety of all concerned will be impacted and costs will be driven upward as well.

We recommend that if there are homes identified where, for convenience or ease of management, residents are being improperly placed in secure areas, then we respectfully ask that the ministry's compliance division deal with them directly. The vast majority of long-term-care facilities manage transfers to secure areas appropriately and should be permitted to continue to dialogue with our clients and manage the risks associated with a resident's condition.

Similarly, if there are systemic pressures and hospitals and CCACs sometimes discharge to inappropriate placements, this unsafe practice cannot continue, and we ask that it be dealt with through other avenues.

With respect to mandatory reporting, our employees are not abusive, they are not neglectful and they are not incompetent. On the contrary, they are accountable, they value their careers and their reputations, and equally as important, they value the dignity of each resident. Mandatory reporting and the negativity of a blame game does not improve our system. Many families of residents offer loving support, but some can also provide significant challenges if there's a lack of family unity or if they're carrying a history of guilt, anger or unfinished business. Facility employees are often expected to absorb that fallout and somehow cure the flawed family unit. For the same reasons that physicians will choose other options, our workplaces will fail to retain the best staff, and we may be unable to recruit qualified replacements. The highest possible quality care proposed by Bill 140 cannot be achieved if our valuable human resources are lost due to the imposition of rigid rules and punishment. We recommend that the tone of Bill 140 be modified to reflect a respectful approach, with emphasis on quality improvement and recognition for performance.

With respect to the resident bill of rights, Bill 140 sets up unreasonable expectations of long-term-care homes by entrenching the bill of rights in legislation. However, there's no corresponding requirement that resident decision-making capacity or competence be confirmed. There are no corresponding responsibilities of residents or their representatives either to fellow residents or toward staff.

There was a recent Stats Canada survey on the work and health of nurses, and it clearly showed a high rate of stress-induced mental and physical health issues associated with patient assault on nurses.

Licences are of issue to us. We are a C-level home. Portions of our facility are clearly below a C, with three- and four-bed wards. Some of our folks go across the hall to a bathroom. We ask that consideration be given so that our folks have the right to access the same level of comfort and service as residents of A-level homes.

A 10-year licence moratorium and a potential to be advised at seven years is problematic for us. We recommend that budget allocations and licence restrictions be examined and that ministry incentives be applied to support C-level homes.

I'd like to close with a final recommendation that I believe would make a difference on the ground, and that is that the Ministry of Health and our elected officials offer consideration to the positive impact that the not-for-profit sector is already making, that the balance be maintained between the for-profits and the not-for-profits, and that these contributions be acknowledged in the legislation.

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

HILLTOP MANOR

The Vice-Chair: The next presentation will be by Hilltop Manor nursing home. Welcome. You can start whenever you're ready. Before you start, please state your name and your colleague's name for the record.

Ms. Dianne Mason: My name is Dianne Mason. With me today is Bernard Bouchard, administrator of Hilltop Manor. Thank you for this opportunity to comment on Bill 140.

I'm president of Hilltop Manor, a family-owned and operated long-term-care home. I also serve as a board member of the Merrickville District Community Health Centre. My parents, Oscar and Rose Fader, started our family business, Hilltop Manor, in the village of Merrickville in 1963 with 28 residents in the historic Harry McLean House. At the age of 16, my brother and I began working in the home with our parents. As a family home, we all worked to care for our residents. We considered our residents as our extended family.

Given the increasing care levels and needs of our residents over the 10 years we were in the Manor house, it was apparent that the physical structure was in need of improvement. With the passing of the Nursing Homes Act in 1972, a new building was built and our licence was increased to 60 beds with the provision that we participate in the provincial homes for special care program. We financed the building of the new home by taking out a mortgage. The new Hilltop Manor opened for residents in July 1976. But 31 years ago most of our residents walked into the home, spent little time in their rooms, and some of our residents drove their own cars. The space requirement at that time was suitable. Needless to say, our residents' care needs have once again dramatically changed.

In April 1998, the government introduced new design standards. We were classified as a C home, having eight four-bed wards and limited dining space. In an attempt to meet our growing requirements for space and resident privacy, we requested additional beds and capital funding to once again upgrade Hilltop Manor. All of our requests to the Ministry of Health and Long-Term Care have been denied.

We have continued to provide excellent care to our residents and their families and have been a model employer to our dedicated and caring employees over the past 43 years.

Our home has received ongoing three-year accreditation from the Canadian Council on Health Services Accreditation since 1986, over 20 years. We have enjoyed a positive and productive relationship with the Ministry of Health and Long-Term Care and all of our community partners.

The proposed limited licensing provision of Bill 140, as presented, without a capital renewal program for B and C homes is a serious injustice that will, I believe, lead to the elimination of long-term-care homes in rural Ontario.

I am here today to ask for your support in amending Bill 140 so that Hilltop Manor has the opportunity, after 43 years of exemplary service, to continue providing the excellent care that our residents and families deserve.

Should you decide to keep the limited licensing provisions of Bill 140, as stated, please introduce an appropriate capital renewal program for all B and C homes across Ontario.

Mr. Bernard Bouchard: Thank you for this opportunity to comment on Bill 140. I have spent the last 18 years of my work life as a front-line administrator, social worker and advocate for residents and their families, and employees working in long-term care. I have served on the board of directors for the Ontario Association of Social Workers, eastern branch, and as president of the Ontario Long Term Care Association. I continue to work on an ongoing basis with First Nation groups in the development of long-term-care homes and, more recently, have accepted to sit on the collaborative governance development team for the southeast LHINs. I'm looking forward to representing all long-term-care homes in the southeast LHINs. We are at a very important crossroads with the introduction of Bill 140, and I would like to spend the time available on one of the most serious issues before us: the limited licensing provisions of Bill 140.

In support of my colleague's request for an appropriate capital program for B and C homes across the province, it would be reasonable to ask the question: Why is an appropriate capital program for B and C homes needed as part of Bill 140?

Since 1998, we have seen a significant commitment to seniors and their families with the introduction of 20,000 new long-term-care spaces and capital funding. The current government has continued this commitment with the recent announcement of over 1,750 new long-term-care spaces.

As our population ages, these commitments are welcomed by all of us working on the front lines and in our communities. While we support these initiatives, after 43 years of service to our community in Merrickville and on behalf of our residents, their families and our employees, I ask the question: What will be our role in the long-term-care system, and what will our future be?

In 1998, nine years ago, the government introduced five structural classification categories for all homes in the province. It was determined that there were 16,000 residents living in unsuitable physical buildings designated as D homes. The D homes were those homes that did not meet 1972 standards. The older homes, unlike the B and C homes, did not take out mortgages and upgrade, but remained structurally non-compliant over the years. In order to address these poor physical plants, a new D home program was introduced by the government. This D home program included capital funding of $10.35 per resident, per day, for 20 years. Most D homes took advantage of this program and are now new homes, with only a few municipal homes that chose to remain as D homes.

1110

From a resident's perspective, it made moral sense to all of us to address the structurally non-compliant homes first. It was always my understanding that once the new homes were built and the structurally non-compliant homes were updated, the B and C homes would be given an opportunity to upgrade to a new design standard. These new design standards would eliminate the four-bed wards and increase the dining and activity spaces. We have been patiently waiting for the last nine years and are still waiting.

There are approximately 35,000 residents currently living in B and C homes today. The introduction of Bill 140 is an opportunity to correct this serious injustice. In your deliberations, please keep in mind the quality of life of those 35,000 residents, many of whom share their bedroom and bathroom with three other heavy-care residents 24 hours a day, seven days a week, 365 days a year. Four-bed ward accommodation for Ontario residents in long-term care should be eliminated over time. Just to repeat myself on that important point: Four-bed ward accommodation for Ontario residents in long-term care should be eliminated over time.

As a care provider, limited licensing without an appropriate capital program for B and C homes will be disastrous. Some of the negative outcomes that we can reasonably expect include the inability of a home to get financing, attracting and keeping long-term employees, ongoing deterioration of our home's physical plant and losing our licence through unrealistic government requests or through an RFP process. It is disappointing that while this legislation took three years to write, it will introduce limited-term operating licences linked solely to the building's structure, without a plan to reassure communities that there will be homes to meet the increasing demand and needs, and that these homes can meet the residents' expectation for privacy and dignity. Without a capital renewal program for B and C homes, sections 100 and 180 of Bill 140 will start the clock of uncertainty ticking. This clock will tick the loudest for the 263 C classified homes, many in small rural communities. Their operators, families, employees and the 27,500 residents will be left wondering what day in the next seven years the ministry will decide to reveal their future.

The solution starts with amending section 180 to provide us with a 15-year-term licence and to empower the government to fund a capital renewal and retrofit

program for B and C homes. 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. I know that our association, the Ontario Long Term Care Association, has presented this solution to you in detail. On behalf of Dianne, her mother, Rose, our residents, families and employees of Hilltop Manor in Merrickville, I urge you to give these solutions your full consideration. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have six minutes left. We'll start with Ms. Martel. Two minutes, Ms. Martel.

Ms. Martel: Thank you for your presentation today. I just want to go to the last page, actually, where you say that as a care provider, limited licensing in combination with a lack of a capital program for B and C homes will be disastrous. Those are pretty strong words. Can you elaborate on—I don't know if you've done any work in terms of your own home—what possible financial costs would be required if you had to do upgrades? Maybe you could share that with us, but also why, as the legislation is currently drafted, you're so concerned.

Mr. Bouchard: We're concerned because the licence is going to put us on a clock in terms of losing the licence. To use a comparison, if you had a temporary job and you went to get a mortgage for your house, the bank would look at you and say, "Okay, you want a mortgage, that's fine, but you have temporary employment." In some sense I look a the limited licensing as creating more insecurity in the sector, and I think that causes a problem. We've heard from other members who have also said that they had difficulty in getting bank financing.

With respect to your first point, I think that ultimately it's really about the residents in the four-bed wards. I think that's an issue that's been in our sector for a long time. I think anyone who works on the front line realizes that when you're living with three other people in a room, given the care levels and the psycho-geriatric problems that we're seeing, it's a recipe for care disaster.

I feel that the capital program is something that is really required for the residents' privacy and dignity. I really think it's important, as we go forward with this bill, that we're able to introduce an appropriate program so that all residents have an opportunity to have more privacy and dignity.

The Vice-Chair: Thank you very much. Parliamentary assistant?

Ms. Smith: It's nice to see you again. I just wanted to follow up on some of the comments you made about the redevelopment plan of 1997, the OLTCA, which I know you're involved in, and their position around that. There were 20,000 new beds introduced into the system at that time, as well as an upgrade of some of the D beds. In their submissions to the government in 2004, the OLTCA said:

"With the addition of the 20,000 new long-term-care beds there are now areas of the province that have occupancy issues, while other parts of the province still have long waiting lists. There are efforts and discussions under way with the government around future supply and demand strategies including 'right sizing' the sector."

What we've done with this legislation through the licensing piece is to try and provide the government with some tools to do some planning. That's just one submission that the OLTCA has made over the years. I could go back to 2003, and again in 2005, when your organization, or the broader organization, has made submissions around the need for planning tools and the need for looking at the sector writ large. What we've heard from most of your members has just been a demand for redevelopment of Bs and Cs, and not a lot of discussion around planning tools or planning for the system. Could you just comment on whether or not you think there's a need for planning the system across the province?

Mr. Bouchard: There's no doubt that there is a need for planning tools. But with respect to the occupancy issue, when the 20,000 beds were introduced, there seemed to be some vacancy issues across the province, but those have dried up quite quickly.

Part of the issue around the vacancy was people waiting on lists for certain homes. So for example, in Toronto you might have a long waiting list for people waiting for Baycrest. They don't want to go to a different home; they want to go to a new A home. But if you look at the occupancy rate in the last, close to two years, there's no doubt that the demand has increased. I know in our home the waiting list is quite long, and even in homes around the area. So I don't think that—we're looking at adding more beds, as opposed to moving existing beds; I think the demand is quite strong right now. But you are correct: When the beds first opened, there seemed to be some lulls across the province in places like Niagara Falls and around the Toronto area. It was a function of the waiting lists and people not being prepared to be placed when the time came.

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

Mrs. Witmer: Thank you very much for your presentation, Mr. Bouchard. This whole issue of limited licensing—the provisions in Bill 140—have created a lot of uncertainty. I heard this morning that there hasn't been any attempt to work with your association in order to provide some certainty and make some amendments to the legislation, and I know you've made a suggestion here. Do you believe that the recommendation that you are providing would restore some of that certainty?

Mr. Bouchard: Well, I think if we have 15 years and we have a capital program, then it will come down to people stepping up to the mark and making those changes that are necessary. Again, initially, our view was that the homes that were structurally noncompliant and were the worst environment should go first, from the residents' perspective. But because there's no capital program for the Bs and Cs, we've been waiting patiently. If someone's given a time limit and they're given the opportunity to make the right choice, they will make the right choice and step up to the mark. I think our members will step up

to the mark and will redevelop. But the plan has to make sense, and I think the key component is the details.

Mrs. Witmer: So I guess I hear you saying that obviously, one of the most significant amendments that the government can make is to amend the limited-term licensing. Without it, there are a lot of residences whose future security and staff are at risk.

Mr. Bouchard: If I'm a young nurse looking for a job, I'm going to want to work in an A facility, because I'll have a longer career than if I work in a B and C facility that happens to be in year eight of a 10-year term licence.

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

1120

WENDY HAWTHORNE AND ETIE JAMES

The Vice-Chair: The next presentation will be by Wendy Hawthorne. Is Wendy around? Welcome. You can start when you're ready.

Ms. Wendy Hawthorne: Good morning, ladies and gentlemen. I would like to start by saying thank you for giving me the opportunity to be here today. My name is Wendy Hawthorne, and with me is Etie James. We are both from Ottawa.

I am a personal support worker and I have been working in long-term care for nine years. The home I work for is a for-profit organization.

I feel that the seniors in long-term care are suffering, not at the hands of the staff, who are hard-working and dedicated, but from the provincial government, which refuses to set a standard for the number of nursing and personal care hours and increase the funding to long-term care in Ontario.

At the home where I work, there are 252 scheduled nursing hours in a 24-hour period. When you divide that by 114, the number of residents residing in the home, you get 2.21 hours a day of nursing care per resident, which is lower than when the Harris government abolished the standard of 2.25 in 1996. If you look at the handout I gave you, I have broken the hours down. Not all the time is hands-on nursing care or, at best, personal care. It shows that our nursing care hours actually calculate in the paid breaks which we are, by law, entitled to take. So when you take away 16.5 hours, you're now down to 235.5 scheduled hours. When you divide that by the number of occupied beds, now we're down to 2.06 hours that the residents get in a 24-hour period, not to mention that there are three meals a day served, there's laundry to put away, a snack to pass, and other miscellaneous little items that are not personal care. So at the end of the day you're down to 1.79 hours of nursing care, or 107 minutes. This is why we need to standardize the number of nursing hours across the board, and increase it to 3.5.

When we are confronted with increased nursing care for residents, i.e., end of life, complex dressing, severe behaviours, we are not given additional staff, and therefore the time needed to tend to these situations is stolen from the other residents. Is this fair?

A few years ago it was introduced that all residents of long-term care were to get a second bath every week. With this announcement came extra funding to help with the increased workload, sequentially creating new full-time positions at the home where I work. A year later it was time for us to be classified, which led our CMI to decrease, which had a direct effect on our funding to be less, causing those positions to be terminated. But we're still continuing to do the extra bath.

When we work short, we try our very best to do the all the work, but it is not possible. Our director of care and executive director have told us that they expect us to do all baths and regular duties regardless of the number of staff on the floor. We have a difficult time doing our job when we are fully staffed; how it can be expected when we are short?

I have the pleasure to work side by side with some of the most compassionate, exceptional and devoted individuals, who feel they need to work through if not part of their break then the whole thing, just so the residents don't suffer.

I could continue with quotes, numbers and facts that you've already been given or will be given at some point through these hearings. Instead I now want to share with you my reality of the day-to-day life in long-term care and why it is so important that the government set a standard of 3.5 hours for personal and nursing care for our seniors in long-term care.

The home area unit in which I work is home to 32 residents, all of whom have varying degrees of dependence. During the day shift there are two PSWs and one registered staff for 7.5 hours and one PSW for four hours. We, the PSWs, are required to assist these 32 residents to the dining room for 9 a.m. This includes washing, dressing, going to the bathroom, brushing hair and teeth, shaving and makeup. It is a very hard and strenuous task when you consider that some of these people require two or three staff due to behaviours or that they use some type of mechanical transferring device. On a rare day, we can be in the dining room by 9:15, but on most days it tends to be 9:30. Once we do get into the dining room, there are still residents to assist with their meal and help out of the dining room.

There are baths and showers to give, four to five on a day shift, laundry to put away, collation to distribute, repositioning of residents who cannot move themselves and aid to all of those who are in need of assistance with going to the bathroom or anything else they might require. Staff coffee breaks need to be taken at this time as well. It is essential for us to try our best to accomplish all of these tasks in an hour and 30 minutes because staff have to start taking their lunch break at 10:45 in order to be ready for the residents' lunch. During the next hour, the floor has only one PSW, which makes it difficult to accomplish next to anything due to the level of care and assistance the residents need.

At 11:45 we start to help the residents back into the dining room for their lunch. There are now only two

PSWs to serve and assist 32 residents during this meal. We can usually have everything done by about 1:10. At this point in the day, we are returning people to their rooms and helping them to the bathroom or back to bed, whatever they may require. We are supposed to take a break around 2, but don't always have time as we still have to dispose of soiled laundry and do another collation pass and our paperwork, which usually takes 25 minutes alone to do. All these things are taking us away from what I am really there to do, and that is to look after the residents. This government needs to set a standard for the number of nursing hours and it needs to be 3.5.

Do you have any idea how hard it is to tell a family member or a resident that I can't take them to the bathroom because I don't have someone to help me? It's horrible. It makes me sick every day. It's not right, but it occurs, sometimes more than once. But it shouldn't happen at all.

