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Mardi 23 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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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 23 January 2007

Mardi 23 janvier 2007

The committee met at 0900 in the Howard Johnson Plaza Hotel, Sudbury.

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

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

The Vice-Chair (Mr. Khalil Ramal): Good morning, ladies and gentlemen. It's 9 o'clock on Tuesday morning in Sudbury, and it's the fourth day of hearings for the standing committee on social policy to deal with Bill 140, An Act respecting long-term care homes.

EXTENDICARE FALCONBRIDGE FAMILY COUNCIL

The Vice-Chair: For this morning's session, we have 12 presentations. The first one will be by the Extendicare Falconbridge Family Council. If they are here, they can come forward. I believe you know the procedure. You have 15 minutes. You can speak for the whole 15 minutes or you can divide it between speaking time and questions from the three parties. You can start whenever you are ready.

Mrs. Adrienne Lemieux: Good morning. My name is Adrienne Lemieux. I am the chair of the family council of Extendicare Falconbridge in Sudbury. I have been a member of the family council since its inception in November 2003. My mother, who suffers from Alzheimer disease, has been a resident at Extendicare Falconbridge going on five years now. My father was also in long-term care until his passing in October 2002.

Extendicare Falconbridge is a 35-year-old C-class facility, whose management team and support staff are entrusted to care for 234 residents 24 hours a day, each and every day.

Although Bill 140 contains positive language with respect to resident rights, mission statements, care plans etc., I am disappointed and deeply concerned that the funding section, part VI, does not contain language to ensure that the ministry will fund homes to provide care and programs that residents, like my mother, in long-term care need today. With their frailness and multiple and complex medical conditions—many with dementia—everyone agrees that government should be funding homes to provide at least 3.5 hours of resident care per resident per day.

I have observed, during the numerous hours I spend at Extendicare Falconbridge either visiting with my mother or attending to my family council duties, that the hands-on employees are run absolutely ragged. There is an increasing rate of staff absenteeism due to burnout and illness. When the body gets run down, it is more susceptible to colds and other types of infections. At Extendicare Falconbridge, each personal support worker is responsible for eight to 12 residents, depending on the level of care specific to the assessed needs of each resident. If two employees are off in a particular unit, personal support workers are forced to take on more residents, since they must now provide care to those residents normally assigned to the absent employees. It is an all too common occurrence that a personal aide must care for 14 or 15 residents if replacement workers are not called in or if none are available.

In part II, the residents' bill of rights, it states, "Every resident has the right to live in a safe ... environment." How safe can it be for residents to be cared for by employees who are stressed due to work overload and have to rush from one resident to the next to deliver personal care? There is barely enough time to do a decent job of bathing, dressing, tending to a resident's basic needs and completing what seems to be an increasing amount of paperwork. Many employees often work beyond their scheduled hours. They do this because they really care.

Some residents have no family and others have family who just drop them off and might come by once a year or so. Where is the time for staff to offer a little compassion, a few minutes of companionship? Where is the time for an aide to help open a gift or a birthday card for a resident who, due to diminished physical capacity, cannot open it for himself or herself?

The existing funding levels are simply not acceptable. Government needs to strengthen its funding commitment to long-term care in this legislation and then act on its commitment in the coming budget to increase funding to provide more staff so that residents can get the care they deserve in relation to their physical, medical, psychological and social needs.

I ask that you please amend this bill to include language that the government "shall" fund long-term-care homes to provide the care and services required. This includes the funding to ensure that homes can indeed

provide the restorative care programs and the activity and recreation programs that do meet the assessed needs of the individual residents. What a difference that would make.

The funding formula should also provide for the hiring of adequate replacement employees to ensure that homes are able to provide at least 3.5 hours of care per resident per day throughout each and every day.

In part V, "Operation of Homes," section 72 states, "In order to provide a stable and consistent workforce and to improve continuity of care to residents," every home "shall ensure that the use of temporary, casual ... staff is limited." I shudder to think that homes might risk sacrificing resident care or safety by not providing enough replacement staff simply to be compliant with imposed limits.

I am also very concerned about accommodation types and the ministry's copayment structure. For older homes, there are three types of accommodation: basic—four residents per room; semi-private—two residents per room; and preferred—a single-resident room. For the newer homes, there are two types of accommodation: basic—two residents per room; and preferred—a single-resident room.

My father was a resident in one of the newer homes. He lived in a two-resident room. It was a lovely, spacious room with modern decor and amenities. Since his room was classified as basic, he was entitled to a rate reduction.

My mother is a resident in an older home. She too lives in a two-resident room. Her room is very small. The painted walls, flooring and meagre furnishings look very old. It evokes nowhere near the same feelings of spaciousness and brightness as my father's room did. Given the age and existing structure of this building, it likely never could. Her bathroom is approximately 30 inches by 40 inches and does not accommodate a wheelchair. Yet, since her room is classified as preferred, my mother is not entitled to a rate reduction.

There are ward accommodations—identified as basic—at Extendicare Falconbridge with four residents assigned to them and only a very small bathroom. There are also a few preferred accommodations at this home—two persons per room—whose residents must go across the hall to access their own bathroom, due to poor building design. Other residents and even visitors often mistake that particular residents' bathroom as a public washroom.

Imagine that you are an 80-year-old female in your own bathroom, taking care of your personal business, when suddenly the door opens and you are faced with an elderly gentleman whose trousers are halfway down his knees simply because he's intending to take care of his own personal business.

Many residents who live in these older homes suffer this type of embarrassment and indignation all over Ontario. Imagine that you have lived your entire life in a comfortable home, slept in your cozy bed with warm surroundings, with your personal items that evoke many special, pleasant memories. Then you are forced to live in an old home in a room so small that you cannot even bring in your favourite easy chair and you are told that you must bring but a few personal items. How can this government justify the existence of such substandard accommodations? How can this government justify the double standard in long-term-care accommodations? Because my mother lives in an older C-class home, which is still part of this government's long-term-care program, she pays more than what my father paid in the newer home. In fact, if you look solely at the amenities that newer homes are able to provide because they are built to today's standards, my mother gets much less.

0910

Now even the future of her home is being made uncertain, because a deadline will be placed on the operating licence that is solely related to its physical structure. There is a deadline, but there is no process or plan to address the structural issues I have mentioned.

I urge you to change this bill to provide more certainty for the future of my mother's home and provide language that ensures government will fund the upgrading of the older C-class homes. Government needs to establish an immediate and aggressive plan to significantly improve these older buildings and bring them up to acceptable, livable standards. This will ensure that basic accommodation for all residents in all long-term-care homes means no more than two residents per room and a private bathroom that you can actually get your wheelchair into.

Seldom is my mother served fresh fruit. When I approached the dietary manager and asked why the fruit served is frequently a canned product, the response was, "Fresh fruit is too expensive, and we don't have enough staff to invest the time required in the preparation of fresh fruit." A body nourished with a healthy diet of fresh, wholesome foods will undoubtedly be a stronger, healthier body. I'm told that the daily raw food allowance is approximately $5.46 per resident per day. Would you be able to provide your family members three healthy meals plus between-meal snacks on a budget of $5.46 per day? I know I couldn't.

The long-term-care residents of this province are our most vulnerable citizens, and they, along with my mother, deserve to live in a safe, comfortable home environment and are entitled to the very best of care.

With a history of Alzheimer for three generations in both my mother's and my father's family, it seems likely that I too will be needing long-term care sooner rather than later. If you don't fix what's wrong with the system today, what level of care can I possibly expect when I need to go to live in one of these homes? Make no mistake: The clock is ticking. The baby boomers will be filling these long-term-care beds in droves before too long. Statistics show that Canadian citizens are living longer in their aged years. They are not necessarily living a healthy longer life. More often than not, they enter long-term care and are there for many, many years. I realize that the government has increased funding to long-term-care programs over the past few years, but it

just isn't enough. There must be more funding to upgrade these older homes and to hire more staff to meet all the residents' current needs and the increasing demands of tomorrow.

I thank you for the opportunity to share my views.

The Vice-Chair: Thank you very much. We have three minutes left. We can divide it equally between the three parties. We'll start with Mr. Ouellette: one minute.

Mr. Jerry J. Ouellette (Oshawa): Thank you very much for your presentation. I happened to note in yesterday's Sudbury Star the headline "Pressure to the Breaking Point." I don't know if you noticed that or not, but it spoke about the health care system and the impact on hospitals taking in long-term-care patients as well. I don't know if you had an opportunity or if you have any experience and maybe you can enlighten the committee on what is taking place in that situation. What would happen if the health care system, the hospitals, were to remove those long-term-care patients from the hospitals and put them into the system? How would that impact the system?

Mrs. Lemieux: Well, certainly they'd need to build more long-term-care facilities, because obviously long-term-care-need people currently taking up bed space in hospitals is creating a crisis in health care scenarios all over Ontario in the same fashion. You'd need more space. It takes more money to provide more space, to provide the proper care. More often than not, people sitting in a hospital bed who need long-term care don't have all of their needs addressed properly or adequately because the nursing staff is there to try to heal in medical types of situations, not necessarily the wholesome care that long-term-care residents need.

Ms. Shelley Martel (Nickel Belt): Thank you, Adrienne, for your presentation this morning. You are right: The bill should say that the minister "shall" provide funding, and we will be moving an amendment in that regard.

You are also correct when you say that the government has increased funding, but it certainly hasn't increased to the level that it promised in the last election. The government promised to increase funding for care for residents by $6,000 per resident, and at this point the government has actually increased it by only about $2,000. So we have a long, long way to go to actually have the Liberals meet that election promise.

Tell me, if the government was to give $4,000 more per resident, what do you think might happen to the care of your mom?

Mrs. Lemieux: I would like to think that the money could be used to have the caregivers spend a little bit more time to address her emotional needs to some degree. An elderly person suffering from Alzheimer's, as I'm sure you're familiar with the nature of the disease, tends to have a very short attention span. Often they need to be redirected or they just need someone to sit down and appease the anxiety that they create, because in their mind they're confused. More often than not, my mother is not sure where she is and why she needs to be there, and the personal care workers and the nurses don't have the time to dedicate to sit with her for two, three, four or five minutes to try to calm her demeanour, if she's agitated, or to simply try to make her feel comfortable about her surroundings, to reassure her that she's at home—because this is her home—that she's safe, and that if there's anything she needs, she doesn't need to hesitate to ask. But more often than not, I've gone to visit and found her standing in the doorway, basically just scurrying hoping that she can stop somebody because she has a question to ask, and the staff are just running to take care of a more urgent situation. There aren't enough people to help. It takes money to do that.

The Vice-Chair: Parliamentary assistant?

Ms. Monique M. Smith (Nipissing): Thank you, Adrienne, for coming today. We appreciate the work you're doing as the chair of your family council. Family councils are really important to our long-term-care homes.

I also wanted to let you know that we do appreciate the concerns around the situation in Sudbury and the need for more long-term-care beds. I do note that we've seen the opening of about 414 new beds since 2002, so an increase of about 47%, and a recent announcement of new beds; I think 96 new beds are going to be built in the Sudbury area.

I was interested to hear about your concern around the continuity of care provisions in the legislation. What we've heard from other families and people in the system is the concern that their family member is being looked after by different people all the time and that continuity of care is very important, especially for people who are suffering from dementia, like your mom. It's nice to have the same person in as much as possible; they know her and her personality. That is why we've introduced section 72, which would provide for the continuity of care and try to limit the number of agency staff that we have in our homes. But you seem to have a concern around that. Do you see value in trying to limit the number of agency staff in our homes?

Mrs. Lemieux: I wholeheartedly agree with the principle behind trying to maintain continuity of care and trying to utilize the same staff. But when staff are burning out and are off too often due to illness—because they've caught a cold, they're run down or they've caught whatever is going through the facility that day—you're forced to call in replacement staff. If the ratio of residents to personal support workers was lessened so that you could hire more staff, the staff may not succumb to infections and illnesses. That in itself would help provide continuity of care, and not having a casual person in who is basically given 10 minutes to run through the charts: "Okay, here's the care resident A, B, C, D and E needs. Robert, do the best you can." It's an overwhelming thing. So I do agree in principle, but that may be maintained if there's a higher ratio of workers to residents.

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

FINLANDIA HOIVAKOTI NURSING HOME

The Vice-Chair: We'll move to the next presentation, by Finlandia nursing home. Welcome. You probably know the procedure. You have 15 minutes. Would you mind stating your name before you start?

Ms. Claire McChesney: My name is Claire McChesney. I'm the administrator of Finlandia nursing home.

The Vice-Chair: And your colleague?

0920

Ms. Andrea Turner: I am Andrea Turner. I'm the chairperson of the Finlandia Hoivakoti Family Council.

I have been the chairperson for the family council since its inception in 2005. Finlandia Hoivakoti is a 110-bed nursing home located within Finlandia Village, a four-stage seniors' residence in Sudbury that sits on a 27-acre parcel of land on the north shore of Lake Ramsey. Although the interior has a distinct Finnish flavour, Finlandia Hoivakoti is home to residents from a number of different ethnic backgrounds. It is a picturesque setting for all who live, work and visit there.

I am speaking today on behalf of the families and friends who have loved ones in the care of Finlandia Hoivakoti Nursing Home. While we're pleased to see that Bill 140 emphasizes resident safety and zero tolerance for abuse, we do have a number of concerns that focus on quality of care for the residents of long-term care in Ontario.

As a family council, we are actively involved in ensuring that the needs of our loved ones and all residents are met. What we see on a daily basis are dedicated and caring staff who run between residents in order to attend to the varying needs of each person. The government, we have been told, has allotted enough funding so that the average home provides, on average, 2.5 hours of nursing care per resident per day. This is not nearly enough, especially when the average is much higher in other provinces.

The term "caring," as we see it, refers to not only attending to the physical needs of a person but also making time for a person's emotional needs. We know first hand that these care providers are deeply committed to caring for their clients, but time constraints restrict their ability to provide adequate levels of care to individual residents. The proposed Bill 140, with its emphasis on rules, paperwork and processes, will further reduce resident care time.

One of our greatest fears with regard to Bill 140 is that it will lead to a stronger sense of institutionalization for residents, families and professional care providers. Moving into long-term care is a difficult transition for many older people because they are leaving behind a home which is familiar to them. Thus, it is important for long-term-care facilities to foster a home-like environment in order to bring comfort and enjoyment to residents and to their visiting friends and family. Subsections 77(1) through (3) refer to the posting of information, which under the proposed bill will consist of over a dozen official and legal documents, which in our opinion will detract from the home-like atmosphere our facility is trying to create. Perhaps, beyond the residents' bill of rights and an explanation for the measures to be taken in case of an emergency, the government could allow the resident and family councils to determine what information is to be posted in the home while making all other documents available on the facility's website or by request.

A second concern we have is the government's definition of the term "restraint." Paragraph 5 of subsection 28(1) refers to the keypads on the main doors of all long-term-care facilities, which provide a safe and secure environment for all residents, as being a kind of restraining device for those residents unable to punch in the code which opens the main door. There seems to be a fine line between paternalism and autonomy here. We do not let young children, who are just as vulnerable as a cognitively impaired adult, wander unattended out the front door of their homes, and we certainly don't label our children as "restrained citizens" either. Defining perimeter security as a form of restraint could potentially have a negative emotional impact on all residents, thus making long-term care feel more like an institution than a home.

What makes each long-term-care facility less institutional and more home-like are the unique personalities of each resident. Every long-term-care home, like every other home in Ontario, has a flavour of its own. The regulation and prescription of mission statements and volunteers, as outlined in clauses 4(1)(a) and (b), subsection 4(3) and subsection 15(2), detract from the unique character of each home. Legislating a defined list of volunteers takes away the freedom to address the needs of the current residents. Suggestions and guidelines would be a far more valuable and reasonable way to approach volunteerism because long-term-care homes, although they may try to acquire representatives from various parts of the community, first must ensure that these volunteers speak to the needs of their residents.

As a family council, we recognize the negative effect non-compliance by the facility has on our loved ones, and so we support the government's efforts to make long-term-care homes and their staff responsible caregivers. Subsection 146(3) states that all non-compliance is to be documented. Filing formal reports, and having them processed, responded to and cleared, however, takes valuable time away from resident care. Our fear is that staff will become more task-oriented, focusing more on compliance issues than caring for our loved ones. As previously stated, we see that the staff are run off their feet as it is. Filling out paperwork for a slippery floor hazard caused by a resident's spilt juice, which gets cleaned up immediately, will take away from the already too-little allotted nursing care hours.