The people who are working in long-term care are burning out due to the overwhelming physical and mental demand this type of work puts on you. The Ontario government needs to step up to the plate to fix this situation and set the standard number of hours.

The population that is coming into long-term care is older, frailer and sicker, with more complex medical problems than individuals 10 to 15 years ago.

I didn't come here today to tell you I'm overworked or complain about the conditions I work under. I came here today to try and make you see what it is really like, and to show you that our mothers, fathers, grandparents, aunts, uncles and spouses living in long-term care deserve more and deserve better.

Ms. Etie James: I'm an RPN, in long-term care as well, in a for-profit corporation.

I want you to refer to the PSW assignments that we had to do last year when the two-bath mandate came in. I'm not going to belabour that one; I will just let you look through that. That is one thing in our day that took us quite a lot of time to actually get together.

Briefly, I will attempt to outline life in a long-term-care facility from a registered staff perspective and the difficulties we encounter on a daily basis. The time that the CMI does not account for becomes part of the job. You have a copy of that and I just told you about that. It speaks for itself. There are many time-consuming tasks that eat up our days.

Time spent on doctors' rounds, care conferences, answering phones and making appointments for residents is not accounted for in the CMI.

There is time spent on residents who are: (1) dump-and-runs; (2) psychiatric cases; (3) street people with no families; (4) difficult POAs, often related to number (1); (5) palliative residents; (6) family members associated with number (5); (7) mentally ill family members; (8) quasi-residents who are family members but are there on a daily basis from 8 o'clock to bedtime; (9) immigrant dependants who speak no English; (10) families who don't think they need to do anything and that the home will do it all—including finding clothes for them—are very demanding and require extensive explanations before doing anything requested, usually with language barriers, or who disappear after leaving extensive requests and leaving said resident with no means of communication; (11) family members with restraining orders against them who have to be monitored to ensure they don't get into the home; (12) heavy-care residents with tube-feeds, IVs, fractures, bedsores—often admitted from hospitals—oxygen therapy etc.

None of the above are covered completely, if at all, under the current CMI formula or the one now being implemented. Care for palliative, psychiatric and high-needs residents is done at the expense of the rest.

There is excessive documentation, the latest being that the registered staff review and sign all the PSWs' documentation, in addition to our own charting and medication documentation.

There are increased falls from the no-restraint policies, with time spent sending residents to hospital for assessment.

There is time spent documenting unusual occurrences—aggression resident to resident, resident to staff, visitor/family aggression to staff and residents.

Cohort nursing: Time is spent in setting up all the isolation and then trying to keep wandering isolation residents in rooms, and extra time spent managing and reassigning aides' assignments to do cohort nursing, often with no extra staff—especially true for the evening and night shift.

There is time spent with family members with very sick and dying residents; also mentally ill family members.

There is time spent assisting PSWs when there's not enough help, keeping in mind that we can help them with their work but they can't help us.

Each admission takes four hours of paperwork to complete: care plans, assessments, drug orders, setting up the tick sheets, consulting with families, setting up referrals where needed.

1130

Documentation to comply with CMI/MDS: The conservative estimate is that it will take four to five hours to switch from CMI to MDS for each resident. Half of our registered staff have still not had the training. The extra time needed is not funded.

Time spent trying to accommodate the latest directive from the MOH, the most controversial, being that residents could not have their medications with their meals, resulted in very angry comments from the residents who were aware and demanded them anyway, resulting in the doctors having to write orders to this effect—more useless paperwork. The chaos this caused, especially in the mornings—it was tried, with less than encouraging results.

Three point five hours of care legislated as the minimum level for each resident would at least accommodate some of the heavier-care residents and ensure something is left for the rest. As it stands now, the rest get very little.

Thank you for allowing me to share with you a day in our life in LTC.

The Vice-Chair: Thank you very much. We have just 30 seconds left, so my apology. Thank you very much for coming.

OTTAWA HEALTH COALITION

The Vice-Chair: We'll move to the next presentation, by the Ottawa Health Coalition. The Ottawa Health Coalition is here? Okay.

Welcome back to our committee. I guess you have presented several times to our committee. You can start whenever you're ready.

Ms. Marlene Rivier: I'd like to start by thanking the last two presenters for giving us a view of life on the front lines in long-term care.

I'm here representing the Ottawa Health Coalition, which is a collective of community members and organizations in the Ottawa area committed to maintaining and enhancing our publicly funded, publicly administered health care system. We also act to generate discussion in our community about matters in the public interest related to health care and healthy communities. We work together with our sister local health coalitions and with the Ontario Health Coalition and Canadian Health Coalition.

We are disappointed that Ottawa was not selected as a site for these hearings, which we feel has diminished the opportunity for members of our community to contribute. Also, the timing of the announcement of the hearings was problematic, and we would hope that the committee would consider an extension to the consultation process. We would also appreciate there being a process for consultation in the development of the regulations that are to be established.

I'm not going to read my submission to you but just try to highlight a few things and acknowledge the work of the Ontario Health Coalition and ACE in their presentations to this committee and to indicate that we concur with their conclusions.

We're all aware of the fact that we have an increasingly needy population in our long-term-care homes. Patients are more quickly discharged to long-term-care facilities from acute care hospitals with serious medical problems. We're also seeing increasing numbers of individuals with serious mental health problems residing in homes, in part due to the closures of provincial psychiatric hospitals. Also, because of the decreased availability of home care, more people with physical disabilities are being forced into long-term care. We're seeing more younger residents who are finding a lack of age-appropriate programming, and we feel this is an important issue to be addressed. The residents' bill of rights, along with those concerns, also recognizes the needs of religious and ethnic minorities.

I am assuming that you've seen the convergence of views around the need to reinstate a minimum care standard, which was eliminated by the Conservative government in 1996. We are calling for a minimum care standard of 3.5 hours of personal care per resident per day, with the understanding that the government will be carrying out research necessary to define the care levels more precisely. We're asking that, in developing the tool, which I understand is under way, attention be paid to the needs of people with mental health problems who are living in our long-term-care facilities and often require a great deal of care which is not captured by the current tool, which means that they are not getting the care that they are needing. That can result in a revolving door back into acute care facilities and specialty mental health facilities to help these individuals to regain their stability.

The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers.

We need in our long-term-care facilities a healthy, stable and well-trained workforce. Infection control is a real concern in view of the reliance on casual and agency staff. Surely SARS has taught us that when we have a very mobile workforce of low-wage workers who have to construct employment from a variety of casual jobs in various institutions, we are unnecessarily exposing very vulnerable residents to the risk of infection. Also, it's important for the social milieu that we have this stable workforce in our homes. Adequate staffing is necessary to protect residents from assaults involving co-residents and to stem the rising tide of staff injuries due to violence in the workplace. Inadequate staffing also increases the reliance on chemical restraints.

The presence of a registered nurse on a 24-hour, seven-day-a-week basis: It needs to be a nurse who is not a nurse manager but one charged with the sole responsibility to attend to the health care needs of residents.

We are calling for greater protection for publicly administered long-term-care facilities. There is a great deal of research that has demonstrated that the care in non-profit and public long-term-care homes is superior. Profits are maximized when staffing is minimized. Reduced staffing levels also impact the rate of staff injuries, and the cost of increased workplace injuries is in part borne by the taxpayer through WSIB claims. Over the years, we've seen operators shifting costs from the accommodation envelope from which they draw profit to the nursing and personal support envelope. This is something we know has had an impact on care and available staffing. We ask the government to take some real measures to correct that. There's been word of some efforts in that regard, but they don't appear to have had much impact.

Ontario has a preponderance of for-profit beds, exceeding the rates in other provinces. We believe it's in the interests of the public good that this trend be immediately and significantly reversed.

Not-for-profit board members typically serve in a voluntary capacity for the public good, and we believe that they should not run the risk of individual fines.

We're also suggesting that fines for non-compliance should be pro-rated in accordance with the number of beds of the entire organization rather than a single unit and according to status as for-profit and not-for-profit.

Advocacy is very, very important when we're talking about vulnerable people. It's important that councils have a voice in appeals and be able to obtain the necessary information they have to speak to inspectors etc. in order to effectively represent the interests of residents. It's also important that the independence of these councils from facility operators be established and maintained. We need an arm's-length third party who can play a role in assisting people in these facilities. We would propose an eldercare ombudsperson who can receive and process complaints.

Regular unannounced inspections must continue, without exception. Strong and effective sanctions need to be applied where homes are consistently non-compliant with significant care standards. That would include the non-renewal of the licence to operate. These inspections must include the contracted-out services in order to preserve a level playing field.

1140

In the interests of transparency and informed choice, detailed information concerning the results of inspections and key indicators of quality service, including average staffing levels and historical data, should be made available on a public, user-friendly website.

I've made a few comments about definitions and I'll just say that we concur with the Ontario Health Coalition that it's essential that we define the term "neglect" and that we agree with the Advocacy Centre for the Elderly to adopt the definition of "abuse" that's used in one of the ministry's policy documents.

We also want to underscore the necessity of making direct references to the Health Care Consent Act in this legislation to make sure that people working in these facilities and operating these facilities understand their obligations to obtain informed consent to treatment.

We also feel that references need to be made to the Personal Health Information Protection Act for the same reasons in terms of people fully understanding their obligations, to underscore the right of access of individuals and substitute decision-makers to personal health information.

We feel that the whistle-blower protection is really a keystone that needs some enhancement. Whistle-blower protection must be improved and such measures as gag orders in employment contracts must be made unlawful. Financial barriers to whistle-blowing must be eliminated and the legislation must embody strong deterrents to employers who may be tempted to dismiss or suspend employees acting in the public good. Penalties to employers who violate these provisions must be substantial and clearly spelled out in the legislation and/or regulations. The proposed provincial ombudsperson must have jurisdiction to intervene in such instances.

In conclusion, this submission is by no means a comprehensive examination of Bill 140. You have many submissions before you which more properly aspire to that standard. In our submission, we have attempted to identify those aspects of the bill which we regard to be of fundamental importance in regulating the facilities in which some of the most vulnerable members of our community reside. In doing so, we hope to have fulfilled our responsibility as a health care advocacy group representing the people of Ottawa to speak to issues in the public interest and for the public good. Thank you.

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

Ms. Smith: Thank you for your presentation. We have heard from the health coalition in Toronto. We appreciate hearing from the Ottawa group.

I just wanted to talk a little bit about the minimum standard question. We're presently at about 2.86 in the province. I just wondered what the health coalition saw as being included in the calculation of the minimum standard as far as hands-on care.

Ms. Rivier: I don't think I'm in a position, really, to speak to the technical aspects of that, but my understanding of that reported number, first of all, is that there have been some questions about how that number was arrived at and the reliability of the information that was relied upon in arriving at that number. Also, I think it falls below the number that has been recommended as the bare minimum in terms of the prevention of risk. So I'm not particularly impressed. I think that I will leave it to the experts to determine how best to determine what that level of care should be, but clearly, 3.5 is a minimum.

The Vice-Chair: Mr. Yakabuski.

Mr. Yakabuski: Thank you very much for your presentation today. I appreciate you coming here from Ottawa, as well.

We've heard other presentations with regard to the increasing level of care that is needed by the residents today. I recall nursing homes that opened in the 1970s. People drove up in their car, unloaded the suitcase and went in. Now we're talking about situations, as you've articulated here, of people with significant mental challenges. I think it's proper to gauge that that is only going to increase the challenges for our staff in these homes. Where are we going to get to if this government does not (a) amend this legislation and (b) at least keep their promise with regard to the amount of funding they've committed to, which was additional $6,000 per resident? Where are we going to be, say, a few years down the road, this piece of legislation unamended and that money not there? What's the condition going to be in our homes under those circumstances?

Ms. Rivier: Clearly the conditions in homes will continue to deteriorate, as they have been deteriorating since the Harris government removed the minimum standard of care.

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

Ms. Martel: Thank you for your presentation. The government says right now that we're providing about

2.85 hours of hands-on care, but we heard from two groups of workers this morning, and the situation in their own homes was that they are averaging a little over two hours. If it's legitimate, 2.85 hours is less than what was recommended in the Casa Verde inquest. That recommendation was 3.06 hours pending a government review of needs, and, once that review was done, to reassess at that time. So we are a far cry from even what was recommended in Casa Verde. I'm wondering what was used to arrive at what the government's using as a figure now.

Why do you think there has to be a minimum standard that's actually legislated in place and why should it be done through this bill?

Ms. Rivier: I think it's the only way we can guarantee a proper level of care. We know that level of care doesn't exist right now and that some of our most vulnerable who are least able to advocate on their behalf are suffering because of it. I think we would all agree that a society is judged by the treatment it provides to those who are most vulnerable among them. I think it reflects rather poorly on us as a society that we have allowed conditions in our long-term-care facilities to deteriorate in the way that they have.

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

SAFE SENIOR SYSTEMS

The Vice-Chair: We'll move to the last presentation for the morning session, which will be by Safe Senior Systems. Welcome to the standing committee on social policy.

Ms. Janet Parry: Thank you. My name is Janet Parry and I am vaguely connected to the Ottawa Health Coalition. But I'm here now to present my innovation, my invention, which is Safe Senior Systems. I am most honoured that you have selected me to appear before you.

Mr. McGuinty and Mr. Smitherman have realized that the provision of new, innovative equipment will help nurses and patients. I hope that my presentation will stimulate you to think about the basic issues that are challenging in the care of our aged population.

As you will have seen from my brochure, Safe Senior Systems is entirely relevant to every stage of senior care in the future, worldwide. The introduction of this system to the living accommodation of the patient allows the preservation of the dignity of the patient and convenience for the caregiver in facilitating these most necessary activities. It enables the patient to stay where they want to be, and not become a burden on the health care system—taxpayers—and/or their families. It cuts down on workplace injury to caregivers and clients and saves them time and unpleasant, unnecessary work. They might even have time to feed the patients, to make sure they actually eat the food.

Failure to cope with incontinence has many repercussions, everything from the great distress of lesions to the vast amounts of extra work and laundry, all of which are expensive.

Yesterday, the magazine Rehabilitation and Community Care arrived with an excellent article from Dr. Keast working with the Canadian Association of Wound Care. I brought you copies at the back of what has been developed into a book over the years that I've been going to trade shows. With his energetic and, I reckon, costly program, he is quoted as saying that they can save up to $1.2 million per year in a 100-bed hospital and cut pressure ulcers by 35%—to which I say "Only?"

I have searched with no success for an estimate on the annual cost of monster diapers for the same-size facility. I was tempted to write to him and say, "Why don't we use my equipment and just not get the lesions?" but I'm only joking. It is a very difficult problem. We are dealing with frail, old skin, patients who have some mobility issues and, of course, poor nutrition causing failing health and strength.

Dr. Keast lists immobility, friction and searing—as attendants strain and injure their backs pulling and heaving patients—and wet, even soiled conditions as the primary contributing factors to the medical conditions he is seeking to address. At last, somebody is really doing some work on it.

1150

Further, in a previous issue of Rehab and Community Care Medicine, the publisher of that same journal—not the editor, the publisher—bemoans the new rules on diaper changes, the reduced frequency of which will of course be disastrous. It'll just make everything very much worse.

I should perhaps briefly describe what we are proposing. Safe Senior Systems, as you can see in my brochure, has four components which can be acquired individually and the other parts added according to the needs of the patient.

The first is a comfortable armchair with headrests and a reclinable back. Inside the chair there is a macerator toilet with pump. This is connected to two one-inch pipes which protrude at the back, one for water and one for waste, ready for easy attachment to any part of the plumbing system. It can possibly be put next to the bed at night to avoid those night trips and falls and hospitalization, which is one of the major troubles. The macerator is a well-established technology, most often seen in boats. The manufacturer confirms that it can be installed in any location in the house, which no doubt explains the tremendous success already being experienced in Europe.

The second is a strong support table, which attaches and can lock onto the chair. The table is sturdy enough for the client to pull themselves up and lean on while the chair seat swings up to reveal the toilet. If in rare cases assistance is required, it is only to facilitate a forward movement—"Up you come, love"; that's all it is. Compare that with sideways transfers, lifting and the risks associated with moving the patient onto and off commodes, and the long journey and waiting for the patient every time, not to mention the distress associated when the patient must also wait for the ever-scarcer assistance after they've completed all this. So this is a double whammy.

Third is the newly designed shower shell—that's the latest thing—which you can see on my website. It can be inserted under the patient, permitting washing to be achieved with a hand shower. The waste water is disposed of down the toilet with a flush.

These three units form the basic care package for home or institution. A fourth component is available to assist clients to remain in their homes longer, which is a major step forward.

One of the big dividing lines in geriatric care is when doctors and families determine that the patient can no longer live alone. The daughter knows she has to be working full time. Often the decision is based on the resources available for care, not necessarily on the extent of the illness or the competencies of the patients themselves.

The fourth item comes into use at this time: The rollaway can be added, possibly locked on, to the other two. I used to be very timid about saying "locks," but all the therapists said yes. It can accommodate everything that a patient could possibly need during the day alone: a four-litre fridge for snacks, a microwave, space for selected hobbies and entertainments to be accessible, a phone with pre-set numbers, remotes, converters etc. Depending on the situation, a respiration monitor or even a video monitor can be attached so that the daughter can see what's going on there. With these options, a worried daughter can, with confidence, say, "See you at 6, Mum. Have a good day." She can be assured there will be no "I just popped downstairs to put the kettle on" explanation for a broken hip or a burned-down house.

The patient can be seated comfortably for long periods, including, in recline, for naps. Being able to stand independently and safely provides much-needed exercise. Right from the start of the illness they've been doing this, so they never lose their legs, unlike those chairs that throw them into the air.

Another component which is being asked for by nurses is a foot-raiser.

Another dividing line is the transition from residence to long-term care. The reason is often incontinence. Once achieved, this decision is irreversible, even if it wasn't necessary or was due to infection or something.

The installation of even a few of the Safe Senior Systems chairs would be useful in all settings used temporarily for borderline patients, because nurses complain that there is no intermediate step between these two grades. Installation could be done in both residential and hospital situations.

I hope you will take time to visit the safeseniorsystems.ca website, where you will see the endorsements that have been received from nurses' unions and the Canadian occupational therapy association. Head nurses who were consulted during development said, "I can't think why this hasn't been invented before."

An accountant from the health service in BC, where they have extremely high statistics on seniors, could see at once the positive effect installation of Safe Senior Systems would have on reducing the pressure on his service and the related financial implications. Whether installed privately by patients in their own homes or required by medical authorities, it would result in massive savings as well as satisfaction to people.

At present, with the aid of the National Research Council, or NRC, we are seeking to identify a manufacturer with vision to engage with us in the production of Safe Senior Systems, with the objective of having working pilot installations in place in several facilities in Montreal and Ottawa for inspection during the UN innovation show, Expo Ageing, which is to take place in Montreal in 2008.

I believe that there is a manufacturer who has had to change a diaper on his mother or empty his beloved wife's commode who will see the potential of this system and will engage in what is sure to be, given the demographic reality we're in, a very lucrative venture. We must remember that we are preparing this for ourselves and our families. I may say it's for you. I've got a safe senior system. Respectfully presented.

The Vice-Chair: Thank you very much for your presentation. We have about three minutes left. We can start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. Certainly it is something that those people looking forward to the future can expect to have at their convenience. Thank you so much.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you for your presentation. Can I ask what prompted your interest or your involvement in these technologies?

Ms. Parry: I had wonderful grandmothers, and I've been a therapist with geriatric interest all my life. I can remember being at a technology show for aging about eight years ago and thinking that it would be nice to have an armchair in the bathroom, and then thinking, "No, that's wrong." It's taken me this long to get here—and money.

Ms. Martel: How long were you providing occupational therapy? Were you doing that in long-term-care homes?

Ms. Parry: Yes, in geriatrics of all sorts. I did a lot of locums in Montreal—relief work—so that I would go and see all the various geriatric teams in almost all the hospitals. I also had I think four actual jobs, some in the UK and one here.

The Vice-Chair: The parliamentary assistant.

Ms. Smith: Thank you for coming. In our consultations early on in the process we heard a lot about aging in place and the real need for our seniors to stay in their homes as long as possible, because that's where they do best. And we've certainly gone a long way in trying to invest in home care and other resources in communities to allow our seniors to do that. Seeing the development of one more resource is always helpful, so I want to thank you for your presentation today and for providing us with this information.

The Vice-Chair: Thank you very much.

I believe the morning session is over. I want to tell the audience that the room will be locked, so I guess nobody is allowed to be here. Take your personal possessions with you. For the staff, you can leave yours here because I think you'll be back.

That's it. We are now recessed until 1 o'clock sharp.

The committee recessed from 1158 to 1302.

ROYAL CANADIAN LEGION, ONTARIO COMMAND

The Vice-Chair: Good afternoon, ladies and gentlemen. Welcome back to the standing committee on social policy for the afternoon session.

We're starting right now with the Royal Canadian Legion, Ontario command. I believe you know the procedure, sir. You have 15 minutes. You can use the 15 minutes for presentation, or you can divide it between presentation and questions. Please, before you start, state your name and your colleagues' names for Hansard.

Mr. Jim Margerum: My name is Jim Margerum, veteran services chairman, Ontario command. My colleagues are George O'Dair, our first vice-president, and Erl Kish, our immediate past president of Ontario command.

The Vice-Chair: Welcome.

Mr. Margerum: Ontario command of the Royal Canadian Legion thanks you for the opportunity to submit our comments and position on your proposed Long-Term Care Homes Act, 2006, Bill 140.

Ontario command has some 160,000 members and 424 branches across Ontario; in addition, our ladies' auxiliary has some 40,000 members and 132 auxiliaries. We have an enviable record of advocacy and service to veterans, seniors, youth and communities since 1926. We contribute millions of dollars and our volunteers contribute countless hours of their time to the above activities. We are one of the largest advocacy groups in Ontario, and we are very proud of our track record.

We will first address the failure of this bill and the Minister of Health to provide for an ombudsman to oversee long-term-care homes and investigate complaints of care. Our second part will be related to the proposal covered in Bill 140 by way of general comments and questions regarding the new legislation, its implementation of new requirements, time frames to comply with new provisions, and how the government ever expects the nursing homes to fund the heavy load it will place on their annual budgets.

Several comments and observations: We recognize the bill will bring all nursing homes under a single act and address seniors' problems and anomalies in the existing three acts currently covering nursing homes in Ontario. Finally, all will be singing from the same sheet and we will clearly define legislation and provisions applicable to all nursing homes, eliminating the differences and loopholes in the current three acts. This is long overdue and will result in improved standards, accountability, safety and security of quality of care provided to residents in nursing homes in Ontario. While in principle we welcome Bill 140, we have serious concerns if it is enacted as presented. It will definitely impact the hands-on care to residents and the ability to find volunteers for boards of directors, and it will wreak havoc on nursing home budgets in their attempt to comply with new regulations, without taking into account the funding shortages they currently face.

Ontario command is very upset and disappointed that Bill 140 does not include an ombudsman to protect seniors residing in nursing homes, who are our most vulnerable citizens.

In early December 2003, when the Minister of Health, Mr. George Smitherman, was interviewed about the horrendous treatment some residents received, he introduced a number of measures to address the deplorable and unacceptable conditions uncovered by the Toronto Star series. One was more advocacy for residents in the form of a long-term-care ombudsman. At meetings with Ontario command representatives, we believe he made the same statement.

An Ontario government advisory committee, the Ontario Seniors' Secretariat's advisory committee on long-term care, which has 13 seniors' organizations and represents over one million seniors, unanimously recommended the implementation of an independent ombudsman for long-term care in a letter sent to the Minister of Health, the minister for seniors and the Premier of Ontario. Further, in their annual reports to the OSS committee, all 13 seniors' organizations supported the position as stated in the letter to the Minister of Health. Surely, when all members of his advisory committee on long-term care support this position to provide more advocacy for long-term-care residents in the form of an ombudsman, he should implement it within the provisions of Bill 140.

The Bill 140 proposal to create an Office of the Long-Term Care Homes Resident and Family Adviser instead of an ombudsman is no better than the current provisions he has as Minister of Health to appoint an investigator or investigating committee. It has not worked in the past, and the adviser proposal has no powers or authorities that are effective.

The most effective and simplest way to provide advocacy for long-term-care residents, spouses and/or family within Bill 140 is to provide the necessary clauses to expand the current mandate of the Ontario Ombudsman, Mr. André Marin, to include long-term-care homes and investigate complaints of care.

We are unable to comprehend the minister's reversal in his position and failure to provide for our most vulnerable citizens in Ontario, our seniors residing in long-term-care homes. Where is the transparency that the government speaks of in dealing with long-term-care residents' complaints? We have to wonder why he is afraid of an independent ombudsman reviewing and investigating long-term-care residents' complaints. This provides the advocacy role that is missing and is not addressed in a satisfactory manner in the proposed Bill

140. Surely our seniors deserve the advocacy role an ombudsman would provide to residents.

Our position is very clear, and Bill 140 must include provisions for expanding the current mandate of the Ontario Ombudsman to include long-term-care homes and investigating complaints of care.

Our general comments: We have concerns and questions about some provisions as outlined in the proposed Bill 140, and they are as follows. We realize we are not hands-on, day-to-day operators or professionals in long-term care, so we've left that to other presenters on what they face in trying to comply with the new bill and new legislation.

1310

We are concerned about the funding problems that nursing homes will face if required to comply with the legislation. How can their current annual budget handle the large funding required to implement the necessary measures to comply? There is no question that hands-on care and staffing services will suffer if they are required to take money out of the current budget and there are no provisions for phasing in necessary measures from the Ministry of Health or other government sources. What provision is there in Bill 140 to prioritize or delay some provisions to enable a home to comply without a reduction in hands-on care, services and staffing simply because their current budget does not have sufficient funding? We believe they already face staffing shortages, maintaining the obligatory level of care and the safety and security of residents.

We believe that more funding must be provided to enable a home to comply with Bill 140 provisions.

We believe that homes must have provisions for phasing in measures on a priority basis and within their funding ability until the government provides the necessary funding to complete measures to meet compliance.

While there have to be enforcement measures, punitive action—fines—to address homes that disregard Bill 140 measures, you must not penalize all homes. You have to have a reasonable time frame for a home to meet compliance, and their efforts to meet compliance must be measured and taken into consideration before any penalty is imposed. We believe that the enforcement area of the legislation is to weed out bad homes and should not impact the majority of good homes that we feel do their best within their ability and funding.

We feel that training, best practices and other measures must be provided for and funded by the government. This improves the hands-on care and service provided by a home, and they should not be denied this training simply because they lack the funding.

In closing, we strongly believe that providing care and support of residents in long-term-care homes is, and must be, a congenial and supportive partnership between the nursing homes, the Ministry of Health's long-term-care division and advocacy groups and organizations such as the Legion, service clubs, church groups and any other advocacy group in Ontario. Together we can accomplish a working relationship which will improve hands-on care, safety and security and the feeling of residents being wanted and treated in a caring and dignified manner. Long-term care can be improved if we work to a common goal of ensuring that residents receive the best care that Ontario can deliver.

We urge you to make provisions in Bill 140 to include the implementation of an ombudsman by expanding the mandate of the Ontario Ombudsman to include long-term-care homes and to investigate residents' complaints.

We thank you for the opportunity for the Ontario command of the Royal Canadian Legion to present our submission to this committee.

The Vice-Chair: Thank you very much for your presentation. We have about three minutes left, to be divided equally among the three parties. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation today, General and, thank you for the work that you do with veterans who are in long-term-care homes and also for the work you do generally with veterans in the community.

You released a press release on October 5, 2005. You said, "At a meeting in March 2005, the minister"—that is, the Minister of Health—"asked the Legion to be patient and wait for this legislation to be introduced. He indicated that his government would have a solution and create an ombudsman to oversee long-term-care homes and investigate complaints of care." Do any of you want to comment on what was said at that meeting and what your understanding is of what was promised?

Mr. Erl Kish: Yes. I was at that meeting. The question was asked of the minister if we would have an ombudsman. He guaranteed us that we would have a person in the form of an ombudsman. Perhaps the terminology would be different, but the job would be done. I do not see the adviser as being a person who can do the job of an ombudsman. An adviser is an individual who reports back to his boss, not to Parliament as a whole. An adviser is another person in the chain of command who has somebody to work for, not for us as the public. An ombudsman does. So I think that the mandate he promised us was not given, and it's not the first time to do with health care that we have not received what was promised.

The Vice-Chair: Parliamentary assistant?

Mr. Margerum: Excuse me. In one addition in the back of the attachment you will find an interview with the Minister of Health in the Toronto Star dated December 8, 2003, where he definitely refers to the creation of an ombudsman to handle complaints. So that's with your attachments.

The Vice-Chair: Thank you very much. Parliamentary assistant?

Ms. Smith: Thank you for being here and for all the work that you do. Certainly, we've had chats over the years about the work that you've been doing.

I've been wanting to ask you some questions about your request for an ombudsman and the role exactly that you wanted it to play. The Ombudsman currently, as he is mandated, can only investigate a situation once it has occurred. So after an incident has occurred, they can go in. He can also choose not to investigate; it's his

discretion what he investigates. And he certainly doesn't have a role of advocacy on behalf of anyone; he investigates and makes a report. When we first started our discussions around the ombudsman/advocate role, we talked a lot about the need for someone to assist in managing the system, to advocate on behalf of residents or family members when they feel that their concerns are not being addressed. So I wonder about your request now to expand the role of the existing Ombudsman, whether that is really going to meet the needs that we had originally discussed.

Mr. Margerum: I would point out one thing that's most important. Earlier this morning, one of the presenters pointed out the fact that the best place to solve a complaint or a concern is on the floor, on the spot, as early as possible. However, we can document many complaints that were never resolved, and the final closure to that was coffin-led closure. Coffin-led closure is when the person dies and the family wants to get on with their life and they drop the complaint. Our concern is that some of them are systemic problems existing in long-term care and they have to be addressed. The reason for an ombudsman is for that very reason: to ensure that these problems don't carry on. If it is not resolvable within the level of the facility or at the first level with the Ministry of Health, it then goes to the ombudsman if the ombudsman deems the problem to be in his bailiwick or in his jurisdiction.

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

Mrs. Witmer: Thank you very much for your presentation, Jim and colleagues. Again, I just want to add my compliments to the work undertaken by the Legion. I am a proud member myself, and I do appreciate the work you do on behalf of veterans and members.

I guess there's disappointment concerning the fact that the ombudsman position, as you had envisioned it, is not contained herein. But I see it as quite simple. You're recommending that we make an amendment and expand the current mandate of the Ontario Ombudsman. Is that right? Is that your recommendation?

Mr. Margerum: Yes.

Mrs. Witmer: That shouldn't be too difficult to do.

Mr. Margerum: No. We discussed this with the current Ombudsman and others, and it is very easy for him, with minimal legislation, to extend his mandate to include long-term-care complaints, etc. The cost would be minimal; no more, and probably no less, than it would be to establish this new advisory role.

Mrs. Witmer: All right. And it would be totally independent from government.

Mr. Margerum: Yes.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1521

The Vice-Chair: We will move to the next presentation, which will be by the Canadian Union of Public Employees, Local 1521.

Welcome, and please state your name before you start.

Mr. Steve Sanderson: I'm Steve Sanderson, and Brian Blakeley is with me. He's a researcher for CUPE.

I want to thank you very much for this opportunity to speak to all of you. I want to let you know that my history is social services. I've been a social service worker since 1973 across Canada. I have worked since 1984 with the Ottawa-Carleton Association for Persons with Developmental Disabilities. In those 23 years I've supervised transportation, support, employment, residential services and respite care. I have also been the president of the local there since 1987. In that 20-year period I have been elected to the social services committee for Ontario six times, for six two-year terms, and I'm presently the third vice-president of the Ontario division.

I wanted to let you know that this is sort of a strange day for me because I'm talking about long-term care and it is exactly one year ago today—January 22, 2006—that my mother, at 94 years of age, passed away. She was living in a nursing home. By the way, she got very good care. We spent a lot of time looking for that home. She had excellent care and excellent supports. I will tell you that that was a not-for-profit home.

1320

What I did want to do today, though—and I think all of you have seen the report that was submitted on behalf of the Ontario division; I'm not going to speak about that. That was my president, Sid Ryan, who presented that. I've given you some information here on the issue that's most pertinent to my concerns. The issue I want to talk about is long-term-care home access protocol for adults with developmental disabilities. You will note the date on it is July 2006. For many people, myself included—and I'm quite connected—this flew below the radar for quite a long time. It's just more recently that a number of us have become aware of it. What I do want to talk about more than anything else—and I think I'm just going to have to quote from the actual document. There are two parts to it. You know that there are three major centres left that are open in this province, and they are being closed by 2009. So the protocol is about moving people from those institutions into long-term care. The second part is about taking individuals who are receiving services from developmental service agencies in our communities and moving them into long-term care.

What we do know already is that there are over 1,600 individuals with developmental disabilities living in long-term-care homes. On the last page of the package I gave you, there is a piece called "Diagnostic Categories of Younger Persons with Disabilities in LTCH." They use two categories, not my nomenclature but theirs: "mental retardation" and "Down's syndrome." That represents 691 individuals presently who are deemed to be younger. So there's a significant number of people who are already there. This is before a protocol is put in place.

On page 2, I want to give you a couple of quotes from the document to tell you why we are so frightened and

disturbed by this document. It says, in paragraph 3, concerning the DS facilities that are closing, "The DS facilities initiative presents an opportunity for DS service providers to consider the transition of individuals with increasing health care needs that they are currently supporting residentially into an appropriate LTC ... setting. This will create DS community-based capacity to accommodate residents moving from the DS facilities."

So, no increase in the number of beds, but taking people out of their homes and putting them into long-term-care facilities to effectively move people from the institutional settings. There is no support there whatsoever for the long waiting list in the communities.

On page 5, point number 1 says, "The CCAC must determine, as the first step of the LTC home placement process, that all community-based resources to meet client needs have been exhausted."

I'm going to refer to a couple of the other documents that I've put into your package. The third document, Quality Supports through Competitive Compensation—A Business Case, made by all of the different umbrella organizations in this province that offer services to people with developmental disabilities through all communities in this province, talks about the inability to meet staffing needs due to the chronic underfunding in the services. I will just read to you very quickly from the conclusion. It says, "The foundation of the developmental services sector is in danger of crumbling" because not enough money is being put into it. "However, the sustainability of this sector is at risk if community agencies cannot attract and retain qualified employees." We're having great difficulty getting people to work as a result of the lack of funding for those services.

The other piece I will refer you to, which you may have heard about already, is called Beyond Numbers. It's about the implications of financial restraints and changing needs of developmental services. That was for the Metro Agencies Representatives' Council, and that's in the Toronto area. The most telling statement is in their summary: "A squeeze is on: The sector has reached capacity, the service system is overloaded, and there are serious shortages in services. The capacity of the sector to manage current and future risk is of concern as service pressures continue to challenge the seriously depleted and stretched service system. The organizations do not have the resiliency they need to meet the service challenges ahead."

On the question of exhausting the system, it will be very clear that people will be moved very quickly into long-term care because the developmental service system is completely underfunded. This is coming not from me, but from the umbrella agencies that represent 95% of all the services that are offered in this province.

What I want to do now is just give you a couple of the other major concerns that we're fielding with regard to this document. For example, on page 7, it talks about individuals, but where there are a number of individuals applying for long-term-care home placement, there will be a method of dealing with that too. So now we're talking about multiple placements of individuals from the institutions, whom Madam Meilleur talked about bringing into the community and into long-term-care facilities.