Funding penalization for non-compliance, found in section 152, has also raised some concern because we feel it will detract from resident care. Withdrawing a home's funding for non-compliance reminds me of international economic sanctions. It is not the bureaucrats

who suffer the consequences; in this case, it will be our loved ones. If the government were to force the owner/operator to hire an outside expert to assist the facility with compliance, at the operator's expense of course, the home would maintain the standards of living and safety for the residents while working on its compliance issues.

Along with our plea to reconsider funding penalization, we feel it is absolutely necessary that the government maintain and/or improve upon its financial commitment to resident care. Subsection 88(1), however, outlines that the government has removed its commitment to resident care. Bill 140 reads that the government "may" fund long-term-care homes, whereas existing legislation reads that the government "shall" fund long-term care. Word choice is important. If owners and operators of long-term care are obliged to meet the expectations of Bill 140, then the ministry has an obligation to provide adequate funding to enable the home to meet the quality of standard set forth by the ministry. The family council feels quite strongly that the role of the governing body is to steer owners/operators in a direction most beneficial to the residents, but that can only come from sufficient funding.

Long-term-care facilities are home to a growing number of older adults. It is important that this new legislation not only protect our older family members and friends, but also create an atmosphere where those who have chosen to care for older people in need can do so in the most beneficial way possible for the residents who call long-term care home. We urge you to remember that what our loved ones need most is to be cared for in a holistic sense. Thus, we ask you to be mindful of the increased paperwork, processes and a doctrine of absolute compliance which are sure to lead to a stronger sense of institutionalization for the residents and where the term "care" will become task-oriented, as opposed to our loved ones living in a home-like setting where care is understood through the quality time staff spend with individual residents.

In addition to the issues raised in our presentation, we urge the committee to support the detailed amendments submitted by the Ontario Long Term Care Association.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left; we can divide them equally. We'll start with Ms. Martel, one minute.

Ms. Martel: Thank you very much for your presentation this morning. Just a couple of points and then I have a question.

You're right: It's interesting that the current legislation before us has "may" instead of "shall," and one wonders how that happened and why. We will move an amendment that will say "shall" again.

Also, when you talk about section 77 and all the paperwork, it's interesting that the government also says that any regulated documents have to be certified by a lawyer. I don't know what that's going to mean in terms of the documents you have in the home and that whole process as well.

Looking at all of the increased obligations, what's your concern with respect to resident care when you look at the bill and you look at all of the new obligations and requirements that are going to be put on the home?

Ms. McChesney: If I may, I think our genuine concern is that all of this detracts from the care of the resident. One of the things that we are trying very hard to do is to maintain, as well as try to enhance, the physical and mental fitness of our residents. That's virtually impossible to do as we get more and more bogged down with the paperwork that's required. The hours that should be going to that type of care, then, are being taken up by this type of thing.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: I just wanted to follow up on that point on the paperwork. With regard to subsection 146(3) that you were concerned about—documentation of non-compliance—it's actually the inspector who comes in and does their annual inspection who must document non-compliance, not the home. And there's no obligation in this legislation to require that a home document a slippery floor when the juice has been cleaned up. I don't know where that came from. It was talked about last week. There's no obligation. In fact, the paperwork obligations that are in the legislation reflect what is for the most part already in the guidelines and the policy manual. There are a few around restraints—I know that you've addressed some of it around the security of the homes—that do add some paperwork. The documentation that we're requiring is really to ensure resident safety and that we are focusing on a resident who is in restraints and ensuring that the use of restraints is limited to very specific circumstances. I just wanted to try to address that concern.

At the end of your presentation—which I really appreciated; thank you—you talked about loved ones and the approach being holistic. I'd just point out to you that in the plan of care, we've really tried to ensure that everyone is involved in developing a plan of care, that it's resident-focused and that it's multi-disciplined so that everyone who has a role to play in that resident's care is involved in developing a plan of care, including the family members or someone of significance to the resident. I take your points, and I thank you for the work that you're doing on the family council and for running a great home.

0930

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

Mr. Ouellette: Thank you very much for the presentation. I just want to continue on about your concerns with the amount of paperwork. I know in the past that, for example, the health care system was given funds to hire nurses. However, the nurses didn't provide patient care; they ended up doing data entry. I think what I'm hearing is that basically the same sort of thing may take place here. What do you think an adequate level of hours would be, as opposed to 2.5 per day, to take care of the paperwork as well as increase the level of care?

Ms. McChesney: At this point, we certainly have discussed moving to at least three, but when I'm talking about three hours of care, I'm talking about the care to the residents. That does not in any way touch on any hours that are spent doing the paperwork.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1623

The Vice-Chair: The next presentation will be by Dave Shelefontiuk. Welcome, sir. You have 15 minutes. You know the procedure, I believe. You can start when you are ready.

Mr. Dave Shelefontiuk: I'd like to thank the committee for letting me speak today. On my right is Brian Blakeley; he's CUPE research. I'm Dave Shelefontiuk. I'm the president of Local 1623, the hospital workers.

The Canadian Union of Public Employees, Local 1623, represents approximately 1,000 support and clerical employees at the Sudbury Regional Hospital, including both full-time and part-time employees. On behalf of those members, we would like to thank the committee for making time for us to speak today.

Committee members are likely aware that CUPE and Local 1623 are strong supporters of public health care and public hospitals. Thanks in part to the struggle of working people, hospital services are protected by the Canada Health Act and its five principles: universality, comprehensiveness, reasonable access, portability of coverage and public administration.

Unfortunately, many other health care services do not receive such protection. It is alarming that the hospitals are playing a smaller and smaller role in health care. We understand that a recent report from the Canadian Institute for Health Information has reported that in the mid-1970s hospitals accounted for 45% of total health care, but by 2004 only 30% of total expenditures went to hospitals, which is a pretty big decline.

It is the policy of the provincial government to move services out of hospitals and into the community, be it home care, long-term care, clinics etc. While we, as hospital workers, recognize that in some, but not all, cases this is appropriate, we are concerned when we see that such changes are a rather thin disguise for reducing the level of care to patients.

Across the province, thousands and thousands of hospital beds have been eliminated since the early 1990s. It is now widely recognized that a lack of beds is a key factor causing very high bed occupancy levels, helping to create an ongoing crisis in emergency rooms, forcing the cancellation of surgeries, creating unacceptable wait times and encouraging the outbreak of superbug infections in our hospitals. A recent example of that is the Norwalk virus, which is very prevalent here in Sudbury.

There has been a very serious bed shortage in the Sudbury area for some time. We have attached some newspaper clippings to this brief illustrating this crisis. Part of the problem, we believe, is a lack of hospital beds.

A recent example of the wait times is that I took my mother-in-law into the emerg last week. She waited in that emerg on a stretcher for two and a half days before a bed was even made available.

As in other hospitals, we have seen our beds cut. I'd like to draw your attention to one specific area of bed cuts. There used to be 64 complex continuing care beds, or, as they used to be called, critical chronic care beds, in the hospital. This number has been reduced to 26.

Complex continuing care beds have been cut not just in Sudbury but across the province. If they are replaced at all, it is with long-term-care beds. But complex continuing care beds are funded at a much higher level than the long-term-care beds, so when you replace complex continuing care beds with long-term-care beds, there are fewer resources to provide proper care.

Earlier, CUPE looked at this transition and found that these changes had a very serious impact on the level of care. CUPE initiated a survey in Ontario of workers in complex continuing care hospitals and a former complex continuing care hospital that was changing into a long-term-care facility. The survey was developed by front-line health care employees working in conjunction with CUPE research and sociologist David Hubka. The study assessed the impact of funding cuts on workload and patient care and provided a voice for front-line workers in these facilities. The study provided a comparison of respondents from a facility that was undergoing the transition from complex continuing care to long-term care and hospitals that still provided a complex continuing care environment. The government was turning the Perley and Rideau Veterans' Health Centre into a long-term-care facility. At the time of the study, funding at the Perley stood approximately halfway between complex continuing care and long-term-care funding per resident.

Respondents at the Perley usually noted more workload problems. They were more likely to report working before or after hours without pay: 73% versus 53% at the surveyed hospitals. They were more likely to report working during their lunch period: 67% versus 54%. They more often reported that they were doing more unpaid work than four years previously: 54% as compared to 45%. They were more likely to report that their workload is increasing: 100% versus 90%. They were more likely to report that their workload is hurting their health: 86% versus 77% of respondents at the hospitals.

Similarly, respondents usually noted more quality of care problems. Perley respondents were more likely to report that patients have one tub bath or shower per week or less than respondents at other facilities. Perley respondents were more likely to report that they have patients who seldom get out of bed due to a lack of resources. They were more likely to report having patients who do not get out of bed due to a lack of exercise: 76% versus 57%. Some 44% of Perley respondents report

that this is an increase from four years earlier, compared with 34% of other respondents. They were more likely to report that they had less than five minutes per day to talk socially with each patient. They were more likely to report that they had less time than four years ago.

Overall, these findings suggest that funding cuts and the resulting staffing shortages have a measurable impact on the quality of care provided in chronic care hospitals.

We've attached a copy of the Perley report.

These sorts of changes continue to happen here in Sudbury, with the attendant cuts in care.

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Until recently, the Sudbury Regional Hospital had 37 long-term-care beds. The recent announcement of 10 long-term-care beds made that 47. They now have reduced that number to 26. This has resulted in five nursing staff for these beds during the 12-hour day shift and three for the 12-hour night shift. That is a total of 96 hours of staffing per day. That means that each resident is allowed 3.7 hours of direct nursing care a day. These are difficult shifts to work. The staff find the workload challenging and sometimes unbearable. We've filed workload grievance after workload grievance and nothing gets done.

We find it difficult to believe that quality care can be provided at a long-term-care facility with less than three hours per day of nursing and personal care. We know that many of the CUPE members who work in long-term-care homes do not believe that even that level of care is provided. We do not believe it appropriate that these or any other services be moved out of hospitals to cut the care. But all too often, it looks like that is at least part of what is going on. We believe that there is an urgent need for minimum staffing standards. We urge this committee to propose a minimum of 3.5 hours of nursing and personal care per resident per day to start.

On behalf of the members of CUPE Local 1623, I'd like to thank the committee for hearing us out.

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

Mr. Jeff Leal (Peterborough): Thank you very much, sir, for your presentation, with your background. My question for you: There's been a lot of discussion while we were in Kingston yesterday about how to define the components of the 3.5 hours of direct care. We heard a number of ways that that could be attained. I'd just like to get your view. You're a front-line worker. You have lots of experience. How would you define those components that make up the 3.5 hours?

Mr. Shelefontiuk: I look at 3.5 hours as being direct nursing care. If you combine as recently heard on the news that in Kingston they assessed that it costs $1,400 or $1,500 a day to run per patient, and if you look at 3.5 hours, that's 3.5 hours of direct nursing care. That's not including the dietary staff or housekeeping staff. I think to get a more personalized view with the residents, the nurses need to be there at 3.5 hours.

The Vice-Chair: Mr. Ouellette.

Mr. Ouellette: You specifically mentioned in your presentation the five nurses who provide 3.7 hours. The legislation enshrines the mandatory RN. Do you believe that there should be a ratio of RNs to the number of patients? I don't see anything that specifically states that. The RN could be handling from large numbers to small numbers.

Mr. Shelefontiuk: Being CUPE, which represents registered practical nurses, the short answer to that is no. I believe that a registered practical nurse is equivalent to an RN.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for providing the comparison of what level of care is required for chronic care patients in a hospital, and that even the 3.7 hours that you calculated is not enough. When you look at some of your colleagues who work in long-term-care homes, you're finding it hard to imagine how they're able to provide any care at all. Maybe you can give us an idea of what you hear from some of your colleagues who are working in some of the homes locally about the care they're expected to provide and what they're realistically able to do.

Mr. Shelefontiuk: I can tell you just briefly what my understanding is, but I'm sure when they follow up, they'll present a better case than I will. My understanding is that they don't even have time to sit and talk to the patients or work with the patients. They're running and running just to get a bare minimum of stuff done. As far as the cleaning part goes, there have been recent outbreaks of Norwalk. Being long-term-care residents, they're not leaving their beds as often as some of the others, like hospital patients. So the cleaning standards, with the money they're getting—they're just doing the bare minimum; nursing standards—bare minimum; dietary—bare minimum. That's my understanding.

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

JOANNE GRAHAM

The Vice-Chair: We'll move to the next presentation, by Joanne Graham. Is Joanne Graham here? Welcome. You can start whenever you're ready. I believe you know the procedure. You have 15 minutes. You can speak for all of the 15 minutes or you can divide them between speaking and questions.

Ms. Joanne Graham: During my presentation I'm going to mention time frames. These time frames, implemented by the Ministry of Health, are from your last meal of the day to your first meal in the morning, and from your first meal in the morning to your nourishment, to the middle meal; time frames as in positioning of residents, whether it's every hour or every two hours, depending on the resident, depending on the location and everything.

Who am I? What do I know about long-term care? Well, I'm Joanne Graham. I am from a small town up north called Kirkland Lake—population 10,000. I've

worked in this field as a caregiver most of my life. I have seen long-term care come from next to nothing to where it is now. Let's not stop till it is what it should be: great.

I am sure you will hear many reasons during these hearings why we need more funding. We are only a few voices for many who can see that 3.5 hours are needed. I hope that I will give you a different look into the needs of long-term-care residents. Who are these seniors? They are people I have known all my life. They are someone's hairdresser, teacher, doctor, someone's mother or father; people who have been sent from hospitals that have downsized, from the psychiatric hospitals that are closing. We have group home people who don't fit into the group home setting because of age or behaviour. These elderly ones are confused, with different illnesses from Alzheimer's, frontal lobe damage, depression, schizophrenia, Korsakoff's and more, illnesses that we are only learning about how to live with now—all these residents in the same place with all these mixed feelings, mostly fear. And with fear comes lashing out.

Most seniors have been through hard times—the war, hunger, moving to this great country of ours, doing without so we can do with. All these hardships don't just disappear because times have changed, as the caregiver knows only too well. The caregiver tries to meet the needs of all her residents. She calls to the registered staff—the doctors, the gerontology doctor—for guidance. She is faced with time frames, and the ever-so-kind words from the doctor: "Approach in a calm manner. Take your time. Let the resident be aware of their surroundings." The chemical restraint is not popular. Don't get me wrong, the caregiver is not for restraint of any kind for it only makes their job harder. Safety of others is high on the caregiver's list—so many residents, so many different needs, so few staff.

The night shift, with only a few staff: positioning of residents who are unable to; making sure the resident is dry and comfortable; doing night-shift cleaning; looking for the elderly woman's lost child—she is in the past, but we are in the present; the war hero who relives every night the terror of war; the 60-pound man yelling, "There's a woman in my room"; holding the hands of the dying. Yes, we are peacekeepers, pastors, cleaning staff. A lot of the time we are the last face they see. We go without breaks to stay with the residents to keep them safe from themselves, or just to be with the resident whose needs are greater than ours.

The evening shift—a shift that very few want to work: Sundowners and other behaviours increase greatly. Gentle reminders, a light touch—slow and easy is how to go. But there are these time frames again. The noise from one resident will start angry outbursts from another. If you had the time, you could see the behaviours multiply. On the evening shift families come to see their loved ones. They want to know how they can help to bring their loved ones back in time so they could be as they once were. Families' needs are great as well. We give comfort. They cry; they get angry; they demand results. I often hear, "My father never did hit out before." But he does now.

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Day shift: Only one hour to get the residents up, washed, looking good, transported to meals, fed—toilet activities, bathing, nourishment and appointments. Let's not forget charting: intake, output, skin assessment, circulation, good colour/poor colour, meals, supplements, walking—did they walk, did they not walk—anger/no anger. So many difficult residents in one place.

We haven't even spoken about the residents in our home going back to their original language—Polish, Russian, Finnish, German—on and on it goes. Communication takes time, and there is no time because we have time frames to meet.

As you are aware, we the caregivers have a hard job. Who doesn't, nowadays? A caregiver can be spit at, hit, sworn at, tossed around like a playtoy several times in a day, depending on the day. What worked yesterday may not work today. We all know it is the illness, not the person, but it takes time to find out what will work. We all know that different diseases have different stages and different behaviours, from early stage/middle stage/late stage. These diseases are different challenges. And there's no time. We have worked without relief for staff for years. The staff can't even get time off when they need it. The staff don't stay. The work is too hard with not enough staff. The people would like the type of work in long-term care if they had the time to do their job. We were at 2.25 hours years ago, and that wasn't enough. We've never seen that since.

Please understand: Staff go without breaks. They get degraded at times. They do things that are unsafe, like rushing. This rushing is not so they can sit; they rush so they can spend time with the ones who need it the most.