On the same page, item number 9, it says that where the needs cannot be met, the developmental service agencies in those areas will be forced to put their workers in there—so an intermingling of workers. But bear in mind that the agencies themselves do not have the financial capacity right now to deal with the needs that they have to take care of in their own agencies.

A final point that I want to make is on page 9, point 22. This is the scariest part for me. It says, "In situations where a number of individuals from one facility have been referred to a specified LTC home setting and there is a desire to maintain relationships, the LTC home may consider the development of a specialized area within the home to provide service to individuals with similar needs." So we have people in an institution, we move them to another institution, and then we put them into a smaller pod. How is that integration into our communities? I find this very, very troubling.

I know that the time is short, but I do want to mention a couple of other documents that I've put into the package. One of them is called Doublespeak: The Ontario Government's Betrayal of People with Developmental Disabilities by Dr. Patricia Spindel. For those who don't know her, Dr. Spindel is an expert in both developmental services and in long-term care. Her major thesis in this document is about the twisting and manipulation of the terminology used in the developmental services movement—"inclusion" and "equality," in effect—to re-institutionalize individuals with developmental disabilities into long-term care. She also has a very good piece on the history, moving from the Ministry of Health to the Ministry of Community and Social Services and now the move backwards.

I referred to a reporter by the name of Trish Crawford, who did two major pieces. One is called "Lost in Transition," which is about what happens to individuals after the age of 21: mandated services, no mandated services, extremely long waiting lists. The other one she wrote, which is very significant, is called "Fragile Fighters." It's about closing institutions. Her point is not that she's against that but that there's a multi-faceted lack of services available for people as they move into the community.

In fact, this document that I'm talking about, the protocol, is a way for the government, which is stuck right now, to deal with 1,000 people moving out of institutions without services, a chronic underfunding of the associations for community living that can't meet the needs, and waiting lists in the thousands across the province for people who can't get supports.

What I say to you is that this protocol has to be shelved; you have to get rid of it. You have to not put people into long-term care who should be in the community. I know that the government is putting in money, but there needs to be a significant infusion into services for those people who have developmental disabilities to actually be in our communities.

The Vice-Chair: Thank you very much. We have about three minutes left. We'll start with the parliamentary assistant. You have one minute.

Ms. Smith: You talk about the protocol a great deal. I don't know how the protocol impacts on Bill 140, but I appreciate your perspective today.

I do point out that the protocol is very clear at the beginning that each resident is assessed, and only where a long-term-care home is the most suitable setting to meet their health care needs would they be admitted into a long-term-care home. In Bill 140, as you know, we set out a great deal of our own protocols on assessments of needs and determining who in fact can be placed in long-term care. So I would suggest to you that given the restrictions that are in Bill 140, only those who have the appropriate needs would find themselves in long-term care in the province.

1330

As well, in this protocol that you've outlined for us, it is outlined on a number of occasions that each individual will be assessed to determine their needs. Of course, there would be no admission into a long-term-care home without that person's consent, and that's part of the legislation. My understanding is that the Ministry of Community and Social Services and the Ministry of Health are continuing to review this protocol, so that there are ongoing reviews. Perhaps you can just give a quick perspective on how you see the admission requirements under Bill 140 working in conjunction with this protocol.

Mr. Sanderson: I think it's quite clear—and that's why I brought up the issue of exhausting any other alternatives—that the alternatives will not be there. So it then becomes one of the choices that people make. I'm not saying that there will not be an assessment—that is not my point; simply that that's the route, and it's pushing people into those circumstances, to the point where we have multiple requests potentially being made to one home. How that happens, I don't know. It should be going to developmental services.

The other issue—

Ms. Smith: If I could just follow up on that point: If you've been here for some of the other presentations, you've heard a great deal of input from people about the waiting lists for long-term care and about the demand for long-term care. Your conclusion that there are no alternatives but long-term care and therefore they'll all be going in that direction just seems a bit at odds with the reality of the population already moving toward long-term care and looking for placement. I don't see how you see long-term care as being the only solution.

Mr. Sanderson: No, I'm not suggesting—I'm saying that the protocol is proposing it as a major solution. In light of the fact that many of the services are not available, that will become one of the choices. By the way, it also states that developmental services will offer services in those long-term-care homes.

The Vice-Chair: Mr. Runciman.

Mr. Robert W. Runciman (Leeds–Grenville): I was a little perplexed by your suggestion about surplus beds in the long-term-care system because I know, in the city we're in at the moment, one of the problems with the hospital sector here is the lack of availability of nursing home beds and the fact that they can't move people out of the active treatment beds at the hospitals. That's causing, I think, a significant problem. I'm not sure if that applies right across the province.

I gather what you're talking about here is the additional investment in community-based services rather than what you're classifying as reinstitutionalization by going out of these facilities like Rideau Regional into long-term care. I know that the folks in my own area who are in the long-term-care sector are not enthusiastic about, for example, having individuals from Rideau Regional, who have very significant, heavy needs, being placed in their care. They think these are very significant challenges that they're not prepared to cope with and would rather see a facility like Rideau Regional, where these people at least would have the opportunity to live out their lives prior to that kind of a significant change taking place.

I guess you don't see a place in the province for institutionalized care for any kind of individual. Is that what you're suggesting in your proposal as well?

Mr. Sanderson: What I'm stating is, the reality is that there was a 2012 date for closure; it has been speeded up. That's causing a tremendous amount of turmoil because the services are not there in the communities.

Mr. Runciman: I agree.

Mr. Sanderson: We're trying to shift services out. People are not against that, but we need to have the basis for that. We need to have the doctors, the nurses, the physiotherapists; we need to have the staff in the residences and the day programs; we need to have augmented transportation services, and they're not there. So that's a major concern for us.

The reason I put the two together is because we are talking about the ministries coming together to work together on issues. But if the services are not present, then people are going to be put at risk, and people in long-term-care homes are going to be put at risk also, I believe. The 3.5 hours will not meet the needs. So why the protocol is there begs that question. That's why I want to say that there are 1,600 individuals already in long-term care who have a developmental disability of one sort or another, and there are younger people there too. We feel that it's more appropriate that they live in the community.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation. The relevance of this to Bill 140 goes back to a presentation we heard last week from the MS society, which strongly suggested that there were people with multiple sclerosis who couldn't get supports in the community and were being inappropriately placed in long-term-care homes. That's exactly what's happening with this protocol, and we've encouraged the minister on at least two occasions to get rid of it. It is telling service providers to force their clients who are now in the community into long-term-

care homes to free up spaces for residents who are coming in from Huronia. So we see a displacement of people now in the community into long-term-care homes to make space for people coming from the DS facilities. The issue is, why aren't we providing the funding to allow the people in the community to age in place?

It's interesting that the protocol also says that additional funding will come from the developmental services sector to support placements in long-term-care homes in order to ensure the supports and services are there so that the safety and well-being of other residents are not affected. Clearly it's not an appropriate placement and clearly the money in the developmental services sector should stay and be increased and enhanced to keep people in the community. I think that's what the point is with respect to Bill 140. I certainly hope that the government is going to shelve the protocol because I think many in the community sector know exactly what's going to happen here; that is, more people being forced into inappropriate placements and putting other residents and staff in those long-term-care homes at risk.

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

I believe the next presentation, by the United Steelworkers, has been cancelled. Is anybody here from the United Steelworkers?

COUNCIL ON AGING OF OTTAWA

The Vice-Chair: We'll move to the next one, by the Council on Aging of Ottawa.

Mr. Al Loney: So I get half an hour, do I?

Thank you, Mr. Chair, members of the committee. Our brief is very short. It doesn't mean that we're measuring it as being unimportant. The fact of the matter is that there are a number of things in the bill and the major thrust of the bill which we do like, but we have some caveats, and that's really what I want to point out today and not go through the whole iteration of everything you've heard before. I've read the briefs from a number of the different groups, including the Ontario Health Coalition and the Advocacy Centre for the Elderly, and I think they make some very good comments, but I want to go into a couple of things.

Funding has been mentioned repeatedly here but I don't think anybody sitting here in the audience or around this table can possibly see that more funding is not needed for the long-term-care sector. It's backed up badly. I don't know about every corner of the province in terms of it, but certainly in Ottawa it's backed up badly, although a few years ago, when a big number of new long-term beds came on, we actually had a surplus for a little while. But that's sure changed.

I think too that education of staff is vital. We see more and more dementia patients, more and more people with cognitive disability, and I think there's some special training needed by staff to know how to properly deal with these folks. Maybe that runs right into my next point, which is the high degree of illness and injury of staff working in these long-term-care homes. I think a lot of the heavy care is really quite important there. I was in hospital visiting my wife recently and another woman was wheeled into her room who weighed in the order of 450 pounds. I saw the nursing staff trying to cope with that person. The reality is—I'm no little guy myself, and I'm telling you, there's an awful lot of work needed and an awful lot of help, and you have to have enough people and you have to have them well trained.

The matter of accreditation: We feel pretty strongly about this. As you undoubtedly know, in the province of Quebec and some other provinces, accreditation is a requirement. It's mandatory. In the system in Ontario it's still an option. I would like to see that made mandatory.

The amount of nursing care that's required: I guess we could argue forever on that. But we do feel that a minimum of 3.5 hours of care should be in the legislation and should be funded. I think those two are very closely linked. If you don't have a number to which you're at least going as the minimum, it's hard to then argue that, "Hey, my funding isn't enough." There are various weightings that have been put in this. I remember back when the criterion for going into a nursing home was that you had to require a minimum of 2.5 hours of nursing care. That's quite a few years ago. My hair is now white. I recognize that.

On the matter of restraints, I'm told there is legislation, the Patient Restraints Minimization Act. Why is this not part and parcel of this act? Why does it not apply? Why is there some, frankly, rather wishy-washy comment about restraint? I think that chemical restraint is altogether too often used. That's perhaps partially explained—by some, anyway— as being a lack of staffing, but the fact of the matter is, I believe that chemical restraint to the degree it's currently used amounts to elder abuse in a lot of parts of this province.

1340

It has been a long time since this subject has been visited in legislation, and it would be nice to think we can get it right, and maybe it would last for a while again. But I really do feel that you have to address the issue in a very hard-nosed way and say, "Unless we're prepared to put more money in"—and I keep hearing about this extra $6,000 per patient. Frankly, I think that would go a long way to redressing some of these problems with staffing. In our group, because we deal specifically with the elderly, we are very much aware that there is more and more heavy care—and more and more people. We're living longer, folks. Frankly, you may be great at 70, but you may not be so great at 95. The fact of the matter is that at some point we're all going to pay a little visit, probably, to a long-term-care institution. Those patients require much more care than the average patient did, I would suggest to you, 20, 30 or 40 years ago. That's where we're at.

I thank you very much for the opportunity to address you today. If you have any questions, I'll be glad to try to answer them.

The Vice-Chair: Thank you very much for your presentation. I guess we have a lot of time for ques-

tions—over six minutes, two minutes for each side. We'll start with Mr. Runciman.

Mr. Runciman: Thanks very much for coming in from Ottawa, I gather. I wonder about your own consultation in appearing before the committee. Is this simply members of the council, or do you talk to the operators and staff of long-term-care facilities to get some feedback from them?

Mr. Loney: Our organization is multi-faceted. We have a large number of various committees and task groups; one is called the house issues committee. Several of the providers sit on that committee, so these issues are addressed, and indeed the brief was discussed with that committee as late as last Friday before coming down here. These points that I've made are very strongly felt by that table.

Mr. Runciman: I know that I've met, I think, with every long-term-care facility in my riding. There seems to be unanimity in terms of a whole range of concerns, and you've certainly touched on some of them: the whole issue of licensing and the impact that's having on their ability to fund improvements to their own properties, for example; the director's liability in the non-profits—these are volunteers; the concern they're having with respect to being able to attract people to serve in that capacity under this legislation and the implications attached to it.

I have to say too, when we talk about licensing, I think there's a real concern in a riding like mine, and it would impact many areas in eastern Ontario which would be classified as small-town rural. Many of these facilities are the major employers—Kemptville is an example. I think the payroll there is about $200 million. The bulk of employees are female. They're very concerned about their ability to meet these standards which are being applied without the necessary funding to meet them in many respects, inspectors coming in, and the possibility of beds being moved out of a region. That's the way they're interpreting this legislation: We could be losing not only the jobs and the economic impact, but also those beds for residents in a catchment region. I'm just wondering if you're hearing that kind of feedback from the folks you've talked to as well.

Mr. Loney: Yes, but the overriding comment that I would make is that it's very patient-centred. All of the concerns we have for the workers—and the owners of these establishments in some cases—are all secondary to the patient. I think we have to realize that the patient who's in there is the number one concern we all should have, and we should make sure that the funding and the regulations are such as to give the best care possible.

I don't believe that you can regulate every turn and every thing that happens, but you can regulate some basics. I think it should be done; I think it's well overdue. We need to make sure that when mother, grandmother, aunt or whoever goes into a long-term-care home, we don't have to go in three times a day to check on it to make sure they're all right.

We do a lot of work with elder abuse. More and more of the cases we're hearing there and with the special unit with the Ottawa police are delving into cases in long-term-care institutions. The fact of the matter is, there is great concern in the community in terms of where we're going with all of this. You'd be hard-pressed to find anybody in a person-on-the-street interview process who would say, "No, you're spending too much money on long-term care and nursing homes." I think the answer would be the opposite: You're not spending enough.

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

Ms. Martel: Thank you for your presentation today. You said that you can regulate some basics, and I agree with you. One of those very basic things you can regulate, in my opinion, is the amount of hands-on care that a resident in a home will receive every day. There was a standard when we were in government. It was cancelled by the Conservatives. The Liberals, in the last election, promised to reinstate a standard. There is no standard for hands-on care that appears in this bill. The standard that should be in place is not the one that was in place 10 years ago, when it was cancelled by the Conservatives. It has to be, as you say, 3.5 hours.

Another area where staffing standards have been recommended and where the government has failed to respond is around the area of those nursing staff who deal particularly with people who are aggressive, who have behavioural issues. In a coroner's inquest that was carried out after the death of two residents by another resident at Casa Verde, one of the recommendations of the coroner's jury was that you have staffing standards in place for nurses who are dealing with people who have violent and aggressive behaviours. That is not in the legislation as well.

So when you talk about some basics, I think those are pretty clear, fundamental basics, and I hope the government is going to change its mind and put some staffing standards in place so that every home has to operate to some level. Certainly, more care can be provided, but at least there's going to be a bottom line of care for every resident in every home.

Mr. Loney: You don't think these guys are listening to me today?

Ms. Martel: Well, we'll see. Clause-by-clause is a week and a half from now; we'll see.

The Vice-Chair: Thank you very much. Parliamentary assistant?

Ms. Smith: In fact, we are listening, and a lot of the concerns that you've raised today are addressed in the legislation, so I want to be able to take this opportunity to point out some of them to you.

Mr. Loney: You'd better point them out.

Ms. Smith: You were asking about further consultation on the regulations. We have in fact said, last week in committee, that we will be consulting on regulations.

Mr. Loney: That's good.

Ms. Smith: You talked about the need for investment, and I agree there's an ongoing need for investment. As we describe it, long-term care is definitely a work in progress. We have invested $740 million in the last few years—an increase in its budget of 34%. We've seen an

increase in staff of 4,800 in the last two and a half years, and that includes about 1,100 new nurses. You talked about some specific areas where you wanted to see improvement, including education and training for staff. I would point you to subsection 74(6), where we actually mandate that the homes provide training on abuse recognition and prevention, caring for persons with dementia, behaviour management, the minimizing of restraints, palliative care and other areas that can be included in the regulations. So it's right there in the legislation, your concern about dealing with dementia care and behaviour management.

You spoke a little bit about the safety of staff, and certainly that is of utmost concern to our government. We've invested about $42 million in new equipment in the last couple of years, including lifts, which I think has improved the quality of life of some of our staff—although I recognize that it is a heavy workplace; there's no doubt about it.

You wanted to see the inclusion of the Patient Restraints Minimization Act. I would just point out to you that through sections 27 to 34 of the legislation, our restraint minimization regime is actually more comprehensive than the Patient Restraints Minimization Act. It includes PASDs, personal assistant support devices; it also includes some restrictions around transfer to secure units. The Patient Restraints Minimization Act is really focused on hospital use and hospital care, and in long-term care we thought that we needed a more fulsome restraint provision, and that's why it's in the legislation. So I'd just refer you to take a look at that.

Also, with respect to chemical restraints, subsection 34(6), I believe, is where you'll want to look, where we say that you cannot use a chemical as a restraint. Only a doctor can prescribe that, and if a doctor does prescribe it, there are some limitations and some reviews that have to happen in a home in order to limit the use of that.

I think that addresses some of your concerns, and I hope you'll have an opportunity to take a look and see what's in the legislation.

Mr. Loney: I would suggest that I've already looked at those sections, and I don't feel the wording is adequate, frankly.

The Vice-Chair: Thank you very much, sir, for your presentation. I think we're over time here.

1350

FRONTENAC-KINGSTON COUNCIL ON AGING

The Vice-Chair: Next will be the Frontenac-Kingston Council on Aging. Welcome. Before you start, please state your name and those of your friends who have come with you.

Ms. Christine McMillan: My name is Christine McMillan. I'm listed as the as the only spokesperson because I applied for a time to present to you. I'm accompanied today by Brian Brophy, who is the president of the council, and John Osborne, who is our executive director. I also serve as the chair of the issues and concerns committee as well as secretary to the board.

Mr. Brian Brophy: The Frontenac-Kingston Council on Aging, founded in 1991, is a registered charity managed by a volunteer board of directors, the majority of whom are seniors. We are a member of the Councils on Aging Network of Ontario, all of whom share a deep concern about issues that demean the quality of life of seniors in our province. Our mission is to educate the general public and provide grassroots information and advice to decision-makers at all levels of government.

From our perspective, Bill 140 is the beginning of a good idea, similar to Herman, the cartoon character who looks at a square wheel he has shaped out of stone and states, "I think I'm on the verge of a good idea." Since the purpose of this consultation is to provide advice, we will not dwell on what is right with the bill but rather on amendments that we hope you will include.

Mr. John Osborne: Shortage of long-term-care beds: Right from Brockville through to Belleville last week, you noticed in the Kingston Whig-Standard headlines of how our hospital has come to a halt in being able to move people through. Desperate measures are being looked at, which brings us right to the forefront today. The shortage of long-term-care beds is a crisis in our community. Currently, 400 seniors are on a waiting list for a bed in long-term care. The Kingston General Hospital has 66 seniors in alternative-level-of-care beds in the hospital, which has created a crisis even for the use of surgery. They can't move people into these beds. The crisis may even worsen over the next 15 years, when it is estimated that the Ontario population aged 65 or older will soar to 2.7 million as the baby boom generation reaches its peak. That's an increase of 1.4 million over the 1996 census.

The hospital restructuring committee believed that the solution was in home care, but we have learned that keeping seniors in their home alone, with minimum care, creates its own problems of isolation and depression. Retirement residences provide an alternative for seniors who are able to afford the $36,000 or more per year. For middle-income and low-income seniors there are very few options beyond this.

There is a great need for an affordable alternative to private retirement homes. We are pleased to report that the council on aging has received a small grant from the federal government's New Horizons for Seniors program to help put together a model for us in this community to start with.

We're recommending, in relation to short-term- and long-term-care beds, that the government take steps to relieve the pressure on long-term-care facilities and on alternative-level-of-care beds in hospitals by providing funding on a 24/7 basis for home care within various models of supportive housing to accommodate seniors and younger people with disabilities.

Ms. McMillan: You're going to hear a lot in our presentation, as I'm sure you've heard from everyone, about the need for additional funding. What I want to say right at the beginning is that the members of our council

don't accept that it's impossible to provide adequate funding for the care of our aging population, or that it will take years to resolve. As Depression kids, we saw what can be done.

In 1939, we had a minimal army, no naval vessels and no air force. By 1945, because there was political will, we had a well-equipped army, our naval fleet was the fourth largest in the world and we had an air force of which we were proud—and the debt was paid off by 1959. So we're saying to you, it is political will; it's not shortage of funds.

I'm going to quote something that John Gerretsen said on November 7, 2002. He's our honourable member and I think it's right that we quote it here. He said, "Do we really think, in terms of the way we take care of our seniors, that it's good enough to rank dead last when it comes to nursing services and personal care services we provide for our seniors in" long-term care? We couldn't agree more with that statement.

Both these documents are startling. What I'm referring to here is that there were two studies done. There was an auditor's report and the PricewaterhouseCoopers study. Both these documents were startling indictments on the care of our elderly citizens. Both identified that the level of care for residents in Ontario's long-term-care homes was and remains unacceptable. If you visit some of them, you'll see frail, elderly seniors secured into their wheelchairs, sleeping and slumped over. They line the halls of too many of the Ontario long-term-care homes due to overworked staff and underfunding of programs to stimulate residents.

The printed election brochure of this government stated that 2.5 hours of minimum care would be restored and that the previous minimum number of baths per week would be increased from two to three. It was expected by seniors that both these promises would now be embedded in legislation.

Other presenters have provided you with the statistics on standards of care in provinces throughout Canada. It is sufficient for us to say that we strongly support their contention. We are urging the government to amend Bill 140 to include a minimum standard of care of 3.5 hours per patient per day in long-term-care homes. We also urge that it be weighted by the assessed acuity of the resident's condition. In other words, there's 3.5 hours per patient, but if some patient needs four or five hours, they can get it because there's going to be some light care that won't need as long.

We urge the government to amend Bill 140 to include a minimum number of three baths per patient per week, as promised during the last election. And we urge that what they call "baths in a bag" not be considered baths. That is a short form for what's happening in order for residents to even get a sponge bath.

I guess the next thing that I wanted to really talk about was the nutrition in long-term-care homes. It's a constant complaint that we hear from families and from residents in long-term care. I'd like to quote for you something from Canada's Division of Aging and Seniors report. It was put out in November 2001. It said, "Combined with physical activity, good nutritional status is a key element for seniors to avoid progression of chronic conditions. However, as health and functional capacities deteriorate, the prevalence of malnutrition increases dramatically, reaching 60% in nursing homes and hospital settings."

And then you heard the submission to the committee on finance and economic affairs this past December from the Ontario Association of Non-Profit Homes and Services for Seniors, in which they said, "Because of funding restraints, long-term-care homes are restricted in their ability to provide fresh fruits and vegetables that are an important part of any diet."

From our point of view, the issue of adequate food for residents in long-term-care homes is akin to the Dickens story of Oliver Twist in which Oliver in the workhouse is punished for asking, "Please, sir, may I have some more?" We went on a local shopping trip here. We used the Ministry of Health's nutritious food basket tool, and there is absolutely no way a resident in long-term care can receive adequate nutrition on $5.46 per day. That must provide three meals a day, with a second choice for each meal, as well as snacks and nutritional supplements. If we deduct 10% for wholesale purchases, we were still looking at $7 per day or $49 a week. That's a long cry from the $35 a week that nursing homes now get. In this regard, we're asking that the food allowance for residents of long-term-care facilities be increased to a minimum of $7 per patient per day to meet the nutritional standards set out in the Canada Food Guide.

1400

I want to go on to say that the lack of adequate food, in our opinion, would fall into the category of neglect under the province's own elder abuse guidelines. I think you've received a copy of our brochure, because we do elder abuse.

We're also concerned, and we heard in the discussion, that there's an allowance of $12.64 per person per day for food preparation—this is really pretty sparse, because they have to grind, mince and purée versions of each meal. They have numerous special diets that they have to deal with. One of our fears is that, with a limited salary budget, there may be a tendency to provide only liquid canned supplements to those who are unable to chew or swallow. I draw your attention to the recent study by the Baycrest Centre for Geriatric Care, where they said that this is not adequate.

So we request that you review the food preparation allowance with the view of making it commensurate with the special dietary demands of the residents, including special preparation of food for those unable to chew or swallow.

Brian's going to lead us right into dental health for seniors.

Mr. Brophy: Dental care for seniors who reside in long-term-care homes, as well as those who live in the community, requires consideration by the Ministry of Health. While minimal dental care is provided to people on welfare, absolutely none is available to low-income

seniors. While minimal dental care is provided to people with disabilities under the age of 65, absolutely no assistance is available to them when they reach 65.

The recommendations made by the Ontario Dental Hygienists' Association to this committee is one which we ask you to seriously consider implementing. If good dental care was available for all seniors in long-term care, many would be able to chew and swallow their food; nutrition would be improved, resulting in fewer cases of infection; and the effects of gingivitis on the general health of the individuals would be reduced.

We recommend the Ministry of Health and Long-Term Care explore the cost of dental care for seniors who do not have dental insurance, both within long-term-care facilities and for those living independently in the community.

Mr. Osborne: Finally, of course, it all boils down to money: Where do we find in Ontario more money? But it does have to be found.

The senior population will be growing steadily all along. Right now, the overall funding for long-term care has not matched inflation, let alone the steady increases in seniors living their own lives for longer terms, and those being shifted from hospital beds, once considered—and funded—as chronic-care placements.

"Seniors themselves are making up the shortfall, paying almost twice as much in monthly basic accommodation fees as nursing home residents in British Columbia, Alberta, Saskatchewan, Manitoba and Quebec," as per the Ottawa Citizen's research by Paul McKay in the nursing home series he did.

Basically, we're recommending, first of all: Try to extend the tax base to cover the needed funds in the long-term-care system. But if not, then look at the current lottery revenues and see if we can draw more out and put more priority in that area for long-term care—if not, then the possibility of creating another lottery or other source of income that can be dedicated to long-term care and seniors' health.

We also have two other recommendations: 5 and 6. I'll go back to those—

Ms. McMillan: Maybe leave those, because we're out of time.

The Vice-Chair: Thank you very much for your presentation. I guess there's no time for questions.

Mr. Osborne: In conclusion, if I may wrap up: "A civilization is judged by the way it treats the most vulnerable of its citizens." That's Margaret Mead. Is the current state of long-term-care homes, the rising allegations of understaffing, underfunding and the lack of care and food for frail elderly men, women and younger disabled persons something by which you wish to be judged by history?

The Vice-Chair: Thank you again.

ALMONTE COUNTRY HAVEN

The Vice-Chair: We'll move to the next presentation, which will be by Almonte Country Haven.

Welcome.

Mr. Rick Gourlie: Thank you. Ladies and gentlemen, distinguished guests and friends, my name is Rick Gourlie, and I am the administrator of Almonte Country Haven. It is an 82-bed C-class home in Almonte. I have worked in the capacity of a social worker, a front-line worker, a supervisor and an administrator with many populations, including autistic, mentally handicapped, victims of crime and senior citizens, working in Alberta, British Columbia and Ontario. So I thank you for this opportunity to speak about Bill 140 and how it will impact the residents of Almonte Country Haven.

I believe Bill 140 started out as a good piece of legislation but lost sight of what it was trying to achieve. The intention was to create a bill that would enhance the long-term-care experience, make life better for those living in it and anticipate the needs of those in the future. I am sad to say that somewhere our primary objectives have been lost.

I would like to address two major issues with Bill 140. The first is the limitation of licences, with no guarantees to the communities, the residents or the staff within the homes. The second is the increased documentation, which will translate into less time providing actual hands-on care.

Let me begin by saying that Almonte is located 20 minutes from Ottawa, yet, despite its proximity to the nation's capital, Almonte retains a very rural flavour. The residents who move into our home are people known to our staff. They're known to the residents in the home as well as to their families.

Many volunteers assist our home by offering both large, group programs and small, one-to-one individual programs. The inclusion of these community members in our home has been a key factor in our success. If Bill 140 is passed unchanged, Almonte Country Haven may have only seven more years of operation before our doors are forever closed—closed after nearly 30 years of compassionate service to the community; closed to the volunteers; closed to the residents and their families; closed also to the many staff who have worked for over 25 years in our home.

If you close our doors, you will punish the residents, their families and the staff as well as the entire community, because in our small town we are considered a major employer. You will punish all the people who have believed that they are building a place for their future. Imagine how an admission process is going to go: Families will soon learn not to select a C home for fear of possible closure in the future—so the need to relocate a loved one in a foreign home in a foreign community.

We need the committee's reassurance regarding the continuation of our home in Almonte. Please don't make the mistake and think that the community will forget the actions of closing a home within their community only to then open another home in a different community. Indeed, the community will become jaded. So please, listen carefully; act wisely.

To address my second point, I refer to the Residents' Bill of Rights. It's a cornerstone upon which the ministry

standards were founded. I believe the intention behind the creation of the Residents' Bill of Rights was to allow us to see issues through the eyes of the resident.

1410

I hope the ministry is better able to understand the implications of what it proposes by telling you of a resident's life from Almonte Country Haven. This is the story of a woman named Louella. Louella opened the Almonte Nursing Home, operated that nursing home and later was admitted into the same home that is now called the Almonte Country Haven.

Louella opened the Almonte Nursing Home in the late 1950s, and during the days when Louella operated the home she gained a reputation as a woman of great conviction and kindness. Louella once told me that the key to her success was that she genuinely cared about each and every person who was admitted, and she always had time to listen to their stories. Louella would often pass my office, call out and say, "Come out here, you. Talk to these friends of mine." Then she'd laugh because what she'd said was, "At the end of the day, it's not what you write in that book that will make a difference. It's what you do and how you touch their soul. That's what people want."

In 2001, Louella moved into the home that she had actually created. She lived in a four-bed room. Louella was not a rich woman. She had lived her life giving to others without concern for herself. She believed in creating a legacy, a living legacy. Every morning Louella would wheel down the hall in her wheelchair, greeting residents with the same morning greeting. She'd call out, "Make a good day of it, now. You'll have to work at it, but do your best to make a good day of it." Those are simple words, but in that regard I am here today to make a good day of it and work at making Bill 140 good legislation for everyone.

In our home, many of the staff joined our workforce straight out of school. They never had a desire to move to a big city; they wanted to build a life within their community without a commute, a life that would have purpose. They have been able to achieve this at Almonte Country Haven. They chose a profession that has allowed them to have hands-on impact on the quality of life for the residents. They did not choose this career to record every aspect of their care, to document everything from intake to output so that all of this could later be offered up as proof to the ministry that the care they are providing has actually been provided.

The ministry does not seem to understand that the need to provide the many layers of documentation actually takes time away from the individual who's giving the care. Louella had it right over 50 years ago.

Bill 140 is designed to create an intimate relationship with documentation. We are being forced to focus on the proof of care, not the provision of it. Here are just a few examples.

Subsection 6(6) requires that resident and family have the opportunity to participate fully in the plan's development and implementation. There is, however, no guarantee that all of these people will be available to be interviewed or contacted. So the only way that a home can demonstrate its compliance is to set up a paper-based system that can be shown to the inspector who comes to document this involvement.

Subsection 15(2) sets out the requirement for measures to encourage the participation of volunteers from a list of organizations. Once again, the only way to demonstrate that this is happening is to document all of these measures and the communication with all of the listed organizations.

Subsection 18(3) requires communication of the zero-tolerance-of-abuse policy to everyone attending or visiting the home. Homes will have to print off and circulate the policies on a daily basis, and can only demonstrate compliance through the tracking of their distribution.

Sections 28 to 31 set out the requirements relating to restraints. Again, more documentation will be required to demonstrate that each element of these sections is being met. This is not because there is currently widespread use of restraints, but rather it's because Bill 140 establishes magnetic locks on exterior doors as a restraint. In our 82-bed care home, this perimeter barrier would be a restraint for 65% of our population. So that means 54 people will have to have hourly checks, with the corresponding documentation to demonstrate the check was completed. This potentially would translate into 24 hours in a day times 54 residents times 365 days, which would equal 473,040 entries in a single year. If it takes about 10, maybe 15 minutes to do your check and make your documentation, over a one-year period that time will translate into 118,260 hours, or the equivalent of 60 full-time workers.

Interruption.

Mr. Gourlie: Thank you very much. Clearly this was not the intention of Bill 140. The current hourly checks are not specifically intended for perimeter barriers.

Clause 76(1)(d) sets out that each home must provide any revisions to the information package to any person who has received the original package. This will require regular updates, as well as a system to track who has received the original information package and then subsequently who will receive all the revisions within the packages. Without documenting this, how can we demonstrate that this has happened? We'll have to document it to confirm compliance.

Subsection 76(2) sets out the content of information packages that will have to be created. Inspectors will have to verify in more than 600 homes that these packages do comply with the legislation. Similarly, any revised packages will require inspection for compliance. Clause 78(1)(b) sets out that regulated documents will have to be certified by a lawyer. Each home will have to set up a process and create the required paper trail to demonstrate complete compliance.

These are just a few examples that are in addition to our current documentation requirements. Clearly, Bill 140 is not about providing better care. It's about revising policies, setting up procedures and putting in new

protocols to meet compliance so that documentation will be in order for the inspectors. It says nothing about care.

The simple act of holding hands, offering support and human contact is lost with the adoption of Bill 140. My friend Louella would be shocked to learn that Bill 140 is placing documentation over human contact. Louella believed in creating a legacy, one that you can be proud of, a legacy that reflects both care and compassion.

I ask you, if you were scared, alone, confused and living in long-term care, what would you prefer—someone who would hold your hand and offer kindness and reassurance or documentation?

Don't limit our ability to offer care by restricting our licences and don't overburden us with more documentation. Please, help fix the problems with Bill 140 and join us in supporting the OLTCA's proposal and Elizabeth Witmer's private member's motion to enhance the legacy that was started so many years ago with a kind and caring woman by the name of Louella.

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

1420

PROVIDENCE MANOR FAMILY COUNCIL

The Vice-Chair: The next presentation will be by the Providence Manor Family Council. Welcome. If you don't mind, can you state your name?

Ms. Carol Robertson: My name is Carol Robertson, and this is Linda Dowdle.

Thank you for this opportunity today. Actually, the previous speaker had me at Louella.

We're here today representing the family council at Providence Manor. I would like to start by telling you a few things about us. We also have a brochure which we have included in your package.

Providence Manor is a charitable home in Kingston with 243 beds. The family council at Providence was founded in October 2004. Currently, we have 16 active members and a staff liaison that meet monthly.

The council has developed its terms of reference. Council members sit on a variety of Providence committees, such as long-term care, laundry, the dining experience and diversity awareness. The council has also provided information and in-service to other families on such matters as power of attorney, a program on how to feed residents and a Parkinson's support group. We also initiated and submitted a petition to John Gerretsen, our MPP, requesting additional funding to increase the minutes of care for each resident.

We have implemented a life history project for residents so that staff and residents can better appreciate the rich life that each resident has had prior to coming to Providence Manor. The council is in the process of developing an action request form for families or residents to use to address unresolved issues.

We would like to speak to you today about four key areas in Bill 140:

(1) Provincial staffing standard: As families, our biggest concern is the quality of care that our loved ones receive. We believe that quality care is significantly dependent on the amount of time that staff can spend with a resident. The present model allows for residents to receive between two and 2.5 hours of care per day. This is a minimum amount of time which does not recognize the complex care that many residents require to move, dress, bathe and eat. In addition, without enough time for personal contact and interactions, the dignity of the residents is lost.

We are requesting that Bill 140 establish a provincial staffing standard, and that this standard provide for a minimum of 3.5 hours per day of nursing and personal care for each resident. We are also requesting that the bill recognize that specialty units for residents who are aggressive or significantly cognitively impaired need a different staffing standard and a staff with a particular set of skills in order to provide the level of supervision and interaction required. We would like to see a separate provincial staffing standard for these units as well.