I ask you: At 3.5, give our elderly dignity during the last part of their life. That's it.

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

Mr. Ouellette: Thank you very much for your presentation. At the start of your presentation, you mentioned about the group home settings aspect. Are you sensing that there should be specific homes for specific illnesses or needs for long-term-care individuals?

Ms. Graham: I'm only a health care worker and I don't know, but I do know that you need the time to approach these people. You cannot approach them in a hurry. We need doctors to come in and assess and give us some guidance on how to deal with these people. We don't have the doctors. We don't have the time.

Mr. Ouellette: To continue on, then, on that train regarding the amount of time, do you believe, as I stated to the last presenter, that an RN is required? It's established, but it doesn't state the level of care, so an RN could be for a small group or a large group. Do you think that there needs to be an assessment based on the number of individuals who are being taken care of?

Ms. Graham: I think the assessment should be on the care the resident needs at the time. In our home, and

that's only what I can deal with, what comes out of the nursing budget is certainly not all hands-on care. The dietitian who comes up and charts—that portion comes out of the nursing budget. The office girl who comes up and makes appointments and does scheduling—that comes out of the nursing budget. We also have the DOC who comes up; the RN who does a lot of paperwork. We have the RPN who does the medication. All of this comes out of the nursing budget, but the actual hands-on care is limited. Certainly I'm not saying that they are not needed or are not a big asset, but the actual hands-on care is very much limited. It seems to me and my coworkers that we are taken last as far as looking into what the needs of the residents are, when we should be looked at first and foremost.

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

Ms. Martel: Thank you, Joanne, first for coming from Kirkland Lake, because that was a long way to come to make your presentation, but secondly and more importantly, for the presentation that came right from the heart. Thank you very much for doing that.

You focused on the fact that you don't have enough time. In response to my colleague, you pointed out some of the things that are included in the nursing envelope that strictly really aren't hands-on care. I've been advocating for some time that the legislation clearly state and have a provision for 3.5 hours of hands-on care. Right now there isn't any rule about how much care can be provided. There used to be, when the NDP was the government; it was cancelled by the Conservatives. The Liberals promised to put a standard of care back in, but they haven't. What could your coworkers do if there was actually a rule or a law that said that a minimum of 3.5 hours of hands-on care had to be provided to your residents every day?

Ms. Graham: Certainly I think the home would benefit by this. The residents would be more comfortable. They would have more of a bond with their caregiver. We do have primary care where a staff person has the same residents every day, so we try to deal with that. But to pass somebody and say, "I will be back in a minute," and know that you are unable to—I think that would solve the problem of dignity for the people at their last stage of life, which is a must. I think that certainly would help.

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

Ms. Smith: Thanks, Joanne, for coming, because Kirkland Lake is a bit of a trek. What home are you at in Kirkland?

Ms. Graham: Extendicare of Kirkland Lake.

Ms. Smith: Great. I just want to touch on two things that you brought up. You talked about the fact that the health care aide/personal support worker spends a lot of hands-on time with the resident and you talked about their role in resident care. I just wanted to point out that in our plan of care in the bill, we are setting out that all those involved in the care of the resident have to be involved in the assessment and developing of the plan of care. So it's definitely creating a role—in some homes, it did exist; in some homes, it didn't—so that the personal support workers or the health care aides are involved in the assessment and then in the drafting of the plan of care.

But I did want to focus in on the 3.5-hour question and what you would include in 3.5, because I was interested in your discussion with Mr. Ouellette about what is included in the nursing envelope. You noted that the RPN does medication and that there are others who are included in that nursing and personal care envelope. In the 3.5 calculation that you're seeking, who would you include?

Ms. Graham: I certainly would include the RPN who hands out the medication and the personal support worker who does the hands-on care, and I think the others should be in administration.

Ms. Smith: Okay. Thanks.

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

LYNN GRANATIER

The Vice-Chair: Next would be Lynn Granatier. Welcome, Lynn.

Ms. Lynn Granatier: Thank you. My name is Lynn Granatier. I'm also from Extendicare Kirkland Lake. I've been with Extendicare for probably 10 years. I am a PSW; I'm the front-line staff.

"Dear," came the fragile voice from behind the privacy curtain, "Come here. Hold my hand. I'm scared. I've just been here for a couple of days. Everything is so strange and scary here." The thoughts that are crossing my mind are: "I've got one resident sitting on the toilet; I've got two more residents waiting to get to the bathroom with the mechanical lift; I've got another resident in bed, waiting to get up for lunch—all this before I can go on my break. This old woman is not my resident. I have to take 10 minutes out of my precious time to comfort this poor old woman." What a sad, but true, story.

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When I started working at a nursing home, my grandmother was alive. She was so proud of me. She told me I was going to be able to help the old folks. She has now passed on, and I try to treat my residents the way I wanted people to treat her.

Here's the truth: I am one person. I have eight people to care for. They need me to do total care for them: wash, dress, feed, bathe, toilet, change their briefs, put them down for a nap. Nowhere in my schedule is there time to meet their emotional needs. I work on a floor where there are a lot of residents with cognitive impairments. These people need one-on-one time that we just do not get. With the lack of this time, there are many, many behaviours that are dealt with by restraints, either chemical or physical. I ask all of you: Is this the best we can do for our seniors? Is this the respect we owe them? You and I will be their age in the not-too-distant future. I hope I will never end up in a nursing home. I hope you never

end up in a nursing home. But if you do, are you going to be happy with the decisions you are making?

Thank you.

The Vice-Chair: Thank you very much for your presentation. I guess we have lots of time for questions. We have about 10 minutes, and we can divide them equally. We'll start with Ms. Martel.

Ms. Martel: Thank you very much for your presentation and for coming, again, from Kirkland Lake. I assume the two of you came together.

Ms. Granatier: Yes, we did.

Ms. Martel: That's good. A safe journey back.

You've been with Extendicare for 10 years. Can you tell the committee what changes you've seen over that 10-year period in terms of staffing, the level of care that residents require etc?

Ms. Granatier: Where to begin? I know that workloads have increased incredibly. We have been given more chores for less time, and when I say "chores," it's a terrible way to put it, because we're dealing with people.

With the increased two baths a week, it has increased our workload enormously, because when you increase the bath, you're talking about behaviours, you're talking about someone who may not want to have a bath. So you have to approach all of these with kid gloves.

Feeding is another thing. At my particular table, I have a group of eight people. I feed three people at my table, each and every one of them with individual needs.

I could go on and on with the increased needs and the lack of time that we have.

Ms. Martel: When you talk about the two baths per week and what that means, because you could have residents who are fighting that very aggressively—

Ms. Granatier: Oh, definitely.

Ms. Martel: —was there a staff increase to allow that to happen, and are you actually able to provide baths versus what has been referred to as a "bath in a bag," which is more of a sponge bath?

Ms. Granatier: We at our home really do try to do our baths. I'm sorry; what was the first question?

Ms. Martel: Did you see an increase in staff? You've said this increased your workload. Was there some kind of increase in staff—another part-time person, another casual person who came in?

Ms. Granatier: When we had the one bath a week, I was a bath girl, and I really enjoyed that job, but with the increase to two baths, the bath positions disappeared and we did have one more full-time staff. But that took the job of two bath girls. So, yes and no; we had a transfer of positions.

Ms. Martel: In terms of the residents you are caring for, you talked a little bit about baths and some of them not being comfortable with that. How many of them are mobile, for example? You talked about the number that you need for feeding. I'm assuming that's not tube feeding.

Ms. Granatier: We have at least 27 feeders on our floor, probably 25% mobile, 75% of whom use a mechanical lift.

Ms. Martel: And in wheelchairs?

Ms. Granatier: Oh, yes. With the wheelchair, we have to use the mechanical lift to put them in the tubs or to put them in the showers. So, yes.

Ms. Martel: Okay. Thank you.

The Vice-Chair: Ms. Smith.

Ms. Smith: I appreciate, Lynn, that you came as well. Thank you for being here and for your presentation.

I just wanted to ask you, because you're a front-line worker and you can tell us a little bit about this: We've had different comments about this "bath in a bag" question. It's my understanding that some of the residents prefer a sponge bath to the discomfort of going into a full bath, so sometimes for those residents a home will choose to do one sponge bath and one full bath in order to meet the needs of the resident. Is that an accurate description in some cases?

Ms. Granatier: The people who have a hard time with the bath are probably the cognitively impaired people. So it's the people who don't know any better that we have to make decisions for, and that's why they're there. If they are extremely resistant to having a bath, it's not worth putting them through that, but sometimes it's better for them to have a bath than to not have a bath. In our home there are very few cases when there's a bed bath given, as opposed to the two baths.

Ms. Smith: I wanted to ask you the same question that I asked Joanne, and that was about the 3.5 and what you would see included in that number. We talked about the different people who have involvement and interaction with the residents and what they would see as being included in the number of hours of care.

Ms. Granatier: I would be really selfish there and say probably PSWs and maybe RPNs.

The Vice-Chair: Mr. Ouellette?

Mr. Ouellette: Thank you very much for your presentation. You mentioned that you take care of eight individuals.

Ms. Granatier: Yes, I do.

Mr. Ouellette: Can you give a breakdown of how you feel that those individuals would receive the current 2.5 hours of care? You being one individual, obviously there are other individuals who provide that care for them throughout the day. Can you just give us a breakdown of how it operates in your facility?

Ms. Granatier: There are some individuals who need more care than others, and, unfortunately, the ones who need less care get less care. The ones who need more care, obviously, you have to take away—our home is not 2.5. I believe our home was broken down to 1.91. So they don't get that. But, yes, some of the individuals who can care—well, we don't really have any who can care for themselves, but the ones who can do more for themselves get less care than the ones who have to have more care.

In the 2.5 hours, you have to remember that we have mechanical lifts that we have to deal with. That means we need two people to do that. So again, we're taking two people to do one resident, and that cuts into our time as well.

Mr. Ouellette: So what would be an adequate level at your particular facility, then, if you're at 1.91 and you're having a difficult time complying with that?

Ms. Granatier: What would be an adequate level?

Mr. Ouellette: Yes.

Ms. Granatier: Three point five hours.

Mr. Ouellette: Even at the 3.5, we've heard about the amount of paperwork that potentially could occupy you. Some of the concerns are that, as opposed to patient care, you end up doing part of your 3.5 just providing paperwork. It's administration. Do you know of any particular way to ensure that that is not one of the ways that those things happen?

Ms. Granatier: The paperwork is important, because if it's not written down, it didn't happen. We have to have a way of tracking what we do. But I don't think a maximum of paperwork is necessary for us front-line staff. I think that with the increase or a full RN, we should be able to relay a lot of the stuff that happens to the RN and have them do the paperwork.

Mr. Ouellette: So somewhat of a funding model that separates administration from patient care would be one of the ways to go to ensure that patient care is met at an adequate level, as opposed to administrative dollars, as we heard earlier on—some of the nurses' funding envelope taking care of other aspects, as opposed to just nursing care.

Ms. Granatier: That would be excellent.

The Vice-Chair: Thank you for your presentation.

EXTENDICARE CANADA

The Vice-Chair: We'll move to the next presentation, by Extendicare Canada. Welcome, sir. You can start when you're ready.

Mr. Keith Clement: Good morning. My name is Keith Clement, and I'm the regional director for Extendicare Canada for northern Ontario. I'm located at the Extendicare York facility in Sudbury, Ontario.

I would like to firstly thank the members of the standing committee on social policy for giving me the opportunity to comment on Bill 140, the new long-term-care act introduced by the Liberal government.

Let me provide you with some of my background in terms of my experience in long-term care. I have 17 years of experience working in long-term care in Ontario in different roles, seven years as a social worker at our 234-bed Extendicare Falconbridge home in Sudbury and nine years as the administrator of the same home. In 2005, I was transferred to Extendicare York, our 288-bed home in Sudbury, Ontario, and have recently accepted a regional director's role with Extendicare. In my current role, I oversee the operation of eight long-term-care homes in northern Ontario. In total, we care for over 1,129 residents in the north, and we employ over 900 long-term-care employees at these homes.

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I believe I bring to you today some experience in working in long-term care and, through these experiences, a perspective on some components of this act that I support and other areas that I believe must be changed.

Most importantly, though, I have a grandmother who resides in a long-term-care home in Sudbury. My grandmother is over 80 years of age and left Dauphin, Manitoba, over 60 years ago to come to Sudbury to start a family and contribute to the well-being of this community. The long-term-care home that she lives in provides excellent care with the resources that they are given. My family and I are appreciative of the care that she receives.

I'm sure that my submission today and the issues and implications that I bring forward to your committee are not new. My hope is that, by reaffirming and bringing forth these points, the government will listen to different perspectives and act on changes that improve the legislation even further.

I wish to comment on some areas of the act that are positive in nature and that in many cases complement the language in the existing Long-Term Care Act. Clearly, the abuse and prevention language is an important part of ensuring that residents, families and the public are assured that everything possible is being done to protect and ensure the safety of our loved ones. We operate within an environment of frail and vulnerable individuals, and any opportunity that we can create to ensure safety and respect for our residents is an opportunity we cannot afford to miss.

I am also proud to say that in the homes I'm accountable for, the concept of least restraint is one that we not only promote but insist upon. We need language within the act that encourages long-term-care homes to look at every option prior to utilizing restraints. Beyond this, if restraints are necessary as a method of last resort, processes and checks should be in place to ensure the safety and respect of our residents. Restraints should be the exception, not the rule, in long-term-care homes in Ontario. I'm encouraged that this new legislation builds on past standards to ensure the philosophy of least restraint becomes part of our culture in long-term care.

The residents' bill of rights is emphasized in the new legislation and identifies residents' rights as an important expectation of consumers of long-term care. It sets out a framework by which residents should expect to be treated in long-term-care homes. No one can dispute that our residents should be treated with respect and dignity, and the residents' bill of rights is central to this concept.

Of importance to note is that there are also some components that were always in the existing act. As operators, we were obliged to meet these standards on a day-to-day basis prior to these hearings. We're obliged, for example, to ensure a safe and secure environment; to develop individualized care plans; to have complaint policies and procedures in place; to implement quality management systems; and to implement infection control programs in the home. These are but a few examples that the act includes that our residents and the public should expect from long-term-care homes in Ontario.

There are three points I wish to make today related to the act that I would like this committee to consider

making changes to for the benefit of those who reside in our homes.

Our current funding levels are not appropriate for the care that needs to be provided. I acknowledge that, as a government, there have been increases in the funding levels for long-term-care homes. We've seen some positive movement in this area and our care and program envelopes have seen increases. However, much of these announced government increases has been required to operationalize the 20,000 new beds that the province developed over the past several years to meet the growing need for long-term care in the province.

On average, our residents receive 2.5 hours of care per day. This remains too low in light of the increased complex issues that we're expected to meet on a day-to-day basis.

The Ontario Long Term Care Association has outlined to the government a need to increase funding based on comparable data in other jurisdictions and the increased care needs of our residents. I support their recommendations even more strongly in light of the expectations that are outlined in this new Long-Term Care Homes Act.

More troubling is the fact that, although the government outlines in the legislation specific programs that must be provided by the home, the legislation as written is unbalanced as it does not give equal obligation to the minister to provide funding to the home.

Subsection 88(1) should be replaced with, "The minister shall"—not "may"—"provide funding for a long-term-care home consistent with section 1 to provide care and services required in part II."

The government has missed an opportunity, I believe, to instill more confidence in our residents, their families, our staff and the public by not placing the level of importance that they should on the funding model and the need to correct and enhance funding in long-term-care homes in Ontario in this legislation.

I also recognize the importance of documentation in long-term care, as our system is based on providing care on an individualized basis. Assessing, evaluating and communicating these needs is an integral part of ensuring that our residents are receiving the best possible care. There needs to be a balance between the expectations placed on documentation and the need to promote hands-on care for our residents. Too often over the years I've heard how onerous the documentation requirements are in relation to meeting the provincial standards. This legislation creates some more processes and requirements for documentation. For example, for many of the requirements of Bill 140, it's not clear how an inspector will be able to identify compliance with the act without the home setting up a paper trail.

Subsection 18(3) requires communication of zero tolerance of abuse in the abuse policy on a regular basis to everyone attending or visiting the home. Homes will have to print off and circulate these policies on a daily basis and can only demonstrate compliance through the tracking of distribution—for example, sign-off sheets by recipients.

Sections 28 to 31 set out the requirements relating to restraints. The existing policies of the home will have to be revised and updated and then verified to be in compliance by inspectors. Ongoing documentation is required to demonstrate that each element of these sections is met. This is not because there is widespread use of restraints, but rather because Bill 140 establishes perimeter security, secure units, locked elevators etc. as "restraints," and most PASDs meet the definition of "restraint" set out in section 28. In a 100-bed home with a perimeter barrier that is a restraint for 65% of the residents, monitoring, assessment and reassessment of these 65 restrained residents will have to be documented on a daily basis. Under current standards, a resident in a restraint must be checked hourly, with the corresponding note in the care plan to demonstrate that the check was completed. This potentially translates into 569,400 documentation entries in a year. It takes about 10 to 15 minutes to complete a check and document it. Over a one-year period, this translates into 142,350 hours or 73 full-time equivalents of time to document only those 65 residents who are restrained by the perimeter security.

Clearly this is not the intent of Bill 140, and the current hourly checks were not specifically intended for perimeter barriers. However, even with one daily check per resident and corresponding documentation time to provide proof for the inspector, 5,932 hours or three full-time equivalents of time would be required in just a 100-bed home.

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 subsequently received all of the revised packages. Without documenting this, there is no way for the inspector to confirm compliance.

As well, each non-compliance cited by an inspector requires a written plan of correction from the home that is then approved by the inspector for implementation. Since the majority of the existing long-term-care program standards are process standards, setting out what and sometimes how care, dietary service, housekeeping etc. is to be delivered is a requirement. Returning to compliance is not just about providing better care; it's about the homes revising their existing policies and procedures, protocols and guidelines to meet the compliance plan so that the documentation will be in order the next time an inspector arrives unannounced at the home. Bill 140 makes compliance and reporting an absolute and does not give compliance advisers the ability to be reasonable in their interpretation. Therefore, one can only assume from this that it will drive more emphasis on providing documented proof when a facility, for example, is in non-compliance.

1020

Lastly, I'd like to touch upon the licensing scheme in the new legislation and lack of capital renewal commitment. The importance of clarifying this issue further

cannot be overemphasized as the current language in Bill 140 leaves a large degree of uncertainty for the renewal of licensing for B and C homes. Also, in the first round of development in Ontario, capital funding was announced and provided to promote the development of A-standard homes and to rebuild D homes. This legislation does not provide this certainty and in fact places more stress on the system in terms of financing of long-term-care homes and on families, residents and communities, wondering whether licences will be renewed. Residents and their families who reside in B and C homes deserve the same consideration and commitment that was given to other communities when the new long-term-care beds were built to the new design standards. There is no commitment to funding in the current legislation. Our families and residents deserve access to the same physical comforts as the government is helping to provide residents in new and recently rebuilt homes.

I encourage you to consider the presentation to this committee by the Ontario Long Term Care Association in the area of capital renewal and fixed-term licensing. Our association, I believe, has outlined reasonable solutions to these issues.

I'd like to thank this committee for the opportunity to speak this morning on this important piece of legislation that is going to form the foundation by which long-term-care services and care will be provided in Ontario for years to come.

I am confident and hopeful that the presentations you've heard in this community and will hear later on today and others across the province will not fall on deaf ears and that this process will only serve to improve Bill 140. I urge you to consider this submission.

The Acting Chair (Mr. Jeff Leal): Thanks very much, Mr. Clement. We have about two minutes remaining. On this rotation, I start with the parliamentary assistant.

Ms. Smith: We have heard very similar presentations and I have a number of issues with some of the things you said today, but I'll only focus in on a couple.

The OLTCA has put out the number of 2.5 hours per day of care. In fact, the government has said that its calculation is 2.86. Could you tell me what the OLTCA includes in its 2.5-hour calculation?

Mr. Clement: I can't speak for the OLTCA in terms of that calculation. My assumption would be, in terms of the 2.5, Ms. Smith, that it would include nursing care. That's my understanding.

Ms. Smith: How would you define "nursing care"?

Mr. Clement: My understanding in terms of how it's delineated is that it includes hands-on care as well as director of care, assistant director of care support and nursing administration support. The government as well as OLTCA collect that type of information, and my understanding is that those types of calculations are included in the 2.5.

Ms. Smith: Right. You pointed out, on the documentation front, some kind of extreme examples. Can you point to me in the legislation where the homes are required to print off and circulate on a daily basis the communication on zero tolerance or where a home is actually required to document—I don't know how you put it—every hour, I think, the restraint of a resident in a home? Can you point that section out to me?

Mr. Clement: I don't have the legislation in front of me, Ms. Smith, but I can tell you that the legislation is absolute in terms of how it's presented. My experience in long-term care has been, as I mentioned, 17 years, not just as an administrator but in different areas. I am familiar with the process that facilities must go through to meet compliance. Certainly, with this particular piece of legislation, it doesn't promote any leeway in terms of our ability to actually show compliance advisers, for example, our need to be in compliance. So ultimately we are placed in the position where it's process in nature. We do have to prove to compliance advisers quite frequently—

The Acting Chair: Thanks very much. I want to give Mr. Ouellette and Ms. Martel an opportunity. Mr. Ouellette, please.

Mr. Ouellette: Thank you for your presentation. I appreciate the 17 years' experience that you have directly in this field.

My question is going to be quite short. What do you feel the direct impact is going to be with the wording of "shall"? How do you think that's going to impact the sector that you work in?

Mr. Clement: As I've mentioned, over the years I've had an opportunity, Mr. Ouellette, to see layoffs in long-term care. I've seen the process in the system that we've worked in over the past 17 years.

Mr. Ouellette: Do you expect that to take place now?

Mr. Clement: Quite frankly, the process in which we operate currently, we could very well see layoffs in the long-term-care sector as we move forward into the spring. I guess my point is that the government has to commit to funding because of the requirements that have been set out by the legislation. I recognize that there have been some improvements in the funding, but the reality is that I've lived through layoffs; I've lived through having to address issues with family members and residents in that regard. It's not a good situation because we're all in this sector, in long-term care, because we want to provide the best possible care to our residents and to our family members. I believe the government should be committing to the funding because they are committing to the standards. All we're saying is that we want to commit to those standards too, but put the resources on paper as well.

The Acting Chair: Ms. Martel, please.

Ms. Martel: Thank you for your presentation today. Ms. Smith asked you to point to the section in the legislation that would have you handing out information to people who come into the home. Let me help you out. In section 75, it says:

"Every licensee of a long-term-care home shall ensure that persons who perform work at the home, but who are not mentioned in subsection 74(1), are provided with

information in writing dealing with the following before they commence performing work:

"1. The ... bill of rights.

"2. The long-term-care home's policy to promote zero tolerance of abuse....

"3. The duty under section 22 to make mandatory reports.

"4. Fire prevention and safety.

"5. Emergency and evacuation procedures.

"6. Any other areas provided for in the regulations."

What's interesting is, if you look at section 74, that refers to people who provide hands-on care. So that's essentially staff. The question is, is someone who comes in to fix an elevator, who doesn't provide hands-on care, a person you have to give all this information to? Is someone who comes in from Bell to fix somebody's phone someone you have to give all this information to? If you have someone doing some repair work, contract work, is that someone you have to give all this information to? If you have people putting cable in the home for a particular resident, is that someone? They're not providing direct hands-on care.

So frankly, you are right. Under section 75, anybody who performs work, who is not a staff person, has to get all this information before they commence work. I don't see how your home or any other home is going to be able to cope with that. What do you think?

Mr. Clement: I agree with you, Ms. Martel. As I mentioned, I don't have the legislation in front of me, and I appreciate you quoting that. Again, the legislation is absolute, and I've lived it the past 17 years. As you pointed out, we will have to provide that information. So I believe there are some issues around documentation that are quite evident in the legislation. It's clear, as you pointed out, that that's going to be onerous and it will take away from the hands-on care that we would be required by this legislation to provide. I appreciate you pointing that out.

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

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Acting Chair: I now call on John Van Beek of the Service Employees International Union, Local 1. Good morning, sir. You have 15 minutes, and any time left over will be reserved for questions.

Mr. John Van Beek: Thank you very much. I'm pinch-hitting for Cathy Carroll, our secretary-treasurer, who couldn't make it today.

I just want to thank the Chair and the members of the committee for allowing us to make a presentation again. Last Tuesday, Sharleen Stewart, our president, made a plea for 3.5 hours of care. In our brief, in the first half of that, you will notice that all of the Western world is setting a standard for care. The only place in the Western world where a care standard doesn't exist now is actually Ontario.

1030

Last Tuesday, the parliamentary assistant put out a number of 2.86 hours of care that the government claims each resident in the province is getting. I can't speak for the non-profit homes, I can't speak for the municipally run homes for the aged, but I can speak for the surveys that we have conducted in the private nursing home industry, of which we are the largest union, and there is absolutely no way, in terms of what the nursing care envelope presents or allows, that the care is 2.86 hours per resident per day.

My question to this committee, if I may—I think somebody's got to push this government, because the parliamentary assistant has been asking the question, "What do you think should be included in the 3.5 hours of care?" I want to know their methodology in terms of how they came up with the 2.86 hours of care. I think it's somewhat a deflection; it's somewhat spin. She threw out that number when we were in her riding in North Bay last fall, prior to the introduction of the bill. I think somehow the government is running scared in terms of being accountable to the people of Ontario. They made promises in the last campaign and haven't fulfilled any of them.

In any event, what I want to do today is the last part of our presentation, which is some amendments that we think are important that we didn't get to last Tuesday.

Let me start you off at page 26, the issue of residents' rights. There's a clear definition of abuse; in the act, it's defined as "physical, sexual, emotional, verbal or financial...." Nowhere in this bill is there a definition for "neglect of care." I think anywhere that abuse is mentioned, the definition should be extended to be defined also as neglect of care. It's something that staff don't have control over. The claim is that staff can now set up or help establish care plans and make decisions: No, they can't. They can only make decisions in terms of the financial resources that the home has or under the orders of the administration of that act.

I think one has to take a very serious look at abuse. Abuse clearly is a fist in the mouth, but abuse also is having a resident sit in a wet diaper until it's 80% wet. Abuse also is the fact that you can't help some resident with their toileting because two other bells are being rung. What happens if that resident falls off the toilet while the caregiver is attending to two other care bells? Is that abuse? And where does the abuse fall? It falls on the caregiver, right? A neglect of duty, I would think, because she couldn't attend to the needs of the person that she was toileting. So we suggest taking a serious look at what the definition of "abuse" is.

Also, just moving along in the presentation, one has to appoint an ombudsman. There is absolutely no choice. I think the American experience in terms of some of their ombudsmen spokespeople for residential care has worked tremendously well. It's clear in terms of their experience that the thing an ombudsman is most concerned about and that they get the most complaints about is, in essence, lack of care.

I don't think restraints have been addressed by very many people here. I think the issue of restraints in the act is good. The problem is with the chemical restraints. I have a suspicion that more and more chemical restraints are being used, simply in terms of taking a look at the number of drugs that are now being used in the nursing home sector. If you take a look at 2002-03 to 2005-06, drug costs have increased by about 70% over four years. I can't help but think that a lot of this is because more residents are being forced into a comatose state. I understand drugs have gone up and I understand that the population of nursing homes has gone up, but it doesn't account for the 70% total increase in drugs over that period.

Page 28: care and services. There is a provision for 24-hour RN care in the act—it's also under regulation now, in subsection 7(3)—but there's no provision for the number of RPN hours, PSW hours or health care aide hours. Clearly, what we demonstrated last Tuesday in our presentation was that in American jurisdictions there are ratios for an RN provision—for an LPN position, as they call RPNs in the United States—and also for personal support workers. The coroner's jury that looked at the Casa Verde deaths recommended 0.59 RN hours of care per day and 3.06 hours per resident per day for overall nursing and personal care. If you can have a standard for RNs, you can have a standard for the rest of the nursing staff.

Complaints procedure: We're not sure how this is going to work. Now you have a 1-800 number; you don't have an ombudsman. But does subsection 21(2), in terms of complaints being reported to the licensee, eliminate the 1-800 number? It may well.

Whistle-blowing protection: Section 24 is an excellent provision; I think the legislation, really, is limiting in terms of enforcement. It's going to be terribly difficult to encourage the reporting of abuse, particularly when abuse may be difficult to ascertain in terms of a legal context and when abuse really is a one-on-one situation, for which it is very difficult to obtain witnesses.

Staffing: section 72. We recommend that you amend that section to read, "That in order to provide a stable and consistent workforce and to improve the continuity of care to residents, every licensee of a long-term-care home shall ensure there is a staffing ratio of not less than 70% full time to 30% part time." That gives some continuity of care to the residents and eliminates, to some degree, the agency staff and that sort of thing. As a matter of fact, we would recommend no agency staff whatsoever. Then, of course, you add to that section that nursing care shall not fall below 3.5 hours of care per resident per day.

Page 31: training. We strongly believe in the issue that staff need to be better trained in terms of the kinds of illnesses and cognitive impairments that exist in nursing homes today.

The least we can do is elevate the certification level of a PSW. Again, the coroner's jury recommended that health care aides and PSWs have a governing body and that training in psychogeriatric aggressive behaviours should be implemented.

Quality management: Here's where it gets sticky, I think, between the for-profits and the non-profits. There is no enhancement in this act in terms of promoting the non-profit sector. Clearly, if they're going to compete with the large corporations that exist in our industry today, I think it behooves the government to provide some kind of training for boards of directors, particularly in terms of what their responsibilities are.

Funding is a major issue. We've heard from all kinds of long-term-care presentations over the course of the last week in terms of how the industry is underfunded, and we would agree. The problem is that all they're calling for is public money to enhance facilities, which will indeed enhance their bottom line in terms of the value of their property. I haven't heard them talk very much about care at all.

1040

When you take a look at Extendicare, which just the day after the federal legislation on income trusts turned itself into an income trust, when you take a look at some of the examples we provide in the brief, when you take a look at Macquarie Power corporation, which runs hydro-electric projects along with nursing homes and is basically an international finance bank, when you look at all of these kinds of people—residence income trusts, REITs—in the industry, what they're interested in is making a profit for their shareholders, and they're really interested in not paying tax at all. It's my money, it's your money and the Ontario taxpayers' money that's going to that. I'll give you some examples and, to be fair, not all of their money is made in Ontario. But the fact is that there's severe leakage in terms of Ontario taxpayer money going to for-profit as opposed to direct resident care.

We really do suggest that there must be a provision in this act that encourages the non-profit sector. I think that only in terms of issuing further licences, only where there is not a legitimate non-profit operator in a specific geographic area, should one consider a private operator's ability to bid on the licence in that area.

A number of other issues throughout the act: I think clearly, in terms of penalties, we need a very strong commitment from this committee that we won't, and this government won't, tolerate the kinds of abuses that happened in terms of Royal Crest Lifecare, where the Martino brothers basically ripped off millions and millions of dollars from Ontario taxpayers, didn't provide care, and the ministry never stepped in. We were able to resolve those issues as a union. Nevertheless, it was a big blow to the Ontario taxpayer. Those kinds of people should not exist in our nursing home industry in Ontario. We suggest that the fines must be very heavy in terms of for-profit corporations and their corporate directors. If you'll notice, there have to be criminal checks on the staff and everything else, but I don't notice anything in this legislation where there are criminal background checks on the directors of corporations that run the Extendicare, the Macquarie Power retirement residence REITs and that sort of thing.

Thanks. That's our presentation. I hope you'll have a serious look at our recommendations.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, AREA 6

The Vice-Chair: We'll move to the next presentation, which will be by the Canadian Union of Public Employees, Area 6. Welcome again, manifold talent. You can start whenever you're ready.

Ms. Denise Lavoie: Good morning. I would like to thank the committee for allowing me to speak at this hearing on a subject that is so near and dear to my heart. My name is Denise Lavoie. I have been working in a long-term-care institution, York Extendicare Sudbury, for the last 27 years as a health care aide. I am also the vice-president of CUPE 1182 and currently hold the position of Area 6 representative on the CUPE Ontario health care workers coordinating committee.

A minimum standard of 3.5 hours of care is essential to the well-being of those we are entrusted to care for. Currently there are simply not enough hands to care for the residents' daily needs with the dignity and respect they deserve. I'm not saying that they are not getting excellent care; they are, within the confines of the time allotted for tasks. And that is where the problem lies.

Because we have been task-oriented, the human factor has been minimized. Our seniors have all been hard-working individuals, giving us what we have today and making our future possible. Is it now fair to put them on the sidelines and make them wait daily for assistance with such simple tasks as eating or going to the washroom? I personally feel that we do not treat our seniors the way we should. Let's not forget that we may all be in the same position; we cannot guarantee or predict our physical or mental well-being as we age.