(2) Level-of-care funding: Every resident in long-term care has a care plan based on the needs and, to some extent, the preferences of the resident. At present, the funding model allows long-term-care homes to meet only the minimum care standard of this plan. Other areas that add to the quality of life for residents and maintain their dignity are not recognized. An example of this is toileting. Ideally, a resident should be able to use the bathroom for as long as possible. However, time constraints often mean that a resident who requires help to get to the bathroom and assistance in the bathroom is forced into briefs earlier than necessary. Another example is that a resident who requires help walking ends up in a wheelchair earlier because of lack of staff time to walk with him or her. Meal time is another example. Many residents require feeding. A lack of adequate staff members at meal times means that residents have to wait for food, get rushed through their meals and eat cold food.

We see a gap between what the bill provides for resident care and what the current level of funding actually provides. To close this gap, we are requesting that Bill 140 direct the ministry to assess residents in a fashion that raises the current minimum standard of care and fund this higher standard. We feel strongly that new money must be directed to hands-on resident care rather than creating elaborate reporting structures.

(3) Transfer of licences: All long-term-care homes in the province receive money for nursing and personal care, food, programs and support. The money in these envelopes must be spent as outlined by the ministry and cannot be transferred to other areas. Flexibility in spending comes from the accommodations envelope. Providence Manor takes money from the accommodations envelope to increase the nursing envelope by 18%. Likewise, Providence Manor takes money from the accommodations envelope to increase the amount designated for food. This makes Providence Manor a home that centres its decisions on the residents.

In contrast, in for-profit homes, all profits must come from the accommodations envelope. Exceeding the nursing and food envelope would reduce profits. To make money from the accommodations envelopes means a compromise of the quality of life for residents in comparison to life in a public non-profit home. We firmly believe that it is not in the best interests of the residents to allow the transfer of licences or beds from non-profit to a for-profit long-term-care home.

We request, therefore, that Bill 140 strongly support maintaining public and non-profit delivery of care in long-term-care homes. We also request that the provision which allows non-profit long-term-care licences and beds to be transferred to for-profit homes be removed from the legislation altogether.

(4) Family councils: We believe that all long-term-care homes should be required to have a family council. We believe that family councils' input should have a mandatory role in the inspection process. We believe that Bill 140 should provide for some provincial funding to support family councils.

In conclusion, one thing we all know for sure is that the aging process happens. If we were having brain surgery, we wouldn't want a doctor or a surgeon practising minimal standards. We wouldn't want our children in daycare centres that just meet the minimum standards. Why, then, are we satisfied with the minimum standards for a group in our society that is so vulnerable? Bill 140 is our chance to get this right not only for residents in long-term care now, but it also puts us on the right path for ourselves and our loved ones in the future. Please support our request for improved standards of care, additional funding in our long-term-care homes, and for continued support of public and non-profit long-term care.

Thank you for this opportunity.

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

Ms. Martel: Thank you for your presentation today and the work that you do on the family council. I wanted to ask you—because I think you mentioned an assistant, and I'm not sure if that's somebody who is from the home as well, a staff person who gives support to the council? Am I correct in that?

Ms. Robertson: Oh, it's a liaison.

1430

Ms. Martel: And is this a staff person?

Ms. Robertson: Yes.

Ms. Martel: The bill specifically states, "In carrying out his or her duties, a family council assistant shall take instructions from and report to the family council." There have been concerns raised by other family councils that that might mean a staff person, and so they don't want to see that at all. Do you have a sense of that? You have someone already. Is it working, not working? What's your sense?

Ms. Robertson: Our experience has been that that person only comes for a portion of the meeting, and it's only during that portion that she either gives us feedback that we have presented for her homework and on which she is responding back to us, or questions at that meeting that we might have for her, and then she leaves the meeting. In our experience, that system has worked very well.

Ms. Martel: Okay. So what we need is the ability to have some discretion about coming and going, and that being set up.

Ms. Robertson: Right.

Ms. Martel: Just in terms of what you see in your own home, and I want to go back to staffing standards, it's really clear that a significant amount of money is being topped up to actually have staff in place, and even that's not doing the trick, I would gather. What do you see as some of the shortfalls around the staffing that need to be addressed?

Ms. Robertson: In my own experience, and my mother is at Providence Manor, an example would be that it takes me an hour and a half to feed my mother when I'm feeding her. Staff have to do it a lot more quickly, because of the time allotment. So if staff take the time I take, it would already be four and a half hours a day just in feeding, not to mention all the other needs that she has.

I think another example that I can give from my own specific case is regarding safety. Last year, while my mother was being cared for in bed by two staff, Mom fell from bed, and I think it was because they were hurrying; they were rushing through the personal care in bed. Just over Christmastime, Mom suffered a broken arm. Again—

The Vice-Chair: Thank you. Parliamentary assistant?

Ms. Smith: Thank you for your presentation and for the work you are doing at Providence. I had a chance to look at your brochure, and note that a lot of the things that you do and the purposes that you see for the family council are reflected in the legislation in section 58, where we outline what we'd like to see family councils doing.

I just wondered: Your family council was created in 2004. Did you have some assistance from the family council project, which received some provincial funding in order to help some of the homes?

Ms. Robertson: No.

Ms. Smith: You weren't part of that?

Ms. Robertson: No. What we've received so far is a $30 donation.

Ms. Smith: Okay. But did you have the support—they had an outreach worker in the eastern region. I met with some of them in Ottawa, and I thought they were working their way through Kingston. Did you have any support from that worker, that outreach person?

Ms. Robertson: We attended a family council conference.

Ms. Smith: Right. The one in Ottawa?

Ms. Robertson: No, the one in Kingston.

Ms. Smith: Oh, in Kingston. Great. Well, I appreciate the work that you're doing.

In your outline of some of the things you do, you "identify and address concerns and issues" and try to come up with constructive resolution of issues. How is that accomplished through your family council? What are some of the things that you do to accomplish dispute resolution?

Ms. Robertson: Right now, as I said in the presentation, we're working on a resolution form. Of course, the problem is not quite as detailed as Bill 140, but it's trying to get a form that suits the needs of all the residents and that can be implemented in the home for the use of families in order to resolve issues.

Ms. Smith: Great. You also talked a little bit with Ms. Martel about the assistant that you have. That's a staff person?

Ms. Robertson: She's a liaison.

Ms. Smith: A liaison; sorry. And that's a staff person?

The Vice-Chair: Thank you.

Ms. Smith: Are you cutting me off?

Sorry. I'll ask you after.

The Vice-Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for your presentation. That's a great brochure that you've put together. I appreciate the work that you do on behalf of families. I think family councils are serving a very useful purpose in the province of Ontario.

You are requesting here some funding to support family councils. How would you suggest that this funding be provided? Should it be based per resident? And why should you get money? For what purpose would it be used?

Ms. Robertson: That's a really good question. As I said earlier, we just received, and have spent, the $30 in two years. It was a donation.

A lot of our costs involve money for paper in these brochures and also for the printing of the minutes. We also have just initiated a welcoming card so that when the resident is new to the home and has been there for two weeks or so the family will get a card welcoming the family to the home. So we really haven't got many expenses yet and, as I say, we've just spent our $30 donation over two years.

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

ONTARIO HEALTH COALITION, KINGSTON BRANCH

The Vice-Chair: The next presentation will be by the Ontario Health Coalition, Kingston branch.

Ms. Fern Giddings Pilato: Good afternoon. I'm Fern Pilato, not Ross Sutherland. Ross is out of town. He is the chair of the Kingston branch of the Ontario Health Coalition. I'm going to be reading this because I have a propensity to start on something and then start thinking about something else, and I need to stay in line.

The agreement between Ross and me was that I would focus upon the need for the people of Ontario and their government to include 3.5 daily care hours as a minimum standard of care for each long-term-care resident in Bill 140, 2006. He asked me on Wednesday. I got the legislation—the draft bill—read it, and on Thursday learned that I didn't know all my resources. I heard through an e-mail, serendipitously, that there would be something else that I could use. Then I heard it on the radio station; that, of course, is the rocking chair group that was out front. So, for this presentation, I am going to use the identifier of being a Canadian senior citizen at large.

I want to thank you for coming to Kingston, particularly Shelley Martel, Monique Smith and Elizabeth Witmer, as well as all the other members here at this table and in the audience. I want to also underscore my assumption that everyone present is an advocate for long-term-care residents. That means seniors and younger disabled folk. Without a doubt, I am not satisfied by having plus or minus 6% of my cohorts and many younger folk residing in what I broadly consider to be almost warehousing with conveyor-belt characteristics.

With 10 minutes, I can only address the 3.5-hour issue by means of a macro approach versus a micro approach since Bill 140 is comprehensive, with 11 extensive parts.

My supportive points for the inclusion of 3.5 arise from the preamble; part I—fundamental principle; part II—rights, care, and services; part V—operation; as well as part VI—funding.

Preamble: "The people of Ontario and their government ... affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term-care homes." Please note that in 2006 and today quality of life includes health promotion. The history of the people of Ontario and their government is also something worthwhile to note. In 1986, the Ottawa Charter for Health Promotion and Achieving Health for All were adopted. That was 10 years ago, before 1996, when Ontarians and their government withdrew the 2.25 hours of personal care as a minimum standard to replace it by zero, nought. One year earlier, in 1995, the Ontario Auditor General reported that inaction on issues such as staffing mix and appropriate levels of funding meant there was no basis to assess whether further funding was appropriate to meet the assessed needs of the residents. An overview of this phenomenon certainly stimulates red-flagging of possible resident abuse.

The government at that time ran under the banner of Mike Harris's new revolution that was devolving towards a return to a colonial society where quality of life for all had not always been respected versus evolving towards a quality of life for all of society.

1440

Furthermore, the 2002 Ontario Auditor General's report underscored the same situation as the 1995 report, while the 2004 report found only a few areas where there was at least a minimum charge. Today there remain zero hours of personal care as a minimum standard. I did get the Auditor General's report that was just released about six weeks ago, but I didn't get time to read it. An overall

view of the pattern of no change certainly stimulates red flagging of possible resident neglect.

Recommendation: the MDS—minimum data set—with the RAI—resident assessment instrument—yielding appropriate care plans that can be individually implemented PDQ—pretty darn quick. This system is excellent for assessing resident care needs for delivery of appropriate services, compliance monitoring and funding decisions. Canada has been one of the 16 countries doing research on this system for well over 15 years. Ontario facilities have been involved.

My recommendation is that you get 3.5 hours to be included in Bill 140.

Part I, Fundamental principle and interpretation: 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."

Please note that dignity underscores the need for delivery of care services to adhere to standard-of-care practices by all disciplines. Nursing services have been timed and studied well over time. Adequate case mix staffing is well documented and readily available.

Recommendation: that "they may" should be "they shall," as "may" does not indicate commitment, and also that 3.5 hours be included in Bill 140.

Part II,

Residents: rights, care and services: Please note that that the Ontario Medical Association has been clear on the need to amend the intent and verbiage in specific areas, and I concur. Therefore I will not address this issue of what they have said in my presentation.

Residents' Bill of Rights:

"3(1)3 Every resident has the right not to be neglected by the licensee or staff....

"11. Every resident has the right to....

"ii. give or refuse consent to any treatment or care for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent."

Please note that this is a very grey area and incidents do surface that require significant staff time for resolution. For example, 1.5-inch-long mycotic toenails. A resident refused podiatry for months and the family complained to challenge staff to get the toenails cut.

"iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act."

Please note that this presents many challenges when working with other agencies and requires significant tech staff time for a mutually acceptable and amicable resolution. For example, a resident fell, was sent to ER and returned with no hard-copy X-ray report. He only received a telephone call stating that nothing was fractured. The next day, the resident was in pain and could not walk. Pressure had to be applied to get an X-ray report faxed to discover that the resident had a hairline-fractured pelvis. You can't do anything about it except to apply medication until it heals. This required significant staff time for amicable and acceptable resolution.

"12. Every resident has the right to receive restorative care services to promote and maximize independence to the greatest extent possible."

Please note that this is supported by Canada's 1986 charter for health promotion, Ontario's current Action Plan for Healthy Eating and Active Living, and Kingston Gets Active. Implementing this requires much time for staff education and implementation hours. Methods are well documented.

"23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance. by the licensee to pursue these interests and to develop his or her potential."

The Ontario Ministry of Health Promotion website supports this. What I'm getting at is that we need those 3.5 hours to be included in that bill.

Look at the plan of care, section 6: "The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, dietary, recreational, social, restorative, religious and spiritual care." The MDS system does this. A full-time MDS coordinator is essential. All charge nurses must know how to complete the hard copies for quarterlies, annuals and change in conditions. The MDS coordinator will log into the ministry's database to input the information after reviewing the hard copies completed by the charge nurses.

I'm going to "Dietary." You can read that.

Assisting residents to eat takes time. They should not be rushed. A meal should be a social event, and that takes all of us at least 20 minutes. You should have 20 minutes to eat, for health promotion.

The ministry truly needs to address processed-food and canned-good usage. Most are highly seasoned with salt or use salt as a preservative, while most residents have a cardiovascular diagnosis that is best cared for with a low-salt diet.

Example: A physician underscored concern and this need of a family friend, a resident. The physician spoke to the RN, licensee and dietitian about the resident's need to have a low-salt diet. That weekend, the physician arrived at mealtime, assessed the food, assisted the resident to pack and left the long-term-care facility with the resident to be cared for in a private home.

Recommendations:

(1) that the Ministry of Health Promotion include the portfolio for seniors and the seniors secretariat versus the Ministry of Tourism—I had to get that in somewhere;

(2) implement in-house cooking to control salt content;

(3) that 3.5 be included in Bill 140.

Family councils: "May have" should be "shall have."

The "if any" that is attached to "family council" throughout Bill 140 needs to be deleted. A family council should be integral to a well-functioning long-term-care facility.

Operation of Homes, Training: Oh dear, how many seconds do I have?

The Vice-Chair: You have two minutes.

Ms. Giddings Pilato: Okay. Listen, there's really a problem going now in the health care field for the personal care sector. A registered nurse now requires a university bachelor's degree. We have people with associate degrees. There's a definite difference that I can see in the intuitive knowledge care: intuitive practice. That's what you get as an expert after five years of being in a profession. You can see the difference. There's a real challenge there.

RPNs continue to go to associate diploma programs. But there are three cohorts of them. There's one group that could never give parental-method injections.

Another one got robotic treatment: Feed them like turkeys to put them out in the market. You teach them what to do but they don't have the knowledge behind it. Now you finally have—we now have; excuse me—a system where they will get some knowledge and practice.

But it's very, very difficult for the registered nurse because she or he has to look at this and assign work judiciously, knowing that those three things, those three differences, are there. It's very difficult in the unionized situation where seniority counts. Really? And knowledge, skills: The Italians have a good way of saying something about that.

PSWs are the nursing care extenders of registered nurses and work through the registered nurse's licence. Ultimately, the RN is responsible for the PSWs' performance, and this is another challenge in a unionized long-term-care setting.

1450

In conclusion, the nursing/personal care milieu is challenged by this phenomenon. There are five levels of training on occasion just for nursing staff.

Orientation: the residents' bill of rights. I recommend—and I do this with everything that I have. I worked with the Texas attorney general's office as a volunteer ombudsman. The state was divided into 24 regions, and we each took the one with the most complaints. I recommend that the LHINs, the local health integration networks, for each region in Ontario have one full-time elder abuse coordinator who would assist the local communities as well as the long-term-care staff. Meanwhile, approach Laura French of the Prince Edward county CCAC, Christine McMillan of the Frontenac-Kingston Council on Aging, and Sue Carr of the Kingston police.

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

ST. LAWRENCE LODGE

MAPLE VIEW LODGE

The Vice-Chair: We'll move to the next presentation, by St. Lawrence Lodge and Maple View Lodge. Welcome. Before you start, please state your name and the names of your colleagues. You can start any time.

Mr. Mike Kalivas: I will do that right now. Good afternoon, ladies and gentlemen. My name is Mike Kalivas. I am chair of the committee of management of St. Lawrence Lodge, located just outside the city of Brockville. I'm also a councillor for the city of Brockville. With me today is a United Counties of Leeds & Grenville councillor, Mayor Ron Holman, who is the chair of the committee of management of Maple View Lodge, located in Athens, Ontario. Joining Mayor Holman and I are Tom Harrington, administrator of St. Lawrence Lodge, and Denise Owsianicki, administrator of Maple View Lodge. Together, our homes provide care and services for 284 residents.

First, let me state that we believe that the quality of life and well-being of our residents is our number one priority, and we believe that the same can be said for the province and the government of Ontario.

Our homes are proud of the care and services that we provide for our residents. Furthermore, our municipal partners believe in providing for the vulnerable in our society, particularly frail persons requiring long-term care. Our municipal partners have a long history of going the extra mile for our residents.

This tremendous commitment is evidenced by ongoing substantial financial contributions and annual top-up to provincial operating funding levels through municipal contributions to the operating budget and, most recently, the major redevelopment and rebuilding of these two homes at significant capital cost to our municipal partners. Consequently, we believe that our leadership and commitment to providing residents with quality care services is consistent with the spirit expressed in Bill 140, in that "a long-term-care home is the home of its residents ... it is a place where they may live with dignity and in security, safety and comfort."

However, we are quite concerned about several aspects of the proposed legislation. We believe that, without significant amendment, Bill 140 imposes a formula for disappointment rather than success for our long-term-care homes. Furthermore, we are very concerned that if Bill 140 is proclaimed in its present form, without a substantial new financial commitment by the province, our municipal partners' ability to sustain their legacy of caring will be severely jeopardized.

We further contend that the government of this province needs to clearly reflect on the feedback received through this consultation process about the serious negative implications of Bill 140, in its present form, on homes in Ontario. It is incumbent on the government to ensure that our comments and concerns and those of others be given serious consideration before this bill is passed. Significant changes to the proposed legislation are needed if it is to have the intended positive effect on the daily lives and well-being of our residents.

The first point I wish to comment on is the immediate and direct impact on resident care as a result of Bill 140,

since this bill places great emphasis on the enforcement of standards.