The current funding system is inadequate and the current legislation does not have minimum staffing levels. CMI, or case mix index, is a snapshot of a resident at a particular time based on documentation, and documentation only. There is no human factor attached to this system. We, the long-term-care workers, often are the family of those we care for; after all, we are the ones they see the most. We form bonds with our residents and families; after all, they trust us to care and protect their spouses, mothers, fathers, siblings and sometimes their children. Those without families are especially vulnerable and in need of extra care. We are usually there to see to the end of their life. We want it to be dignified and pain-free. And, most importantly, no one should die alone; there is nothing sadder. We go to great lengths to know someone was there with them when they passed. We take great lengths to make sure that this does not happen. We have staff who give up their breaks and come in on their own time to ensure that they are not alone. We are affected by a resident's passing. They do become part of our lives and hearts. I think this is why so many of us stay regardless of the hard work. We are their advocates.

In a 24-hour period, our staffing level, when we're fully staffed by RNs, RPNs and health care aides, is at 2.3 hours of care per resident per day. Those 2.3 hours of care are from all the nursing disciplines stated above. Looking at the normal staffing levels for a health care aide, we have 96 minutes to provide the basic necessities of life in a 24-hour period per resident. They totally depend on us for every single need physically, emotionally and socially. This would include the serving of and assistance with three meals; three nourishment passes; assistance with the toilet or brief changes; baths, which the MOH has stated should be offered twice a week—shameful; how often do you shower or bathe?—assistance with ambulating, lying down, preparing for the day and preparing for bed; and assistance with repositioning and exercise, to name a few. It is not only a challenge but often an impossible task that leaves us drained both physically and emotionally.

On a normal day shift we have anywhere from eight to 12 residents to prepare for breakfast in one and a half hours. This equates to seven and a half minutes to 11 minutes per person. Many of these individuals require extensive assistance. Residents are being admitted with more complex care needs than in the past. This is in part due to the push to keep people in the community longer. So when they come to us, they need more help than in past years. Several residents are confused and have some form of dementia and require extra time to prevent agitation and aggression.

In addition to looking after the residents' immediate needs, we are expected to attend MOH-required in-services, facility in-services and education all within our regular shifts, and we are expected to care for the residents' necessities of life. Funding for staffing levels relies on daily documentation, which can take up 30 minutes or more per shift depending on the behaviour charting needed on any given day. This again cuts into the actual hands-on care time given to the residents.

The issue of violence in the workplace is something that is commonplace. In the instance of those with Alzheimer's or dementia, we are forgiving and understanding. After being in the industry so long, we tend to normalize or accept as part of the job being scratched, pinched or struck by the frail, confused elderly. I know it isn't right, but it does happen. We cannot, however, condone or accept some of the behaviours that are becoming the norm in many institutions. In the last few years, the demographics in nursing homes have changed. We are having to admit younger people with mental disorders, dementia, addictions and resulting behaviours, acquired brain injuries and other disabilities. We also have a percentage of the developmentally challenged residents who are aging and need specialized care. We do not have the facilities to deal with these residents. Previously, we could depend on psychiatric hospitals to house these residents, but they are being closed. These people have the right to be cared for as well or they will be on the streets trying to fend for themselves or end up in the court systems. We do not use physical restraints in our

facility, regardless of the behaviour exhibited. It becomes our job to monitor their actions. We have to institute a "code white" in our home to alert staff that assistance is needed until an aggressive or violent resident calms down or the police arrive to assist in dealing with the situation.

1050

The elderly—confused or aware—should not be exposed to this risk. Special training and expert units are needed to protect the rights of others, and by this I do not only mean the staff. It is also our duty at this time to ensure the safety of the elderly in our care and keep them out of harm's way. We have to be the eyes and ears for those who, in their confusion, cannot remove themselves from a potentially dangerous situation or who may potentially cause the situation to escalate. Sometimes the confused resident is the trigger for an episode. Specialized units would help a great deal in creating a safe and secure environment for our seniors.

As for the safety of the staff, as recently as last Thursday a staff member was punched in the jaw by a resident who falls within this category.

As of the latest budget, Public Interest Alberta and the Capital Health Authority report that funding is at 3.6 hours in that province. The Liberal Party of New Brunswick recently won an election with a pledge to phase in a minimum standard of 3.5 hours by 2008. Nova Scotia is increasing their previous 2.25 hours to 3.25 hours. Saskatchewan was at 3.1 hours in 2001, as reported by PricewaterhouseCoopers.

There is only one way to ensure that the quality of life for seniors is upheld, and that is to make certain that our residents receive a minimum of 3.5 or more hours of care each day, and in doing so, to provide adequate funding for required front-line staffing. Residents' care suffers because there is not enough staff in many homes and the number of hours allotted to care is simply not enough.

Our province is supposed to be the leading province in this great country of ours, yet it will not meet the needs of our aged in their time of need. I simply cannot understand this reasoning. Why is it so difficult to agree to treat our senior Ontarians with respect and dignity?

I would also like to add a little blurb here. I overheard one of my co-workers state, "We do not have enough time and hands to take care of the living. How are we supposed to find the time to care for the dying?"

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

Ms. Martel: Thank you very much for your presentation. I want to focus on page 3, where you say that specialized units would help to create a safe and secure environment for all our seniors. This was with respect to residents with violent behaviours.

As a result of the Casa Verde inquest—it was an inquest into the death of two residents at the hands of another resident in a long-term-care home—one of the 85 recommendations that was made was that individuals who exhibit or who are prone to aggression be placed in specialized facilities or long-term-care facilities with specialty units, and further, that if the decision is made to place these individuals in a long-term-care home, then the Ministry of Health "must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self and others." Unfortunately, the ministry's response has been that they are only considering these recommendations.

I think that more and more homes are having residents come into them who are violent, who are prone to aggressive behaviour, and very little is being done to respond to that. What do you think about that recommendation, and can you give us any other idea of what's happening in your own home with respect to code whites, which clearly point out a need to start to deal with this situation?

Ms. Lavoie: We definitely need a place for these people to go, and I don't think a nursing home is the place for them. I think we do need specialized places for them to go to. They shouldn't be integrated with the frail and elderly. They should have a place of their own.

Ms. Martel: How many times is there a code white?

Ms. Lavoie: Lately, almost on a daily basis.

Ms. Martel: So a code white is to alert staff that assistance is needed because you've got an aggressive or violent resident or that police are arriving?

Ms. Lavoie: Yes. That has happened quite a few times.

Ms. Martel: How many times did the police arrive?

Ms. Lavoie: She works on that unit, so I'll let Valerie answer that.

The Vice-Chair: Please state your name before you start.

Ms. Valerie Trudeau: Valerie Trudeau. We have just instituted the code white in the last month. It has been called once over the PA since I've been there, but we do have instances of a few residents who require one-on-one supervision. The employer has applied to the ministry for specialized funding in order to have the one-on-one supervision. Unfortunately, we don't always have the staff to do that.

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

Mr. Leal: Thank you for your detailed presentation. I want to ask a question concerning the 3.5 hours. Earlier this morning we heard from Ms. Graham, who works in Kirkland Lake, indicating that from her perspective, the component parts of the 3.5 hours should be RPN, PSW and a portion for administration. I'd like to hear your thoughts on what component parts should be in those 3.5 hours.

Ms. Lavoie: I think it should mainly be on the PSWs and health care aides because we are the front-line workers; we are the ones providing direct care, and for the RPNs, because in our facility on the afternoon and night shift, one RPN takes care of 58 residents for their

medical needs, dressings, emergencies that arise; and it's just simply not enough. These are supposed to be their golden years where they're supposed to be well taken care of. You shouldn't have to rush a 96-year-old person, and you shouldn't have to drag them out of bed. They're supposed to be retired.

Mr. Leal: So from your view and your experience as a front-line worker, you wouldn't have an administrative component in that 3.5 hours?

Ms. Lavoie: I don't think so. The RNs do play an important role in a nursing home, of course they do, but we are the ones that do the direct care.

Mr. Leal: If I could just ask one further question, if I have time, Mr. Chair.

The Vice-Chair: Yes, go ahead.

Mr. Leal: I just want to follow up. I was interested, and I'm not sure I heard it: Your code white approach to dealing with a resident who exhibits aggressive behaviour—I was wondering how many times police were actually involved to calm or take appropriate action from that angle to deal with an aggressive—

Ms. Lavoie: To my knowledge—I've been at the home when this happened—at least three times in the last month.

Mr. Leal: Does the Sudbury police force have special training for their officers who might be involved in a response to a code white situation?

Ms. Lavoie: I really don't know.

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

Mr. Ouellette: Thank you very much for your presentation. I have a sister who works as a PSW, and when I mentioned the abuse part of the legislation, she was so thankful that something was coming forward to deal with the actual workers in the field. How do you think the restraint policy is going to affect that relationship with the workers and how they are going to be dealt with by individuals who are, shall we say, less restrained?

Ms. Lavoie: I don't believe in restraints unless there is no other way to do it. I just don't think that the potentially violent people should be integrated with the elderly.

Mr. Ouellette: So how do you take care of them or what steps do you move forward with to address this issue?

Ms. Lavoie: Your approach does mean a lot, up to a point. We don't have the time to take the time to be gentle and try to approach slowly. We don't have the time. If we had more staffing, maybe the aggressiveness level would be lower because we would have the time to deal with this properly.

Mr. Ouellette: So the end result would be what in this particular case as it moves forward as legislation the way it's laid out? What do you expect to see within the facilities then?

Ms. Lavoie: I would like to see the minimum standards up to at least 3.5 so that we, like I say, can deal with these situations in a more timely manner without having to rush anybody, because when you rush people, you do escalate the potential for violence.

Mr. Ouellette: I would imagine that in situations like that where they're not separated into other facilities, that the time—for example, 10 people at 3.5 would be 35 hours effectively—those individuals would demand a lot more time and that would take away from the time the other individuals should be receiving.

Mr. Brian Blakeley: Brian Blakeley with CUPE research. One thing that we need to be careful about is that these individuals being accommodated in long-term-care facilities is not new; it has been going on for a long time. I think you've heard in this presentation and in previous presentations that the response to it needs to be assessment of the individuals and staffing to meet the needs of each individual in the facility. So, as in the school boards with educational assistants, there are individuals in school systems who require one-on-one staffing; there are individuals in school systems who require one-on-20 staffing. It's the funding issue and the 3.5 and the assessment of needs that we think need to be addressed more clearly.

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

1100

TEMISKAMING LODGE

The Vice-Chair: Next will be Temiskaming Lodge. Welcome.

Ms. Elizabeth Brownlee: Thank you. May I go ahead?

The Vice-Chair: Yes.

Ms. Brownlee: Members of the standing committee on social policy, fellow speakers and guests, good morning. My name is Elizabeth Brownlee. I am the administrator of Temiskaming Lodge in Haileybury and currently an acting care services coordinator with our parent company, Jarlette Health Services. I have worked in long-term care for over 15 years of my nursing career and have also held the positions of charge nurse and director of resident care. I am involved with others in attempting to address the health care needs in our community, including LHINs and the Dementia Network in the district of Temiskaming.

Another perspective that I bring to this table is that of being a family member of a long-term-care resident for the past year. I must tell you that this experience provides much clarity to my official role of administrator. It has also provided me with invaluable insight into what it is like for our residents and family members to navigate and function within the context of our long-term-care system.

Temiskaming Lodge is a 25-year-old B facility which is home to 80 special people who require and deserve the best-quality care that we are able to provide. Temiskaming Lodge is employer to 83 caring and committed team members who will tell you that they proudly provide that quality care.

Today I am before you to explain how Bill 140, as it stands, will affect our residents and their home. I hope that the few minutes I have with you will bring you to their bedside and their reality, because, as always, this is about the residents whom we collectively serve.

First, please allow me to set the stage by attempting to paint a picture of the day-to-day realities of life in our home.

Repeatedly, the key issue for our residents and their families is that there is a need for increased staffing levels or more hands available to provide efficient and timely care. This issue is not new, and we are all acutely aware of how care levels in Ontario are below those of many other Canadian provinces.

In our home, and I am positive that I can say "in all our homes," we continually monitor that call bells do not ring for more than a few minutes. However, when staff available are already occupied providing personal care to other residents who may require two or more staff to meet their needs, it is difficult, if not impossible, to attend quickly. Residents and family members will tell you that the staff members in our homes are always on the run. They see their care providers called away from one task to attend to the needs of another time after time. This leaves some residents hesitant to ask for the help that they need and simply does not allow for much of the non-care-related interaction that they crave and deserve. The outcome is sometimes injury from attempted self-transfers, as well as loneliness. This price is too high.

It is upsetting for families to see unmade beds in their loved ones' rooms in the early afternoon, and frustrating for staff to have to explain that the trade-off was that everyone was provided with toileting and changing after lunch—such a basic need. Increased levels of care would not only help us to take better care of our residents but they would help family members to feel confident and reinforce that their loved ones are receiving the care that they want them to have.

This rush and the feeling that there is never enough time is very difficult for our workers, who went into health care to make a difference. The current paucity of health human resources in Ontario and the difficulty recruiting to long-term care means that we not only have to retain our workers but we have to allow their jobs to be rewarding. If we can improve this sense of job satisfaction, we will be able to increase the numbers of personal support workers and nurses, particularly those who want to work in long-term care.

A compounding issue related to unacceptable levels of care is that of safety. When our care providers feel rushed, they are more prone to working in a hurried and unsafe manner, increasing the potential of workplace injuries. Recent funding initiatives to increase the number of mechanical lifts in our homes indicate government's responsiveness to the issue of workplace injuries. I ask you to consider the negative impact on safety for care providers who work under constant pressure to hurry.

There are several aspects of Bill 140 that have the potential to impact on resident care and cause us concern. The concerns that I would like to highlight include increased emphasis on paperwork, increased regulation around internal processes, and issues impacted by licensing.

Paperwork is a concern for us as we have had huge increases in the documentation that we are required to maintain. An example would be the numerous detailed assessments required within hours of admission, such as continence, head-to-toe and pain assessments. While some of this paperwork is important to resident care, it does take us away from the residents and family members who need our interaction and support.

Ensuring that every person who does work in our home has received a copy of our abuse policy is not realistic. Meeting this requirement would mean that an emergency worker, such as an ambulance attendant, would be obligated to have a copy of our abuse policy prior to providing care to a resident. It would increase the time that we spend making copies of our abuse policy and ensuring that we have created a paper trail as evidence. We already spend much time and energy creating awareness and educating about abuse, as we appreciate that the safety and security of our residents is paramount.

Another issue with paperwork is about the number of official documents that we will be required to post on our walls. In our home, we strive to provide a home-like setting that is warm and inviting. Posting a plethora of documents will be a challenge. Smaller homes like ours will have difficulty finding wall space that doesn't compromise the feeling of home that we have worked so hard to achieve.

Currently, we have a policy of "least restraint" in our home, and if we do have a restraint, hourly checks and documentation are required, as well as regular, detailed assessments. Bill 140 proposes to redefine restraint to include the magnetic locks on our doors as perimeter restraints to residents who are unable to manage the code. This would require us to complete detailed assessments and hourly documentation on approximately 60 residents each day. The result would be hours and hours of time spent checking on residents and documenting restraints—time that we simply do not have.

Paperwork is vital to what we do, and our residents do benefit from this evidence of our accountability. However, it is important to keep the amount of time and energy spent on paperwork relative to the time spent providing care in perspective. We must also remain cognizant of keeping our homes looking like homes.

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It is disappointing that Bill 140 does not provide assurance of assistance with capital renewal for our remaining B and C homes. We, along with our residents and their families, have looked forward to having the same amenities as those who now reside in newer homes: more privacy, smaller home areas, smaller dining rooms etc.

Temiskaming Lodge is a B facility and over half of our residents are in four-bed or ward rooms. This frequently poses difficulties with not only compatibility

between personalities but also with providing for individual needs. Residents with no cognitive impairment find themselves sharing their bedroom with other residents who are very confused. These confused residents unintentionally invade the personal space of others and often have rummaging behaviours. Altercations between residents can be verbally or physically aggressive and require staff intervention. Residents find themselves with roommates who are restless at night or require frequent care from staff, which causes noise and disrupts their sleep. New facilities no longer have these four-bed wards, which helps to limit issues and promotes feelings of safety and security for our residents—safety and security, which are so important to the elderly.

The other disadvantage of older homes is that we do not have smaller dining rooms as are now the standard. Instead of a maximum of 32, we have 80 residents dining together in one large room. There is often noise and disruption at meal times and it is difficult to accommodate increasing amounts of equipment. Some residents have physical or emotional needs that result in upsetting behaviours, while some residents have negative reactions to the busyness of this setting. This makes the provision of a positive dining experience quite a challenge for staff.