As you are no doubt aware, long-term-care homes are already seriously challenged financially by current funding levels. Our homes are challenged daily to deploy scarce human and financial resources to meet the ever-increasing care needs and expectations of the people we serve. Staff, in particular, find it more demanding and difficult to meet significant daily workloads. They report that work duties are rushed and there is not enough time to do the little things that are so meaningful for our residents. The need for substantially more new operating dollars is well-documented and I don't believe that we need to expand on the increasing acuity and demands related to direct resident care experienced by long-term-care homes across Ontario.

To meet this very evident need in our homes, our municipal partners invest an additional $1.7 million over and above Ministry of Health and Long-Term Care operating dollars. We believe that this necessary investment provides stable levels of direct-care staffing for our residents.

The concern we have here is that Bill 140 proposes a significant increase in accountability and compliance with standards. Specifically, we are concerned about the level of detail that will have to be produced to prove beyond a reasonable doubt that our homes are in compliance with all aspects of the legislation and regulations. This undoubtedly will require extensive time for staff surveillance, monitoring and supervision, and subsequent documentation, reporting and follow-up.

The new expectations, as outlined in Bill 140, will surely deflect more staff time and energy away from the bedside. Resident care will diminish, unless there is a dedicated investment of new funding in direct support of Bill 140. We believe this required investment has to be clearly distinct from the investment required to close the current funding deficit gap between resident care requirements and operating funding provided by the province.

It should be noted that our resident councils and family councils wholeheartedly support this principle. Furthermore, these councils believe that closing the gap between the level of care required and the level of care funded should be a major government funding priority in the upcoming budget.

Extensive requirements to monitor and prevent resident abuse is another potential area of concern related to the new act. Our homes take their duty to ensure zero tolerance very seriously. However, section 17 of the bill imposes a duty on homes to "protect residents from abuse by anyone." This mandatory obligation has inherent and significant obligations for our homes. For example, imposing this obligation requires the home to somehow manage and monitor not only all interactions between residents and staff, but also other residents, their family members, friends, personal caregivers and other external service providers—a big task indeed, with over 284 residents under our care.

Use of restraints will also pose new challenges under Bill 140. Our homes promote a least-restraint philosophy; however, St. Lawrence Lodge is particularly concerned about the inclusion of a secure unit as a restraint.

Our concerns stem from the following situations. First, from our review of the bill, there are no defined timelines identified to guide the provision of rights advice for individuals admitted or transferred to a secure unit. Therefore, we see real implications and challenges for our local health care system. For example, an admission to the secure unit coming from the local hospital could be delayed due to an extended rights advice consultation process. Second, it is also uncertain what the current capacity in our region is for skilled people with the necessary qualifications to provide rights advice. Finally, extended delays in the secure unit admission and transfer process could conceivably cause St. Lawrence Lodge to be financially disadvantaged by loss of resident days and, subsequently, ministry revenues.

This new legislation will impede or deny residents the special care they need in a secure unit and will again have a profound impact, not only on the home itself but also the home's health care system partners.

The next theme I want to speak to is governance. Bill 140 imposes a heightened level of liability for municipal councillors, appointed by their municipalities to our committee of management, through its harsh approach to duty of care. The bill states that every person on the committee of management who fails to take all reasonable care to ensure that the operation of our home complies with all requirements under this act is guilty of an offence. The penalties under Bill 140 far exceed similar accountability sanctions against members of hospital boards and this approach seems unreasonably excessive and harsh for work of a similar nature to hospital governance. If Bill 140 proceeds, our municipalities may find it difficult to get councillors who are willing and prepared to assume personal liability and risk by accepting an appointment to our committee of management.

1500

As I stated earlier, the level of care provided to residents living in long-term-care homes across Ontario is not keeping pace with the level of acuity. Our municipal partners are exhausting their ability to augment current provincial government operating funding. Bill 140 will no doubt place a tremendous administrative burden on our homes, and this burden should not be borne by our long-term-care residents and our municipal taxpayers. The funding provision in section 88 must commit the government to properly fund long-term-care homes for the work that they do day in and day out. The current language states that the government "may" provide funding. Our residents, their families, and our municipal partners are unanimous and adamant that this wording should be changed to "shall." The provincial government can no longer rely on municipalities to fund the provincial government's shortfalls.

As part of our submission, I would like at this time to also express our homes' support and endorsement of the presentations to the standing committee on social policy submitted by the Association of Municipalities of Ontario

and the Ontario Association of Non-Profit Homes and Services for Seniors.

In conclusion, St. Lawrence Lodge and Maple View Lodge are proud of their tradition and heritage of caring for frail and vulnerable persons requiring long-term care. Our municipal partners strongly support that caring tradition.

Our homes want to continue to work with our partners to deliver the best care possible to those persons entrusted into our care. However, as it stands, this new legislation will impose substantial hardship on our homes. We fear we will fail our residents because our homes will not receive the provincial operating funding necessary to meet these new requirements. Our municipal partners have answered the call to help meet the need. Now it's the province's turn to truly be a leader in long-term care. Our residents who built this province deserve the best.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left. We're going to divide them equally between the three parties. We'll start with the parliamentary assistant, one minute.

Ms. Smith: Thank you for your presentation. Just around the secure unit and some of the issues that you had about the secure unit as a restraint, the Health Care Consent Act does apply and we also provide for the placement coordinator to seek rights advice for the potential resident prior to admission. As well, the section that requires rights advice says that it will be sought promptly. So I think some of your concerns around delay for rights advice and the admission into a secure unit will be for naught given that we can seek it. You probably have a waiting list; most homes do. So if someone is on a waiting list and in need of a secure unit, you will have the ability to get that rights advice while they're waiting. As well, if there is a situation where someone is in a crisis situation and needs immediate admission, the Health Care Consent Act would apply. That person could be admitted and then we would seek rights advice as a follow-up to their admission in order to deal with the crisis situation. So just to deal with that particular concern, I think it has been addressed in the legislation.

The Vice-Chair: Mr. Runciman?

Mr. Runciman: I want to thank you for being here, knowing both facilities and the outstanding facilities they are and the staff and the volunteers who play a role, including the municipal councillors.

I'm curious, Mike, about the secure unit. Have you done any analysis? I know we had a presenter earlier who talked about this section of the act and did, I think, a marvellous job of dissecting the bureaucratic madness of it in terms of the paperwork required. Have you done any analysis of what it might mean to your institutions in terms of cost and time associated with meeting these requirements?

Mr. Kalivas: I'll let Tom Harrington address that.

Mr. Tom Harrington: In terms of the actual timing, just to give you a sense of the scope, we have approximately 35 to 40 transactions, if you will, in terms of transfers into the special care unit, as well as transfers in and out within the facility itself over the course of the year. We're very fortunate that we have assistance from the Royal Ottawa Hospital site, which is actually adjacent to our facility, and we have access to those resources.

The time and energy spent on that certainly takes a lot of staff time. It involves the family congruence with those decisions, and the involvement of the substitute decision-maker in certain instances as well. I can't give you a full scope on it, but it certainly is a time-intensive activity.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you for your participation today. Over and above that, thank you for the municipal share that goes into the operation of these two homes, which is quite significant to provide what is probably a minimal level of care. I mean, you want to provide more, but if that contribution wasn't there, imagine what it would really be.

Mr. Kalivas: What would happen.

Ms. Martel: Exactly. Let me ask a question about liability. What do you want to see the government do with respect to the sanctions that it proposes to apply to the committee of management if that committee fails to take reasonable steps to ensure that the home complies with all the requirements?

Mr. Kalivas: I don't understand why we need to move to a new level. I'd put the question back to the government in saying, "What's wrong with what we're doing now?" Do we need to make a change? I don't necessarily see that. Obviously, for the reasons stated, if we're going to have a move to a new, heightened level, it's going to create complications—I see that—and it will be councillors who will refuse the opportunity to serve on that board. We can't control every person, every act that's happening in the home—and if that does happen, they're going to be charged for it? It doesn't make any sense to me.

As far as I'm concerned and as far as governance is concerned, I think those things are working well now. I don't know why we necessarily need to heighten that to a new level. That doesn't make any sense to me. If we're threatening the role of the committees of management across the province, where are we going with that? We need to reword that to ensure that we have the confidence so that we're willing to serve on these boards. I'm proud to serve on that board, and I don't want to walk away from that because someone else is telling me there's a liability factor. Come on; that doesn't make any sense.

The Vice-Chair: Thank you very much.

HELEN HENDERSON CARE CENTRE

The Vice-Chair: The next presentation will be by the Helen Henderson Care Centre.

Welcome to the standing committee on social policy. Can you please state your name and your friends' names?

Ms. Susan Scriver: I will. Good afternoon. I'm Susan Scriver, chairperson for the family council at Helen

Henderson Care Centre. With me are Larry Gibson, Angela Gibson and Lisa Gibson, administration there.

On behalf of my mother and others who reside at Helen Henderson, I thank you for this opportunity this afternoon. I wanted to meet with you today to try and put a face on the people you make decisions for. In doing so, I hope you will compassionately consider Bill 140 and those who will be impacted by your vote.

At this time in my life, I have one of the greatest responsibilities, next to motherhood, one could have: I am, not through choice, the mother to my mother. I do not like this role, but I do take it seriously, and in doing so, I do not feel that my mother or others are being treated fairly by this act. And although not politically knowledgeable in many areas, I do know first-hand about long-term care and its effects on people and the families who are under its umbrella.

My family's story started just over five years ago in a different city and a different home. Both my parents suddenly ended up in long-term care. But I won't go into every detail of this maze of events. Instead, I will briefly detail bits of our journey.

With the help of caring professionals, we were fortunate to get both our parents in the same facility, or so we thought. And like other families in this situation, we faced the confusion of our lives changing and our roles reversing.

Our first long-term-care experience was not a positive one. This long-term-care experience introduced us to administrative neglect, resident-caused abuse, and a system, lawyers and people who had no idea what impact they made on the lives of others. It was our family's nightmare.

My father has since passed away, and for the past two years my mother has resided here in Kingston. She is in a loving, caring environment at Helen Henderson Care Centre, and our family has finally found peace and trust within the long-term-care system because of the staff who work there. But now, with Bill 140, you have threatened my mother's and my family's peace of mind. You do so in the callous way you present the uncertainty of whether this home will continue to be in our community because Bill 140 places a 10-year deadline on this home's operating licence, yet nowhere does this bill answer the question of what happens after that. The way I read it, the government would be able to do whatever it decides, everything from maintaining the status quo to closing the home and moving the beds elsewhere.

This alone causes great worry for the staff who live and work in this community, as well as all families involved. What bank would provide our administrator, Larry Gibson, money for structural updates—or any money, for that matter—when, with this bill, you could shut him down within a 10-year period? Therefore, I ask you to please amend the licensing scheme that will be imposed on existing B- and C-classified homes.

1510

What I don't understand is that this bill is helping provide for residents who live in new homes and rebuilt D homes. The government provides a 20-year contribution of $75,000 per bed toward the construction of these homes. My mother and others pay the same as these residents, yet you don't feel they deserve the government's commitment to provide funding for their home? I ask you to please amend this bill to commit to a plan of action to invest in the upgrading of older B- and C-classified long-term-care homes.

Overall, Bill 140 is a resident-focused act, and I am relieved to see the provisions on the prevention of abuse. However, part I, section 1 of this act is entitled "the fundamental principle," and it states that "a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort." This fundamental principle inadvertently seeps out to us, the caregivers, as well. When first reading this, it gives us a little peace of mind, knowing this is a principle our loved ones in care deserve. We are pleased to know our government agrees and even guarantees it by making it law. Yet after reading the whole bill, I am forced to ask: Where is the dignity, security and comfort when one must worry about the possibility of being evicted because of this new licensing scheme?

Where, may I ask, is the dignity for our residents who smoke? This government should be embarrassed at the humiliation it caused our veterans who fought for a free country. They have been kicked to the curb to do something some of them have done for over 70 years. I question this government's decision to randomly rule that all smoking rooms need to be updated. What about families and administration making educated decisions on behalf of their residents? Why does this government feel the need to dictate?

But even more importantly, this bill does not address staffing hours of nursing and personal care for residents in everyday life. Bill 140 needs to be responsible by planning a factual funding system, or at least one that would recognize a minimum standard of care, like other provinces in Canada, of 3.5 hours of care per day per resident.

In order for this bill to be effective and responsible to its residents, it is imperative that adequate staff are in place to fulfill its well-intended purpose. As well, adequate staff are needed to cover the many additional hours this act creates in paperwork. Adequate staffing is needed for this act alone and to meet the increasingly complex care of its residents.

My mother requires a great deal of time with her care. She is wheelchair-bound and needs to be manually lifted by a hoist a minimum of three times a day. These procedures can take up to half an hour for each move, and because of past abuse by another resident in a different long-term-care home in a different city, she is terrified and co-operation isn't easy. A great deal of time and patience are needed when dealing with my mom due to her first introduction to long-term care, one where she was not protected from this severe abuse, causing her to live in fear for the rest of her life. In a very short time

after her admission, gone was the trusting woman we brought into care, gone was the woman who never raised her voice, gone was the woman who never had to fear someone approaching her—and not because of her illness, but because of neglect, abuse and understaffing. Yet fortunately today, the compassionate staff who provide her care somehow make the time to help her deal with this fear. They somehow find the time to reassure her.

The time these dedicated, special people need to spend with my mother is far more than 2.5 hours a day. I can't imagine the stress on the staff who lovingly care for so many residents with their own unique personalities and health problems. I worry this stress will in time wear them down and burn them out, and then my mom, along with others, will not continue to get the compassionate care they do now.

Funding is definitely needed for increased staff. When I feed my mom, it takes at least 45 minutes for one meal. I ask you to take note of your own elderly loved ones the next time you share a meal. How long does it take them to eat? Remember, they're healthy. Then think about the staff in long-term-care facilities who are expected to feed all the residents in their care three meals a day, plus tend to their other personal needs, on 2.5 hours of care a day.

Two baths a week is good for some residents, but in reality, an increase in staff is needed to provide them. For my mother, I had to make the choice of one bath because of the trauma this causes her. So now, when that second bath day comes along, she and others have time taken away from them in order that staff is available to provide the second bath.

Activities at Helen Henderson Care Centre are varied and many. It is an amazing program, with fantastic leadership and staff. This department goes way above and beyond the call of duty. However, to ensure people can enjoy these activities, staff from every department are helping transport residents to each activity, taking time away from their own duties to do so. Just the same, there are still many residents who for various reasons cannot attend and who remain in their rooms or in hallways. Loneliness is evident in long-term care. Perhaps if the issue of adequate staff was addressed by Bill 140, then loneliness could be addressed too. I ask you to please amend Bill 140 to address adequate staffing hours of nursing and personal care to include a minimum standard of care of at least 3.5 hours a day per resident.

Time is of the essence, they say, and time is all most residents have. They have lost the ability to fill time. Therefore, it becomes our responsibility to ensure that the essence of their time is filled with dignity, and dignity comes when someone can take the time to acknowledge and understand the other, time to make one feel not only a valued member of society, but a valued member of life. Dignity is not just caring for the body; it involves caring for the human spirit. I wonder if sometimes, getting caught up in the routine and all the hard work that goes into a people project, we can lose sight of the frailty of this spirit. Well-intended as we are, maybe we could do just a little better if we had a more hands-on approach or if we were able to put a face to those we will affect.

Bill 140 overall addresses many issues we as families want put into law. I want you to remember that this act affects real, everyday people like my mom, each with their own differences. They cannot all fit into the same category; therefore, compassion is needed as one of its main ingredients.

In closing, I ask that when considering Bill 140 you remember how your decisions will impact the lives of others. Thank you.

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

Ms. Scriver: That's fine; thank you.

VINCENT DAGENAIS GIBSON LLP/SRL

The Vice-Chair: We'll move to our next presentation, which would be by Vincent Dagenais Gibson LLP/srl.

Mr. Russell Gibson: Good afternoon and thank you, Mr. Chairman. My name is Russ Gibson, but I'm no relation to the other Gibsons who were the previous presenters. I'm here with my colleague Jennifer Leddy, and we are from Vincent Dagenais Gibson in Ottawa, which is a law firm which has for over 100 years represented institutions, corporations and many diverse charitable and not-for-profit corporations and associations, including nursing homes and hospitals. We are not representing a particular client today. The perspective we bring comes from our work with various not-for-profit and charitable corporations in the health care sector, particularly religious organizations.

Bill 140 combines the provisions of three previous pieces of legislation and contains over 200 detailed sections. In our brief presentation we will address four topics: the residents' bill of rights, the mission statement, the duties of directors and officers, and the regulations. We have three amendments to propose respectfully to you.

We support the spirit of the bill to create long-term-care homes that are resident-centred and accountable, where people are respected and may live with dignity and in security and comfort. While the bill of rights is an eloquent expression of the rights of the individual, rights exist in community, and dignity is realized in relationship with others. The common good of the group must therefore be taken into account and the religious nature of homes owned or sponsored by a faith group respected and protected. Many people are drawn to faith-based homes precisely because of their religious character, and it is in this setting that they feel most at home. Long-term-care homes operated by religious organizations also have a history and tradition of excellent compassionate care, good stewardship, and respect for human life and dignity.

1520

Given that subsection 3(3) of the bill allows the resident to enforce the bill of rights against the licensee, and that subsection 3(4) allows for regulations setting out how the bill of rights shall be respected and promoted by the licensee, it is suggested that a new subsection be

added to protect the religious freedom of faith-based homes.

Our proposed amendment is that a subsection should be added to section 3 on the Residents' Bill of Rights. Some possible wording for your consideration is as follows. You will see that it is similar to the provisions in sections 26 and 28 of the Local Health System Integration Act.

"Nothing in the Residents' Bill of Rights shall unjustifiably, within the meaning of section 1 of the Canadian Charter of Rights and Freedoms, require a licensee that is a religious organization or sponsored by a religious organization to provide a service that is contrary to the religious teachings of the organization."