Government has not rendered a commitment with Bill 140 that our home would be eligible for assistance with capital renewal as there has been for new homes or those that required rebuilding to meet current standards. We remain hopeful that you will ensure that our residents in older facilities have access to the same amenities as those in new and rebuilt homes. This challenge is particularly relevant for smaller northern and/or rural homes, and we ask you to show that you have not forgotten us by committing to a capital renewal program.

The issues around licensing affect all homes, particularly homes in the north such as ours. While operators have attempted to manage the fears of residents and staff in understanding what the legislation says, it is impossible to be reassured about the future with the existing wording in the bill. This wording leaves them wondering if the government will decide to close their home; take away some of their beds; ask them to rebuild or renovate without the capital renewal program or certainty over their operating licences required to make this happen; or, indeed, do nothing at all and leave us still struggling to address the issues I just outlined over the next 10 years or more.

This is too much uncertainty in the face of our current challenges. It provides us with no comfort that either the quantity or quality of long-term-care services will be there in our community to meet the increasing need.

The owner of our home needs more reassurance and more information to be able to make sound business plans for the future of Temiskaming Lodge. Our owner takes pride in running high-quality homes and deserves this commitment to be recognized.

Members of the standing committee, I thank you for the opportunity to share with you this morning the realities of the residents and staff of Temiskaming Lodge. As an experienced long-term-care manager and the granddaughter of a long-term-care resident, I hope that this committee will support the detailed amendments that the Ontario Long Term Care Association has submitted.

The mission of Jarlette Health Services is to "Make an Outstanding Difference in the Lives of Others." I hope that you embrace this opportunity as a committee to do the same.

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

LINDA EVES

The Vice-Chair: Next will be Linda Eves. Linda, to my knowledge, you're not representing Leisureworld Caregiving Centre, are you?

Ms. Linda Eves: I'm not presenting for Leisureworld, no.

The Vice-Chair: You're representing yourself.

Ms. Eves: Yes. Good morning to the committee and everyone present. Margaret Mather, who was to present with me today, was called away on a family emergency. She sends her apologies to the committee. If I may, I'll begin my presentation. Actually, it's our presentation, so you may hear "we" instead of "I."

We—Margaret Mather and myself—are both employed at Leisureworld Caregiving Centre in North Bay. We would like to state that we are not here today to represent Leisureworld, but to present our concerns on Bill 140 as both front-line health care workers and members of Service Employees International Union, Local 1.

Let me begin by saying that, in our humble opinion, Bill 140 does nothing for seniors in long-term-care facilities. Inadequate funding means less care can be given to each individual resident—care that each resident deserves in their golden years.

My colleague and I have been employed at Leisureworld in North Bay for a combined period of 38 years. Our residents have experienced favourable care, but the lack of sufficient staff on the floor means the level of care deteriorates. It cannot be overstated that certain residents require considerably more care than others. Currently, we have 148 residents in our home. The total amount of nursing and personal care, with HCA/PSW and RPN hours factored in, is approximately 1.89 hours per day. The Ontario Liberals committed to reinstating the 2.25-hour standard of care that was removed by the Harris government in 1996. This has not been done.

As front-line workers, we are the eyes and the ears of the long-term-care system. We see the need for more staffing so our residents can have the quality of care they deserve, as opposed to the rushed atmosphere present funding levels provide. In our home we have 57 residents on one floor, with five health care aides. Our shift begins at 6:30 a.m. From 9 to 11:30 a.m., one health care aide assists the bath person to do 10 baths, leaving four staff to answer bells, attend to personal needs, make beds, do morning nourishments etc.

Often, there are two or more call bells ringing at one time, and it is impossible to meet resident demands

immediately. The very ill and palliative care residents require more attention from staff. At meal time, one staff may be required to feed two residents, and after the meal the routine is reversed: helping people to bed, attending to their personal needs and charting, which, for the health care aides and PSWs, takes up to 45 minutes—time taken away from the resident.

The present funding formula, the case mix measure, CMM, which determines the case mix index, CMI, does not always reflect resident intervention or activities, due to a lack of time to complete a shift's charting.

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Unrecorded incidents will drive the CMI down, regardless of the changes in resident care or population. Now a new formula has emerged and the ministry claims the new RAI will be the basis of future improvements to the funding system. This would be wonderful; however, if the staff cannot complete the increased charting, then both the funding and the care will continue to suffer. Nothing will change.

Service Employees International Union, Local 1, states this will not be enough to maintain the level of care for each individual. Residents deserve a minimum standard of 3.5 hours per day of nursing and personal care. This must be implemented by the government in Bill 140.

For our members, Bill 140 is a seriously flawed piece of legislation, bordering on a tragedy in a province such as ours. It is a betrayal of the wishes and needs of our seniors and families who have members in these facilities.

Bill 140 outlines the residents' bill of rights, numbers 1, 3 and 4, as follows:

"1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity....

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

"4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs."

However, it falls short by not providing a set standard of care that will go a long way to ensuring that these rights, as outlined, can be met. Only the government can rectify the situation. And we respectfully request that this government heed the concerns of dedicated employees of the nursing homes, the residents and their families by incorporating a 3.5 hours per resident per day standard of care in Bill 140.

Thank you for the opportunity of appearing before the committee on social policy to share our concerns.

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

Ms. Smith: Thanks from coming from the Bay.

Ms. Eves: You're welcome.

Ms. Smith: Nice to see you.

Ms. Eves: Nice to see you.

Ms. Smith: I was at Leisureworld not that long ago having a big dinner downstairs; it was great. I know the great work that you do there and what a good home it is.

I wanted to ask you about your calculation. In your presentation, you talk about the hours per day and you talk about your particular—I think that number, 1.89, is Leisureworld North Bay.

Ms. Eves: Yes, it is.

Ms. Smith: Who calculated that number?

Ms. Eves: I did, and it could very well be wrong.

Ms. Smith: Okay. We've done provincial numbers and our average is about 2.86.

Ms. Eves: My math skills are not great.

Ms. Smith: I was just wondering, how did you come up with that calculation? What did you include in that?

Ms. Eves: All the health care aide hours. We have three floors within our building; we call them cares 1, 2 and 3. The health care aides on each shift; it also included the bath people, which we have; RPNs. We have a float RPN and we also have a treatment RPN. The RN hours were not factored into that. Then I just divided it by the number of residents we have in the building, which is 148.

Ms. Smith: And you didn't include dietary aides or activity people?

Ms. Eves: No, I did not. It was strictly nursing.

Ms. Smith: In calculating the 3.5 that you're advocating for, that you'd like to see implemented, would you include the health care aides, the RPNs and the bath people?

Ms. Eves: Yes.

Ms. Smith: You wouldn't include the RNs or any other people who are involved in the care of the residents?

Ms. Eves: I think the RNs have a very important role within the nursing homes. They give us guidance; they certainly do the care plans.

Ms. Smith: So they are involved in the assessment of the residents.

Ms. Eves: Most definitely.

Ms. Smith: Do you call on your RNs when you have a problem?

Ms. Eves: Yes.

Ms. Smith: So they are involved in the care?

Ms. Eves: They're very supportive.

Ms. Smith: But you still wouldn't include them in the 3.5.

Ms. Eves: Well, I didn't with this.

Ms. Smith: But generally speaking—

Ms. Eves: No, I'm selfish, as I heard earlier. I think we need the direct hands-on care for the residents.

Ms. Smith: Okay. I really appreciate you coming. I'm glad that the weather wasn't too bad this morning.

Ms. Eves: Not too bad. North Bay was a little worse than here.

The Vice-Chair: Mr. Ouellette. Two minutes.

Mr. Ouellette: Thank you for your presentation. To continue on the 3.5, the more we hear about the details, I

find that setting a fixed number for individuals will be very complex to do. We have such complex and detailed requirements by individuals. I think some individuals may require more. You stated that some require two to do certain things and some would require less. The end result is that we would end up robbing Peter to pay Paul, so to speak, as took place, as other presenters have said, when the nursing envelope was used for various aspects.

Do you think that an in-depth assessment would be a far better way to determine individual needs, to move forward with ensuring the quality of care? What I think is going to happen is that if it were moved to 3.5, all of a sudden administration would be thrown in there. They would be doing the same thing and they would find ways to justify it, but the individual would be the one who ends up losing.

Ms. Eves: Wouldn't that be accountability on the part of the nursing home?

Mr. Ouellette: I would hope so.

Ms. Eves: If it is 3.5 hours, that they are accountable to the government for staffing 3.5 hours of hands-on care?

Mr. Ouellette: Right.

Ms. Eves: And that additional areas are not sort of hidden and thrown in? Am I understanding properly?

Mr. Ouellette: Exactly what you said about hands-on care: What is the definition of hands-on care and how do you break down the difference? Individual assessment, a far more in-depth assessment to determine the individual's care levels, would probably have a much greater impact.

Ms. Eves: As I mentioned earlier, the RAI has emerged, which is resident assessment instrument. I'm not really totally involved with that other than our initial charting, which we must do per shift, which does take considerable time, up to three quarters of an hour per staff, per shift, which is taken out of the resident time.

The Vice-Chair: Ms. Martel.

Ms. Martel: I apologize for being out of the room, but I've had a chance to look at the brief and I wanted to ask you some questions. First of all, thank you for being here, because you've had to travel as well.

I guess regardless of what assessment you use, what the tool is, if you discover that residents need more care, then you have to fund the staff to provide that care. In the last election, the Liberals said that they would provide $6,000 more for each resident for direct care, for enhanced care. So far, they've delivered on only $2,000 of that, or about one third. So they've got a long way to go. My sense is that if they actually funded the $6,000 per resident, we would be in a position to meet the needs of residents, no matter what tool we're using for assessment.

If you look in your home and describe some of what's going on, what kind of changes could you make directly to the residents you're trying to care for if you actually had more time and if there were actually more staff, to have the hands to meet the needs of those people you're trying to help?

Ms. Eves: I could see applying nail polish, doing hair—simple things. If residents are unable to afford the hairdresser in the facility, then we would have that extra time. A lot of our residents—or makeup. They wore lipstick. We don't have the time now to meet those needs that maybe they want.

Do we have time to sit and hug someone if they're crying and having a bad day, like we often have? Sometimes they just need a little extra hug, an assurance that everything will be fine and, "I can stay with you. I don't have to run away right away and answer that bell." Their needs have to be met too and it does become frustrating.

Ms. Martel: For you and for them.

Ms. Eves: For everyone.

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

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SOCIÉTÉ ALZHEIMER SOCIETY SUDBURY-MANITOULIN

The Vice-Chair: We'll move to the next presentation, which would be by Société Alzheimer Society Sudbury-Manitoulin.

Welcome. You can start any time you are ready.

Ms. Patricia Montpetit: Mr. Chairman, members of the standing committee on social policy, thank you for this opportunity to discuss Bill 140. My name is Patricia Montpetit and I am the executive director of the Société Alzheimer Society Sudbury-Manitoulin. With me is Janet Bradley, the past president of our chapter's board of directors.

The Société Alzheimer Society Sudbury-Manitoulin was incorporated in 1985. Our mission is to alleviate the personal and social consequences of Alzheimer's disease and related dementias and to promote research. We strive to improve the quality of life for our clients, their families and caregivers through support services, education and advocacy.

One service of the Sudbury-Manitoulin chapter worth highlighting is our adult day program. Client activities happen in a homey setting under the supervision of professional staff who are equipped with the education and experience necessary to care for those with memory loss. However, the day program is but one of many services we provide, including in-home respite, a wandering person registry, supportive counselling, health teaching, support groups, a resource centre stocked with educational books and videos, newsletters and research funding. We also provide education and training regarding dementia care to staff members at long-term-care facilities, retirement homes and community agencies.

Four objectives unite these different programs. The first is to maintain the person with Alzheimer's disease and related dementias in the community for as long as possible. The second is to provide respite for the caregiver of the client. The third is to stimulate, protect and comfort the person with dementia. Fourth is to teach,

train and counsel Alzheimer caregivers, including front-line staff of long-term-care facilities.

Demographics indicate that there currently are 2,650 individuals with Alzheimer's disease or a related dementia in the Sudbury and Manitoulin districts. In the next 25 years, this number will rise to almost 5,000 individuals. Most of these people will spend the final years of their lives in a long-term-care home.

In 1998, the Société Alzheimer Society Sudbury-Manitoulin demonstrated its commitment to the importance of a continuum of geriatric services. In collaboration with Pioneer Manor, the city of Greater Sudbury's long-term-care facility, municipal and provincial political representatives and various community agencies and hospitals, the Alzheimer Society subscribed to the vision of a seniors' campus on the grounds of Pioneer Manor. What makes this seniors' campus so unique is its inclusion of a memory assessment network, applied research, redeveloped long-term-care beds and an expanded Alzheimer day centre. Future plans are for a supportive housing component and short-stay respite beds.

In 2002, our board of directors launched a capital campaign to raise $2.1 million to build the new Alzheimer centre. Last year, we finally reached our goal and began construction to renovate 10,000 square feet of space in a vacated older section of Pioneer Manor. We moved into our lovely new centre last summer.

Having painted Sudbury's long-term care in broad strokes, I now turn to the finer points of Bill 140. There are several recommendations to Bill 140 that we believe, if implemented, will improve the proposed legislation and further protect the rights of long-term-care residents.

Section 27, "Minimizing of restraining": The inclusion in Bill 140 that each facility be required to have a policy designed to minimize the use of restraints is commendable. To ensure that the minimizing of restraining can be accomplished requires further staff training to use various programs that do minimize the need for restraints. Program possibilities include the Gentle Persuasive Approach and U-First, two programs based on the principle of person-centred care for dementia patients. In Sudbury and Manitoulin, specialized training is offered through the local Alzheimer Society chapter to the staff of all long-term-care facilities.

Subsection 74(6), "Additional training—direct care staff": Although we commend the bill's provision on training, an amendment should be included to incorporate management staff as well. Furthermore, it is imperative that front-line staff be granted paid time to undergo training without being simultaneously responsible for patient care. While the Alzheimer Society gladly provides advanced training to local long-term-care staff, our efforts are undermined by the 20-minute slots we are sporadically allotted. During these sessions, the staff member is distracted by her care commitments, with insufficient time given for proper training even under ideal conditions.

Subsection 24(1), "Whistle-blowing protection": While the whistle-blower section is particularly important, it is imperative that an amendment be made assuring that the whistle-blower is protected from retribution.

Section 35, "Office of the Long-Term Care Homes Resident and Family Adviser": The role of the resident and family adviser is not well defined and should be expanded on and clarified in the bill. The role of this office in relation to residents with Alzheimer disease and related dementias will be especially important in light of their often limited capacity for comprehension. In our opinion, this office should provide its annual report to the Legislature as well as to the Minister of Health and Long-Term Care.

Behavioural assessment units: We recommend that a small behavioural assessment unit be established in at least one long-term-care facility in each region, modelled on those already in operation in St. Catharines, Hamilton and Kitchener. Such units would do much to reduce the likelihood of severe aggressive behaviour.

We applaud the expansion of long-term-care facilities in Sudbury to include 96 additional beds. However, our most pressing concern remains an insufficient long-term-care capacity, especially in northern Ontario. In its absence, individuals occupy more costly acute-care hospital beds while awaiting admission to a long-term-care facility. Aside from the financial burden this imposes, we know that people with Alzheimer's disease handle change with greater difficulty than the normal population. To have them languishing in the hospital for long periods is counterproductive, not least because they will be forced to readjust again when finally admitted into long-term care. To combat this problem, we recommend that fast-tracking be introduced to expedite the transfer of hospital patients with dementia who are long-term-care applicants.

We also advise more short-stay beds for people with dementia, as well as more community-based home care, in-home respite and adult day programs in order to help keep people with dementia out of hospitals and long-term-care facilities for as long as possible.

Before concluding, Mr. Chairman, it cannot be emphasized enough that quality care demands adequate resources to enable the success of front-line workers. While Ontario may surpass other provinces in terms of policy progression, without the necessary funding, Ontario cannot translate its policies into practice.

Janet Bradley and I are prepared to answer any questions from the committee. Thank you.

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

Mr. Ouellette: Thank you for your presentation. In part of it you mentioned the U-First program, as well as the Gentle Persuasive Approach and person-centred care. How is that achieved? I would expect that this would require a lot more time in order to do that.

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Ms. Montpetit: That always comes up in these training sessions. I think the standard answer is usually

that it doesn't have to take more time, because the result is that it decreases the number of incidents; therefore there is not as much time required to deal with all the aggressive incidents. However, I think that to initially implement, yes, it does require more time. I think that somebody from one of the CUPE presentations mentioned that they need more time in order to be able to have a gentle approach and not a hurried approach. The more hurried you are, certainly the resident picks up on it and it increases aggression. So, yes.