We have a related concern with respect to the provisions in section 4 which require mission statements to be consistent with the Residents' Bill of Rights. Religious communities and faith-based organizations are very familiar with mission statements and have usually spent years developing them. For religious congregations, they are often closely connected with the spirit of their founder and the teachings of their faith.

Given that the mission is integral to the integrity and identity of religious organizations, we propose for your consideration an amendment that might read as follows. The wording, again, is similar to the provisions in sections 26 and 28 of the Local Health System Integration Act.

"Nothing in this section shall unjustifiably, within the meaning of section 1 of the Canadian Charter of Rights and Freedoms, require a licensee that is a religious organization or sponsored by a religious organization to include any provision in the mission statement that is contrary to the religious teachings of the organization."

Thirdly, regarding the duties of directors and officers of a corporation in section 67, our comments are as follows. According to section 67 of the bill, every director and officer of a corporation that is a licensee must take all reasonable care to ensure that the corporation complies with all requirements under the act. Every person who fails to comply with this section is guilty of an offence. The penalties for failure to take reasonable care are set out under section 177. For a first offence, the penalty is a fine of up to $25,000 or imprisonment for a term of up to 12 months or both. For a subsequent offence, the penalty is a fine of not more than $50,000 or imprisonment for a term of not more than 12 months or both. Compensation or restitution may also be ordered paid to any person who has suffered a loss as a result of the offence.

By contrast, regulation 965 of the Public Hospitals Act requires the board of directors to monitor activities in the hospital for compliance with the act, the regulations and bylaws of the hospital and take such measures as the board considers necessary to ensure compliance with the provisions of the act, the regulations and the bylaws of the hospital.

The penalty for contravening any provision of the act or regulations is a fine of not less than $50 and not more than $1,000. Clearly, the penalty provisions of the Public Hospitals Act are generally less onerous than those proposed in Bill 140 and do not include any jail time.

The duties under both the Public Hospitals Act and Bill 140 appear to be the same: to ensure compliance with the act. The focus, however, is on the collective board in the Public Hospitals Act and on the individual officer and director in Bill 140. Is this simply because most hospitals are incorporated or is it a deliberate move to impress on directors the seriousness of their responsibilities?

The question is whether the standard of care for fulfilling directors' duties is the same in the two pieces of legislation. Under the Public Hospitals Act the board has to monitor compliance and then take such measures that it considers necessary to ensure compliance. That suggests a subjective and less onerous standard. By contrast, Bill 140 requires the directors to take reasonable care, which suggests a more onerous, objective standard.

The statutory duty of care of directors of business corporations is an objective one, namely, to exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. This means that all directors, irrespective of their background or education, must meet the same standard.

Directors of not-for-profit organizations must meet the common law standard of care, which is more subjective in that the degree of skill required of a director is what may be reasonably expected from a person of similar knowledge and skill. Directors are required, according to the common law case of Re: City Equitable Fire Insurance Co. Ltd., to "exercise such degree of skill and diligence as would amount to the reasonable care that an ordinary person might be expected to take in the circumstances on his or her own behalf, but he or she need not exhibit in the performance of his or her duties a greater degree of skill than may be expected from a person of his or her knowledge and experience." For example, an accountant would be held to a higher standard of care on financial matters than a teacher.

Some commentators are of the opinion that the distinction between objective and subjective standards is becoming blurred, given the courts' increasing reliance on business cases, the law reform movement in this area and the difficulty of attributing board decisions according to a variety of skill sets. However, it is confusing to have two apparently different standards of care within the not-for-profit health care sector, especially when some hospitals own and operate a long-term-care home and use the same board to govern the hospital and the home.

While recognizing the vulnerability of residents in long-term-care homes and applauding the intention of the bill to create and enforce safe environments, the proposed duties for directors with the possibility of jail for non-compliance will increase the difficulty of attracting volunteers to the boards of not-for-profit organizations. Directors' liability insurance may also be more costly, more difficult, or impossible to obtain.

We also agree with other presenters to this committee that noncompliance with standards and the incidents of

abuse and neglect are less likely to occur where there are enough staff to do the job and funding to improve the surroundings.

It is suggested that the proposed duties for directors and officers and penalties for noncompliance be amended to bring them more in line with what is required of directors and officers of public hospitals.

Regarding regulations to be made pursuant to the proposed act: Even though Bill 140 is a very lengthy piece of legislation, a great number of items are left to the regulations. It would be important to include a process of consultation with stakeholders. We understand that public consultation on regulations has been built into other health care legislation, a recent example being the Local Health System Integration Act.

In conclusion, I thank all members of the committee for the efforts you are making to improve long-term care in the province. We hope that you will find our suggestions for amendments constructive and that you will take them into account in your deliberations. Thank you once again for the opportunity to make a presentation today.

The Vice-Chair: Thank you very much. We have a few minutes left. We'll divide them equally among the three parties. We'll start with Ms. Witmer.

Mrs. Witmer: Thank you very much for your recommendations. I would agree: There are some reasons to make some changes to the bill. I appreciate what you've put in here regarding the mission statement and the need to take into consideration that there isn't going to be anything here that would impact the religious organization. I hope the government does make those amendments. I think they're pretty simple and would certainly address the needs of your clients. Also, of course, directors and officers—again, I agree that there needs to be something that would be similar to the Public Hospitals Act. So I would hope that the government would respond to that amendment as well. Thank you very much.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation today. I appreciate that you said at the outset that you were not here to represent a particular client, but you do have a lot of expertise so it's good that we can draw on that.

If you think specifically about the new requirements—by that, I mean penalties—for persons guilty of an offence—directors, officers, other staff, etc.—in your experience, given you have a number of clients who work in the not-for-profit sector, what do you think the reaction is going to be from these folks if we can't get a change in this particular section?

1530

Mr. Gibson: Certainly the provisions do suggest that a deterrence effect may be part of the intended results. It would seem to me that it's going to create more difficulties for boards in attracting directors. It's the sort of provision which, on the face of it, is going to make it very difficult, I think, particularly for smaller communities with smaller boards of directors, to attract people to serve on their volunteer boards.

Ms. Smith: I have two really quick questions. My first is, what is it that compels you to want to see the amendments to the bill of rights and the mission statement provisions? I don't see any kind of threat to religious organizations, so I'm a little unclear as to why you feel those two amendments are necessary.

My other is—and I'm glad that you raised this whole discussion around the threshold because, in my view, and I've had this debate—I was a lawyer; I guess you're always a lawyer—with some of our drafting team on "take such measures the board considers necessary to ensure compliance." I thought it was a higher threshold than "take reasonable care to ensure compliance." So I'm interested that you think it's the inverse. Setting aside the penalty provisions, just on that threshold, is that your position, that "take reasonable care" is actually a higher threshold than "take such measures as the board considers necessary to ensure"?

Mr. Gibson: If I may respond, I guess the question is: What is the standard, then? It would seem to me that if we look at it as being an objective standard, then to me the standard would be higher under the new legislation. I think there's some support for that in the business cases.

With respect to your first question, the mission statement for some institutions will recite the values, will recite the core beliefs, maybe refer to a founder. A mission statement for organizations like this has a lot of historical and value-laden meaning. It would seem to me that creating the possibility for mission statements to be influenced by legislation would potentially create a danger in cases where there may be third parties or those who would want to see the mission statement of their religious order be different than what it is stated to be. In those cases, I would perceive there to be a risk.

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

BEV BAINES

The Vice-Chair: We'll move now to the last presentation, by Bev Baines.

Welcome. You can start any time you want.

Ms. Bev Baines: Good afternoon. My name is Bev Baines. I notice that you were greeted by the Raging Grannies this morning. I hope you think of yourselves as being bid goodbye by the engaging lawyers this afternoon. We'll see whether that's your conclusion.

I am a professor of law, women's studies and policy studies at Queen's University. My expertise is in the area of constitutional law and women's equality rights. My research focuses on the Canadian Supreme Court's equality jurisprudence under sections 15 and 28 of the charter.

In my submission, I pose three questions about Bill 140: Why should this bill protect women? Is it accountable to women? How could it be changed to serve the needs of women? I will conclude by explaining that Bill

140, as currently drafted, may infringe women's charter rights.

Why should Bill 140 protect women? Studies show, and you were told this on Thursday by the Ontario Interdisciplinary Council for Aging and Health, that over 75% of long-term-care home beds are occupied by women. Some are frail, wheelchair-bound or confined to bed. Increasingly, they have moderately severe dementing illnesses. A study published in the Canadian Medical Association Journal in 1994 showed that, of seniors aged 85 or more who suffered from dementia, 70% were women.

Dementia and other illnesses such as Parkinson's and MS lead to falls and fractures which, in turn, call for complex care for residents of long-term-care homes. Complex care, whether for women or men, takes time and costs money, yet it is underfunded at this point.

Does anyone seriously doubt that if 75% of long-term-care residents were men, more resources would not be forthcoming? Elderly men, whether formerly in business, the professions or politics, would make it happen.

Unfortunately, elderly women come from a generation that taught them dependency and subordination. They are unlikely to be lobbyists, let alone to be perceived as political calendar girls. But their daughters, granddaughters, and great-granddaughters are different. They will notice how this new law portrays women. They will ask, is Bill 140 silent about their foremothers because politicians want to conceal the fact that women constitute three quarters of the residents of long-term-care homes and to pretend that this fact does not matter?

Is Bill 140 accountable to women? Regrettably, Bill 140 makes little effort to be accountable to anyone. Rather, Bill 140 is licensing legislation, but is it the licensing legislation that women need?

What we do not need is a regulatory regime that uses the exemption process to facilitate the conversion of non-profit homes into for-profit homes. Put simply, for-profit homes make their profits at the expense of their residents and workers.

To explain, both non-profits and for-profits receive the same funding, whether from the government or from residents' fees. For-profits must make their profits from these sources, while non-profits can use these sources to provide better resident care and worker compensation.

In Kingston, the evidence that non-profits offer better care can be found in the long-term-care crisis placement policy adopted by Kingston General Hospital. This policy forces patients requiring immediate placement to select three homes from the hospital's A, B, and C lists. Only one selection may be from the A list, apparently much preferred and oversubscribed. The A list contains only non-profit homes. To move patients out of the hospital as quickly as possible, the policy also compels them to select at least two more homes from the B and C lists, which are composed only of for-profit homes, in which vacancies are more frequent.

By making it possible to convert non-profit homes into profit-making homes, Bill 140 will have a negative impact on the remuneration and working conditions of the affected employees, the vast majority of whom are women. Women comprise 90% of the hands-on caregivers and support staff employed in long-term-care homes.

How could Bill 140 be changed to serve the needs of women? I submit that the government should make three major changes to Bill 140.

First, the act must contain a province-wide standard of care of a minimum of 3.5 to four hours per day of nursing and personal care for each resident. You've heard this recommendation today and throughout the hearings last Wednesday and Thursday. This change would begin to provide the resident-centred care promised in the bill's preamble, whereas the current discretionary two to 2.5 standard is not even sufficient to protect women and men from risk, never mind to dignify residents' daily experiences.

Second, the government must commit to funding the staff required to meet this higher minimum standard of care. This commitment must ensure that that increased funds go mainly into the personal-care envelope destined to pay employees who provide hands-on care and support for residents. These front-line workers are underpaid and poorly treated in terms of their employment conditions.

1540

Third, subsection 103(9) of the bill must be amended to prohibit, without exception, the transfer of a licence or beds from a non-profit to a for-profit entity. Ideally, calls for adding more beds and building more homes should be funded in such a way as to encourage more non-profit bids. In addition, there should be incentives to encourage municipalities, where homes and beds are sorely needed, to enter the bidding process. I note that the city of Kingston just refused to tender in the latest round of bids. "Why?" you might ask, and you might think of funding as being the issue.

In conclusion, does Bill 140 infringe women's charter rights? By failing to provide the standard of care, funding and non-profit accommodation that women need, Bill 140 is inadequate licensing legislation. It promises more harm than benefit to the women—and men—whose interests should be foremost in the revision of long-term-care-home policy.

The Charter of Rights and Freedoms would have us ask of this harm, does it have a disproportionate impact on women? The government's intention or motive is irrelevant. Charter jurisprudence uses a disproportionate-effects test to establish an infringement of the guarantee of sex equality in section 15. Since 75% of the residents and 90% of the employees are women, any harm inflicted by Bill 140's deficiencies would inevitably impact more harshly on women, which is sufficient to evoke the possibility of a charter sex equality challenge. Concerned women might turn to organizations such as the Women's Legal Education and Action Fund, known as LEAF, the National Association of Women and the Law, NAWL, and the Advocacy Centre for the Elderly, ACE, for advice about launching a charter challenge.

I do not advocate spending time and money on a charter challenge. I submit that the standing committee

should take action to forestall a charter challenge by recognizing the significance that long-term-care-home legislation has for women and by ensuring that Bill 140 is changed to reflect women's needs.

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

Ms. Martel: Thank you very much for that presentation, which was much different from others we've heard but very good.

I just want to focus on the funding, because your point number two said that any funding or increased funding should go mainly into the personal care envelope destined to pay employees who provide the hands-on care and the support for residents. This has been a critical part of the discussion during the course of the hearings because the government has argued that they have put $700 million into long-term care. The association of not-for-profit supports for seniors has said very clearly that only about $2,000 of that has really gone into an envelope to increase direct hands-on care for residents, and that about $4,000 is missing if you consider the government promise of $6,000. So a lot of the money didn't go directly into care but went to a number of other things.

If you look at that commitment to funding the staff, I would take it that it's a commitment not just to help the staff but to ensure that it's actually funding hands-on care that the direction of the flowed money takes.

Ms. Baines: Absolutely, it's a direction to use it for hands-on care, and support staff as well in that particular context. But it is not money for the demon of documentation that we've rightly heard about thus far, and it's money in the context in which we also heard earlier that there are four envelopes, only one of which is discretionary funding. I'm not moving to that discretionary funding envelope. It's the pay, personal support, hands-on care.

The Vice-Chair: Thank you. Parliamentary assistant?

Ms. Smith: We have the same investment in that personal care envelope, and that's where we've seen our 4,800 new staff.

I wanted to ask you about your views on the possible conversion of non-profit homes into for-profit homes. We've heard from the non-profit sector that they don't like this section that restricts the ability to transfer the beds; they want to have that ability. You're saying that we should restrict it and not allow for any exceptions whatsoever. I would like to hear your comments on your differing views from the sector. As well, what would you do to address the situation in northern Ontario, where we have a not-for-profit that no longer wants to be in the business of providing long-term care and there are no other not-for-profits willing to step up to the plate? What would your suggestion be in that particular case, where we have beaten the bushes and can't find anyone? How do we provide the services that are necessary?

Ms. Baines: I think beating the bushes is a good idea, but putting more money into the entities that are trying to make this work is the best idea of all, and it's one of the reasons why I said incentives to municipalities. So, for example, in northern Ontario—and I'm not terribly familiar with their governance structure—putting more money into the local governance structure that might be able to take over those homes is the way, it seems to me, that it has to go. If you put it into the for-profit, you're going to lose money to the profit-making aspect of the enterprise. It still won't be helpful to the residents and workers.

The Vice-Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for a very interesting presentation and some interesting points that you make here. What prompted you to put this together, I guess, to ask the question, "Does the bill protect women?"

Ms. Baines: Several things did. One is my mother, who is currently in a non-profit home in Kingston. But it's mainly because I'm also, in another guise, head of women's studies at Queen's, and so I have focused all my life on issues featuring women and I've always, from the beginning, asked the question, "Where are the women?"

Mrs. Witmer: Well, thank you very much, and I think it is important that we continue to ensure in our province that whether you're a male or a female, you do have that equal opportunity and are fairly protected.

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

I want to thank all the presenters today, and all the audience and the staff and members, for their civil participation. We will be adjourning until tomorrow, 9 o'clock, in Sudbury.

The committee adjourned at 1548.

Continued from overleaf

Ontario Health Coalition, Kingston branch SP-1596
Ms. Fern Giddings Pilato
St. Lawrence Lodge, Maple View Lodge SP-1598
Mr. Mike Kalivas
Mr. Tom Harrington
Helen Henderson Care Centre SP-1600
Ms. Susan Scriver
Vincent Dagenais Gibson LLP/srl SP-1602
Mr. Russell Gibson
Ms. Bev Baines SP-1604

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CONTENTS

Monday 22 January 2007

Long-Term Care Homes Act, 2007, Bill 140, *Mr. Smitherman* / **Loi de 2007 sur les foyers de soins de longue durée,** projet de loi 140, *M. Smitherman* SP-1557

Fairmount Home SP-1557
Mrs. Julie Shillington
Mrs. Mary Lake

OMNI Health Care SP-1559
Mr. Fraser Wilson

Maxville Manor SP-1562
Mr. Craig Munro

Rosebridge Manor SP-1564
Mrs. Nelly Hobbs
Mr. David Kent

Providence Continuing Care Centre SP-1566
Mr. Larry Norman
Ms. Shelagh Nowlan

Sherwood Park Manor SP-1568
Mr. Jack Butt
Mrs. Joan Bennett

Ms. Jean Bertrand SP-1571

St. Patrick's Home of Ottawa Inc. SP-1572
Ms. Linda Chaplin

Hilltop Manor SP-1574
Ms. Dianne Mason
Mr. Bernard Bouchard

Ms. Wendy Hawthorne; Ms. Etie James SP-1577

Ottawa Health Coalition SP-1579
Ms. Marlene Rivier

Safe Senior Systems SP-1581
Ms. Janet Parry

Royal Canadian Legion, Ontario command SP-1583
Mr. Jim Margerum
Mr. Erl Kish

Canadian Union of Public Employees, Local 1521 .... SP-1585
Mr. Steve Sanderson

Council on Aging of Ottawa SP-1588
Mr. Al Loney

Frontenac-Kingston Council on Aging SP-1590
Ms. Christine McMillan
Mr. Brian Brophy
Mr. John Osborne

Almonte Country Haven SP-1592
Mr. Rick Gourlie

Providence Manor Family Council SP-1594
Ms. Carol Robertson

Continued overleaf