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

Ms. Martel: Thank you for your presentation. I just want to say to you, Pat, that the work the society provides is excellent. My grandmother was a beneficiary, as you well know, at the adult day program and respite home care before she had to go to Pioneer Manor, and we were very grateful for that.

I just want to focus on subsection 74(6), where the government talks about the additional training for direct care staff and lists the additional training that those who are providing direct care to residents have to receive as a condition of continuing to have contact. All that is well and good, but as you point out on the last page, if you don't have the funding to do it, it's all going to be for naught. I think you made it very clear that you're already having trouble providing training because workers haven't been backfilled by other staff in order to receive the training, and I suspect that the 20-minute slot isn't as much as you'd like to provide either.

Ms. Montpetit: Definitely not.

Ms. Martel: So in a world where the government was providing the funding for training, what would you like to provide? What would be necessary, in your view?

Ms. Montpetit: Many of our sessions—for example, U-First is a full-day training session. If the staff right now are sent to that session, then they do have to have somebody replacing them on the floor. So I think there has to be a certain amount of money in each long-term-care facility's annual budget for backfill, for replacement of staff while they are not on the floor.

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

Ms. Smith: Thank you for presenting today. I'm delighted to hear from the Alzheimer society. I was part of the Alzheimer's walk in North Bay on Saturday morning. It was a great event. We had lots of people out.

I'm glad that Ms. Martel raised subsection 74(6), because we do outline the types of training we'd like to see front-line workers receiving. Included in that are dementia care and behaviour management, as well as least restraints, and certainly part of that drafting was informed by the existence of U-First and PIECES. On my review of long-term care in 2004, I spent a lot of time visiting about 30 homes. We would ask if staff had received U-First and PIECES, and we heard a lot of comments such as that one staff had, but hadn't had the opportunity to train the trainers because of the backfill issue and the other staffing issues.

Ms. Montpetit: Very common.

Ms. Smith: Yes. So it is something we're aware of.

I'd just like to point out that in subsection 24(2) we do set out the defence against retribution against staff or retaliation, and in subsection (3) against residents. So when you were talking about whistle-blower protection, that is there in the legislation.

I also just want to congratulate you on the centre. I know that there was a fire, and I hope that everything is okay in your world and that you've been able to get back into your program.

Ms. Montpetit: Pretty much back to normal.

Ms. Smith: Excellent. Congratulations.

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

ALGONQUIN NURSING HOME

The Vice-Chair: We'll move to the next presentation, which will be the Algonquin Nursing Home. Welcome. You can start whenever you're ready.

Ms. Vala Monestime Belter: Good morning. I'm Vala Monestime Belter, administrator, registered nurse and owner of the Algonquin Nursing Home in Mattawa. With me today is Janet McNabb, director of care. Thank you for letting us share our concerns about Bill 140 with you.

In addition to my role as owner and administrator of Algonquin Nursing Home, I have been a member of the Mattawa General Hospital board of directors, the province's e-health subcommittees, and have been on the CCAC's community advisory council as well as several provincial non-health-related bodies.

Janet is a registered nurse and director of care at our home. She has 30-plus years' experience in acute and long-term care throughout the province. She can speak as a town councillor, chair of Mattawa Community Living, about-to-be board member of our local health unit and, most importantly, as a family member of someone living in a long-term-care home—ours.

We bring this well-rounded perspective to our presentation today on behalf of our 73 residents, their families, our 75 employees and over 200 volunteers from almost every service or church group. We are representing their collective concerns over the implications of Bill 140 for the future of their home and the services it provides.

Let me begin by telling you a little about our home and its role in the small, beautiful and bilingual community of the Mattawa area. My father, the late Dr. Monestime, then mayor of Mattawa, mortgaged our family assets in 1976 to build a long-term-care home for the people of East Nipissing. My mom, Zena Monestime, worked as administrator of our home until her death two years ago. She was also a resident for two years, so I too can speak to you as a family member.

Our home is nationally accredited, provincially licensed and designated under the French Language Services Act. Many of our staff have family members who live in our home. It's a home that you would not

hesitate to live in yourself, and may I suggest as you deliberate and plan any revisions to this act that you selflessly consider your outcomes as applicable to you individually in the future.

Our home is now 30 years old. It's classified as a B home because in 1996 we again personally signed a $1.3-million mortgage to enhance our home. We have a beautiful dining room, good resident living areas and a good staff room. We made this investment as a continuation of my father's original philosophy out of respect for the people we care for and those who provide that care.

These renovations did not in any way bring any financial return on investment. We recognized in 1996, as my father did when he originally built, that the people in our community are not wealthy. They are still loggers, farmers or seasonally employed. They did not and still do not have big company pensions. It's difficult for them to afford the additional costs of semi-private rooms and now, quite frankly, unfair for them to have to, when two people to a room is the basic accommodation standard in new and rebuilt homes.

The bottom line is that we still have four-bed ward rooms. Our residents pay the same fees as those in newer homes in Sudbury, Orillia or Ottawa where, at most, there are two residents to a room. Government is subsidizing this through the capital funding they are providing as part of the 20,000 new bed and 16,000 D-bed redevelopment programs. They will help fund the same for residents who will live in the 1,750 beds that are about to be built. Not so for the 73 residents of our home. They are part of the 35,000 residents throughout Ontario who get noticeably less for their money and, right now, are feeling forgotten.

With the uncertainty created by the provisions of Bill 140 and no commitment to a capital renewal program, Algonquin Nursing Home's residents know that this is their future, assuming the government decides we still have a future. For example, I have two mortgages coming due, one in two months and another in a year. My banker is already skittish. He called me after the government's meeting with the bankers a few months ago, and he was not reassured in the least.

We are obviously concerned over the potential implications of this uncertainty for our existing financing. Along with residents, families and staff, we are deeply disappointed that this is preventing us from moving forward with a planned major renovation project. We have the infrastructure in place and the overall plans developed and ready for submission to the ministry. I have now put these plans on hold. What bank would finance millions of dollars in renovations when I can't tell them with any degree of certainty how long the home will exist to be able to repay that financing? I think it's also fair to say that had we had the reassurance over our future and the sense that we could control our destiny enough to take reasonable risks to proceed, the benefits would have extended to our community, which is also going through an economic hurdle.

In the context of this reassurance, I would like to address the misconception that the licensing scheme proposed in this bill, in our case 12 years, because we are a B home, provides more certainty than our current one-year licence. This is simply not the case. Renewal of our current licence is based on things we can control and influence, such as meeting the provisions of the existing legislation and our service agreement. In fact, this is how it should be, for whatever period the licence is for. The limited-term licensing provisions outlined in section 180 link the renewal of our licence solely to the structure of our building. There is no provision for what we would have to do to keep our licence or identify how long our licence would be renewed for even if we were able to do what the government might ask. In fact, as far as we know, the government could just as easily tell us it is closing our home or moving our beds to another community.

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As you know, just the prospect of this is enough uncertainty for us not to be able to proceed with a major renovation project. If this uncertainty gets cemented in legislation, it is effectively ensuring that if the government tells us to invest significantly in building renovations, we will likely be unable to comply. Even if we were, there is still no hope that we will be able to eliminate our four-bed wards and provide residents and families with the same comfort and dignity that residents enjoy in new homes with the benefit of government funding. The government already knows that requires a commitment to implement a capital renewal and retrofit program.

People have so often noted that long-term care is about commitment to people and community, not just a job, a career or a business. This is a commitment that I have known all of my personal and professional life, and it motivates me to keep moving Algonquin Nursing Home's care, services and culture forward.

Amending the limited licensing provisions to remove the uncertainty and committing government to immediately implement a capital renewal and retrofit program to renew all B and C homes would enable us to do this. I know that our association, the OLTCA, has presented a detailed and workable plan. I'm comfortable with it and I encourage you to support it.

Two elements are necessary for the residents of the Mattawa-Bonfield area to be assured that the long-term-care services they increasingly need are there for them. The first is a home that is capable of supporting the care and service levels they need, expect and deserve. The second is that within the physical structure the management and staff are able to deliver the care required while enhancing the one feature that makes long-term care unique: that it is also their home.

So far I have focused on how Bill l40 impacts the first. Janet will now address a number of issues with this proposed legislation that impact the latter.

Ms. Janet McNabb: First, let me say that from this perspective, there are things in this bill I fully support, things like the measures to strengthen resident safety. In fact, in many of these areas, as they say, its heart is in the right place.

Where our concerns arise is when we look at some of what Bill 140 requires in the context of the day-to-day reality of life inside our home. Our concerns range from knowing there are things we cannot deliver to the impact on care and our home environment. We're deeply concerned over what we see as government withdrawing its commitment to provide the funding that will enable us to provide the care and services that residents need. Stating that government "may" fund, as Bill 140 does, does not give us the same level of confidence as the "shall" fund wording in existing legislation.

At the same time, Bill 140 will ask us to do what is impossible even within our existing resources. I speak, of course, of what you now are all likely aware of: the requirement to provide restorative care programs and activity and recreation programs to meet the assessed needs of individual residents. The concept behind this requirement is a caregiver's dream; in long-term care now, it is only a fantasy. If it remains as a legislated requirement, without the necessary resources and with an absolute compliance program with work and activity orders and financial penalties, it is the beginnings of a nightmare. These requirements are impossible to implement on current funding. We shudder at being faced with this reality and the consequences and impact of being non-compliant.

As you know, we're a small home in a small community. Our staff, family members and volunteers work hard to ensure that our physical environment reflects the values of small-town Ontario to feel like home for the people who lived these values all their lives. It means a lot to the comfort and dignity of our residents.

While it may seem like a small thing in a big city, Bill 140's requirement that we post some 13 official and legal documents on our walls is a big thing for us. They will certainly become a prominent feature of our physical environment. In fact, families and visitors and others are likely to think they're coming into the post office or some other official building rather than a family member's home.

We understand the concept behind this requirement and the importance of families and residents having access to information. We believe a more resident-focused and less institutionalizing approach would be for Bill 140 to specify that this information should be available in the home and let the home, residents' council and families work out how we fulfill that requirement.

With respect to meeting resident needs, I would like to take the opportunity to say that we support the concerns you've heard from other homes with respect to Bill 140's impact on existing care and service levels. I can tell you that in a home the size of ours, when I have to be in my office filling out reports or going around filling out forms, everybody in the home knows it. Even now, they would like to see me have more time to listen to their needs or help them with something.

I would like to close my remarks by addressing the issue of abuse. We fully support the spirit and provisions of this bill to strengthen abuse protection. Resident abuse is simply unacceptable and inexcusable, irrespective of the source. Our home has had a zero tolerance abuse policy for 30 years and we apply and reinforce it with all of the resources and power within our control.

But, please, let me be frank: Government's and indeed everyone else's expectations that the strength and provisions of Bill 140 will adequately address these issues are not going to be met. That is because there are two factors that impact this issue that the provisions of Bill 140 cannot reach.

The first is the requirement for the operator to protect the resident from abuse by anyone. Believe me, we would if we could. We cannot because we cannot monitor every interaction the resident has. We are quite rightly required to provide privacy for residents to visit with their families. We also have no control over the personal financial relationships between residents and others outside the home.

The second issue is the fact that right now, arbitrators have the right to allow staff who have been found to have abused a resident to return to work. If they retain this right, we can implement the full strength of everything in this bill and then have to take it all back because an arbitrator is not held to the same zero tolerance benchmark. Further, staff are going to be increasingly reluctant to come forward and report other staff if they know it is likely that at the end of the day, they're going to get their job back. This is difficult enough in a small town where they're likely to meet in the aisle of the grocery store every weekend anyway—and we only have one grocery store left. You can just imagine the emotional turmoil it's going to create if they know they're going to have to continue working with them as well.

The Ontario Long Term Care Association has submitted detailed amendments to address the specific issues Vala and I have raised. On behalf of the residents, families and staff of Algonquin Nursing Home and the Mattawa-Bonfield area, I ask that you give them your full support.

The Vice-Chair: Thank you very much for your presentation. We have two minutes left—one good, quick question each. Ms. Martel?

Ms. Martel: Thank you for your participation today and for driving to be here.

I want to focus on page 5, where you talked about mortgages. You said, "My banker is already skittish. He called me after the government's meeting with the bankers a few months ago. He was not reassured...." What's that a reference to? This is the first time we've heard about that—or that I've heard about that; maybe others know something more.

Ms. Monestime Belter: I believe that when the bill was first tabled—Monique, please help me out—because there's that little issue of financing, the government went with lots of different banks just to take them through the process. Our banker wasn't there, but he heard whatever was reported. He still doesn't get it. He doesn't think it makes sense. I tried to reassure him. I told him about the process—yak, yak, yak. He's spooked. He doesn't

believe there's any proof in it that I can maintain a long-term mortgage. I said, "I'm the only one in town. This will never happen."

The Vice-Chair: Parliamentary assistant, a quick question?

Ms. Smith: Just to clarify, the ministry and various government officials met with various stakeholders, including the financial community and other stakeholder groups, after the introduction of legislation for technical briefings.

Thank you, Vala and Janet, for being here, for doing the great job that you do and for providing such good care in Mattawa. I'm surprised at some of the things you had to say. For some reason, Karen and the OLTCA seem to be quite concerned about this posting requirement. I've been to Algonquin many, many times and I've been to the Mattawa post office, and there's no way I'd be confused as to which is which.

You run a great home, and we've heard from family members and residents that they want to make sure that they have the information that they need. Not all homes have boards posting even the minimum. There are standards and requirements now that homes post their inspection reports, the bill of rights and the 1-800 number. Well, I can tell you that on my visits to over 30 homes, I've had a very difficult time finding those things posted. So I wonder about your concern around this, because our family members and residents have told us that they want to see more information. They want to have access to that. So can you respond to that—

The Vice-Chair: Thank you. Mr. Ouellette?

Mr. Ouellette: Just a quick question: You mentioned the capital expansion. What form would be needed to ensure your viability?

Ms. Monestime Belter: What form?

Mr. Ouellette: Yes, what type of capital expansion do you need to continue on in your services?

Ms. Monestime Belter: Well, first of all, our residents live in four-bed rooms when the rest of Ontario seems to be moving into two-bed rooms. That's discrimination, I think. The government has helped with that. I would like to see the government continue helping with the B and C homes so that we too could be equal with everyone else.

The second thing is, by tying our licence to a time limit, we can't get a mortgage to be able to do the renovations.

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

We're going to recess until 1 o'clock. For the people here, the room will be locked. Take your personal items with you, because nobody is allowed to come back here during this hour.

The committee recessed from 1159 to 1300.

ST. JOSEPH'S VILLA

The Vice-Chair: Good afternoon, ladies and gentlemen. It's exactly 1 o'clock. We are going to start with St. Joseph's Villa. If they are here, they can come forward and start their presentation.

Welcome to the standing committee on social policy. Please, before you start, can you state your name and your friends' names for the record.

Ms. Monique Landry-Sabourin: Absolutely.

Interjection: Oh, we're not friends.

The Vice-Chair: Okay. You or somebody with you—

Interjection: I'm just teasing.

Ms. Landry-Sabourin: We are more than friends, sir. We work together.

I am Monique Landry-Sabourin and I am chair of the board of St. Joseph's Villa. On my right is Jo-Anne Palkovits, the CEO for the villa.

St. Joseph's Villa is unique in Sudbury. It is the only charitable non-profit long-term-care home in Sudbury. We are also the newest home in Sudbury, having opened in December 2003 with 128 beds. We are located on Laurentian University property, which affords us many research and educational opportunities. Building on the tradition of the Sisters of St. Joseph of Sault Ste. Marie, we are pleased to provide excellence, service, dignity and integrity to our residents and staff. We are fortunate to be governed by a voluntary board of trustees that is representative of the Sudbury community, including lawyers, accountants, physicians, business owners and educators who have much experience sitting on voluntary boards. Today we have with us four members of the board: Sister Mildred Connelly, vice-chair; Mimi Andrews; Al Cruthers from CHCO, and—did I miss someone?

Interjection: That's it.

Ms. Landry-Sabourin: Okay. We have a very supportive board, as you can see.

Our board supports in principle the intent of Bill 140, to build a strong, accountable and resident-centred long-term-care system. However, we are concerned that it falls short of this goal. We believe the proposed legislation is flawed, especially for the non-profit homes, and significant changes are needed if it is to have a positive effect on the lives of our residents now and into the future.

Given the limited time available to us this afternoon, I would like to focus on three key themes identified by our board.

The McGuinty Liberals, in opposition then and now in government, have consistently been very vocal in their support for not-for-profit health care delivery. We were pleased when the government put words into action by clearly establishing a preference for public health care and the not-for-profit sector in legislation such as the Commitment to Medicare Act and the LHIN legislation.

What has, quite frankly, surprised and dismayed us is not only the absence of an equivalent preference in Bill 140, but also that it will have serious implications for the viability of the not-for-profit long-term-care sector. This should be an alarm bell for the public and the government. The not-for-profit sector, including the Sisters of St. Joseph of Sault Ste. Marie, whose legacy we attempt

to live out, delivered value-added services for over a century. And in a sector that is seriously underfunded, it is worth noting that our organization is fortunate to have a foundation that supports us in topping up our operational funding to assist us to pay for cost overruns such as our food allowance. I must say at this point that the ministry allows $5.46 per resident. We are putting in more than that. We are quite surprised that another ministry is giving $12 per day for prisoners. There is also growing evidence that not-for-profit delivery of long-term care results in more staffing and improved care outcomes for residents.

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

The second theme I will speak to relates to governance. Our board relies on community leaders who are willing to give freely of their time as volunteers to serve on the board of the villa. They represent a very diverse group of individuals representative of our Sudbury community. They are not compensated for their time or expertise.

Bill 140 will impose higher obligations—section 67—and harsher offence provisions—section 177—on the directors of long-term-care homes than any other sector in health care, including hospitals. The proposed legislation could result in directors being subject to fines up to $25,000 and imprisonment for any breaches of the act by anyone in the home. This will make it very difficult for us to maintain current directors and attract new ones, especially since penalty provisions are not covered by standard directors' and officers' insurance in Canada. We do not understand why the government wishes to impose such an obligation on board members of long-term-care homes when this is not the standard for other boards in the province. We would recommend that we be treated equally to our health care partners and recommend that the government treat us the same as hospitals under the Ontario Public Hospitals Act.

The third theme I wish to pursue is the impact Bill 140 will have on resident care. Bill 140 proposes a significant increase in regulation. While our board supports measures to enhance standards and ensure full accountability, this legislation is so excessively onerous that the villa will be forced to shift already scarce resources to meeting new administrative demands. Staff will be forced to spend more of their time on compliance and documentation, and this will mean they have even less time available for direct care and services. We are about care and services. The villa is already challenged by inadequate funding. This additional burden of red tape will exacerbate these challenges. We are very concerned that the focus in the bill on prescriptive micromanagement is misplaced and could actually result in a lower standard of care at the villa.

At a minimum, the province must analyze what added financial burden will be placed on the villa as a result of the new regulatory demands and increase operating funding by that amount. Establishing new requirements and standards without providing the means to achieve them is only a prescription for failure. A very clear example is the call that's being made for care standards by many of the presenters. We're not the first ones, I'm quite sure, to tell you exactly this. We certainly support this direction, but only if it is fully funded for all homes.

The provision related to secure units serves as a good example. These units provide residents with significant dementias and behaviours with a safe haven and attention to their needs. Including these units as restraints will require adherence to extensive monitoring and reporting requirements. The workload implications are significant. For example, meeting the documentation requirements for a 30-bed special care unit is projected to require at least one full-time nursing position, with no commensurate benefit to resident care.

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

In concluding my remarks, I want to make very clear that while we are moving in the right direction with new legislation for long-term-care homes, we are on the wrong track with Bill 140. We are very concerned with provisions in the bill that disadvantage not-for-profits such as ourselves, and with the many sections that are so prescriptive and excessively onerous, with no significant improvements to care. We must all—government, providers, consumers and their families—work in partnership to create legislation that enables and encourages innovation, flexibility and excellence in the delivery of long-term care in Ontario.

Thank you for listening. I'm quite sure I've repeated some things that you have already heard, but it was very important for us to let you know where we stand.

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

Ms. Smith: Thanks for being here. I wondered about the comment in your conclusion that "We are very concerned with provisions in the bill that disadvantage not-for-profits." What provisions specifically in the bill do you think disadvantage not-for-profits?

Ms. Landry-Sabourin: I will let our CEO answer that question because she's on the administrative side.

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Ms. Jo-Anne Palkovits: I think a lot of the things around the standards of care that are in there around documentation and things like that.

Again, we have very limited dollars. All the dollars that we currently have right now go into our staffing. We have zero-based budgeting, so there are no excess dollars, for example, right now to hire extra staff for documentation and the like that is required according to Bill 140—perhaps compared, at least in our opinion, to some of the for-profits, who may have some excess revenues that are now going to stakeholders whereby they could actually use those dollars to hire that staff. As I indicated, right now we have a zero-based budget so all of our money is currently being spent directly on care.

Ms. Smith: But that's for your budgeting purposes. You're actually funded the same way as the for-profits, as far as based on your CMI and the care needs of your residents in your home. Isn't that correct?

Ms. Palkovits: Yes, we are funded the same. But as I said, right now we have to rely on our foundation because we're just not able to meet the food costs. As an example, our foundation has very specifically passed a motion whereby any funds that come into our foundation offset the additional costs for food. So instead of what we're currently being provided—I believe that our food costs at year-end were approximately $6.20 a day, so obviously you can see the gap there. When you multiply that by 365 days and 128 residents, obviously that's a significant amount.

The Vice-Chair: Mr. Ouellette.

Mr. Ouellette: Just a quick question on your presentation. In your opening remarks you mentioned that, because of your location, you're able to do research and educational opportunities. Can you just kind of expand on what takes place there or what you may have been able to find out that can improve the system from that experience?

Ms. Palkovits: I certainly will. First of all, we're very fortunate that we are on Laurentian University property. I'm sure you're aware that we have a new Northern Ontario School of Medicine. We're located right across the way. So we actually have formal partnerships in place with the school of medicine, the school of gerontology, the school of nursing, the school of biology, the school of business as well as a variety of several of the colleges in town. But being on the Laurentian University property particularly has enabled us to actually undertake several research projects which are currently on the go. I believe that's probably because of our close proximity, because it makes it very easy for the students and the professors to access our site.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for being here today. How much does the foundation top up outside of the food allowance? Do you also do that directly for staff?

Ms. Palkovits: We do not for staff, but they do assist us in terms of some of our purchases. For example, they have assisted us in purchasing lifts, beds, a lot of things particularly with our activation department because, as you know, that's a very strict and, I would say, small budget. So they've helped us in terms of buying. It may sound simple but, for our residents, it's very important in terms of being able to go on outings. They were instrumental in purchasing a handi-bus for us so that we could take our residents to a variety of outings. Again, without our foundation we would not have been able to afford those things.

Ms. Martel: With respect to the penalty provisions, what does your board think? Are they going to stay on if the provisions stay the same?

Ms. Palkovits: I can't speak for my board.

Ms. Landry-Sabourin: I think everybody on the board would think about it twice.

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

SUDBURY HEALTH COALITION

The Vice-Chair: We'll move to the next presentation, by the Sudbury Health Coalition. They are not here in person; they're going to do it through teleconference. I believe we have with us Anne-Marie MacInnis, the chair. You're on and you can start any time you want.

Ms. Anne-Marie MacInnis: Good afternoon and thank you. The levels of care provided to residents in long-term-care facilities have dramatically changed. Residents are diagnosed with multiple diagnoses and prognoses. As a health care worker in a long-term-care facility for 25 years, I want to give you a detailed account of a 24-hour period in the life of a resident in a long-term-care facility across this province. In an effort to maintain a general flow of information, when you hear the word "staff" or "worker," I am referring to the hands-on care providers.

Generally at 6:55 a.m., staff receives a report from their supervisor, which includes changes to a resident's condition and/or behaviour or appointments that have been scheduled. The staff receives an assignment sheet and is responsible for providing care to a minimum of eight residents, up to 14. They begin gathering supplies such as facecloths, towels, bed linens and topical medications and proceed to wake up the residents.

In the ideal world, a staff member would go into the resident's bedroom and begin to turn on the over-bed nightlight or open up the curtains while speaking to the residents in a soft voice in an effort to gently wake them up so they can begin to provide care. The worker should not be rushing care, because the resident has not been mobile for hours and will experience stiffness and pain. A gentle approach will decrease the anxiety of a resident and also reduce episodes of aggression.

The assumption is that all residents understand and speak English. Sensitivity towards language and cultural needs are important in order to overcome communication and behavioural barriers. The resident may refuse care for many reasons and staff should respect that and return at a later time. At all times, staff are to provide encouragement and promote personal independence.

All residents, as outlined in policies and procedures, are to receive a.m. care. Staff are expected to wash the resident's face, hands, back, armpits and private area and

observe for changes in skin condition, such as redness or ulcers, changes to their eyes, ears etc. The hands-on care providers are the people who initially become aware of these changes and must report this information promptly. If the incontinent product is 80% wet, then the resident can receive a clean, dry product. Body lotions and/or topical medications are then applied.

The resident has the right to go to the common dining areas in their day clothes so the worker dresses them. The resident may be assessed and a decision made to use a mechanical lift on the resident for their safety and the safety of the staff. If this is identified in the personal care plan—most facilities have a no-lift policy, which means two workers should be present; one will manoeuvre the machine while the other spots. Once safely in their wheelchair or geri-chair, staff will comb their hair and provide mouth care. The worker may get their toothbrush and toothpaste and set up the resident in the bathroom to provide their own mouth care with constant encouragement. If the resident is unable to do this, the worker should brush their teeth or dentures, swab the interior of the mouth cavity and examine the condition of the mouth and gums. Fingernails should be inspected, and trimmed or cleaned if necessary.

The worker is to provide the equipment, give encouragement or shave the residents who have been assigned to them. Once a.m. care has been completed, the worker will turn on the radio or television in the bedroom or porter the resident to the common dining areas, where they will sit waiting for the meal to be served. Keep in mind that the worker must complete care for eight to up to 14 residents. The care described above is for one resident only.

The Ministry of Health has outlined specific time frames when breakfast, lunch and supper are to be served. Staff are expected to be in the common eating areas at 8 or 8:30 a.m. Some residents are able to feed themselves with minimal assistance and supervision, while others have to be fed. Staff must provide constant encouragement and supervision and be aware of special diets or swallowing difficulties. The workers serve and feed the residents and clean off tables before serving the next entrée. The dining experience is suppose to be positive, quiet and not rushed. Food and liquid intake is then recorded on sheets.

Some facility operators have cut several hours in the dietary department, and while the residents are eating or being fed, there is clanging of pots and pans and dishwashers are running. The residents are supposed to have a choice at mealtime. More often than not, they do not receive their preference because only a certain amount of each choice is prepared. The worker must then try to explain to the resident why they can not have their first choice. The general expectation is the meal should be served and residents fed in one hour. Breakfast is served to 30 to 32 residents, depending on the size of the facility.

At 9:15 a.m., staff are entitled to begin taking their 15-minute break. More often than not, workers will continue working through their break time in an effort to not fall behind. Some units will only have two workers for the entire eight-hour shift. If a worker takes 15 minutes for their break, the care is limited until there is a full staff complement.

After breakfast, staff then porter the residents back to their rooms and continue providing a.m. care to the residents they could not help before breakfast. Staff must also toilet all residents or change their incontinence product if the indicator is 80% wet. Staff are expected to visually check residents hourly or physically re-position them every two hours if they are unable to move on their own.

Every resident in a long-term-care facility is to receive two baths or showers per week, whichever they prefer. The second bath or shower is to be offered, and if the resident refuses, a bed bath is acceptable by most nursing home operators. Staff must ensure that a bath is provided for the residents who have been assigned to them for the day shift.

It is now approximately 10:15 a.m. and nourishment must be given to all residents. Staff are to supervise, assist or administer the fluids or snacks. At no time are liquids or food to be offered without supervision, because of the possibility that a resident may choke. Food and liquid intakes are then recorded.

It is now approximately 11 a.m. and staff begin to take their unpaid half-hour lunch break. The remaining staff on the floor continue to provide a.m. care: baths, showers, re-positioning, answering call bells or changing the resident if the incontinence product is 80% wet. Throughout the entire eight-hour shift, they are to report any unusual physical or behavioural changes and answer call bells.

It is now approximately 12 p.m. and lunch is provided to residents. Staff porter the residents to the common dining areas and record their meal choices. Coffee, water and milk are served, and then the main course. Some staff remain in the dining room, while others go down the hall to feed residents. The food and liquid intake is then recorded.

At approximately 1 p.m., staff begin portering residents back to their bedrooms and toilet or change the incontinence product if it is 80% wet. Some residents will be placed in bed and their day clothes will be changed if dirty; others will remain up and should be physically repositioned. Workers who choose will begin to take their much-needed last 15-minute break; others will continue to work through their break.

Each time an incontinence product is changed or a resident is toileted, staff should provide peri-care. When a resident pulls their call bell, it should be answered promptly.

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At approximately 2 p.m., afternoon nourishment and snacks must be served. Staff must supervise and assist. The intake is then recorded. Staff must then document activities of daily living and document the care that was provided on their residents and report concerns. At all

times, workers are responsible to keep the entire living space and work areas clean and safe for the residents, visitors and co-workers. Other assigned duties include bed making, bed changes, ensuring rooms and bedside units are clean and tidy, putting away personal clothing and ensuring that the call bell is easily accessible to the residents and in good working order.

The afternoon shift and night shift workers have a different routine, and the staff-patient ratio, of course, is increased.

A high number of workers will report to work 15 or 20 minutes earlier than required, they will work through their 15-minute breaks and lunch periods and stay longer than eight hours to complete care and documentation for fear of being disciplined, suspended or terminated. Some nursing home operators take advantage of the good nature of the workers and demand more work with less staff, i.e., not finding replacements unless more than one worker has called in sick. The workload is overwhelming.

Some staff have immediate family members or friends who live in long-term-care facilities. They are not allowed to participate on family councils, even though this is supported by advocate councils and family council members.

The 24-hour period described above is a normal day and does not include changes in a resident's condition and/or behaviours, flu outbreaks, infectious diseases or when a resident becomes palliative and is nearing the end stages of life.

Workers in long-term-care facilities are cutting corners in order to provide some kind of care to all the residents whom they are responsible for. I have heard stories of women who are giving birth to multiple babies. It is heartwarming to hear how the community will come together and local business owners will give free food or diapers for a year or a car dealership will donate a minivan.

Have you ever heard the saying "once a man, twice a child"? Residents are diagnosed with Alzheimer's or other cognitive impairments and are becoming increasingly frail, and levels of care regress to that of a child.

I applaud the efforts of the government regarding Bill 140. The ministry requires facilities to meet minimum standards when constructing a building, i.e., door frames, the size of the bathrooms, how high the window can be from the floor. I am appealing to the government to legislate a minimum staffing standard of 3.5 hours of care per resident per day for current and future residents who will be calling a long-term-care facility in Ontario their home. This will begin to ensure that residents will receive dignity and that workers can adequately begin to meet the residents' physical, psychological, social, cultural and spiritual needs.

The Vice-Chair: You've left six minutes; we are going to divide it equally between the three parties. We'll start with two minutes for Mr. Ouellette.

Mr. Ouellette: Thank you very much for your presentation. Your comments regarding the specific time frames, with breakfast, lunch and supper to be served: Do you think that will increase the number of part-time workers in order to comply with those guidelines at those times?

Ms. MacInnis: Increase part-time workers? I don't understand your question, because I don't see how that would happen.

Mr. Ouellette: I don't know how you'd be able to fulfill the expectations in the time that's allowed to provide that service unless you had individuals who could come in for those times specifically.

Ms. MacInnis: Right now they do have short shifts, and a lot of times those short shifts are scheduled around meal times, specifically to help with that. Would it increase that? I'm not too sure.

Mr. Ouellette: The other thing is the start. You mentioned that when they come in in the morning, they receive the documentation at 6:55, which includes the changes to a resident's condition or behaviour or appointments. Who does the condition or behaviour changes through the evening, when those individuals leave, so that they can pass that on to the person who's providing the care?

Ms. MacInnis: Generally, it's on a census report, and it would be the registered nurse in that unit who would give a verbal report to the workers prior to their shift.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you, Anne Marie, for the presentation. In terms of what's happening right now in homes, if someone calls in sick, are they being replaced or are the other workers, more often than not, just picking up the slack?

Ms. MacInnis: I can't speak for every home, but a lot of nursing home operators have plans. If one staff member calls in sick, the directive to the registered staff is, don't call people in. Some facilities say that even if two people call in sick, don't call until the third person calls in sick. So what happens is that staff are working short, and we're not given any kind of clear directive. After you leave work the day before and you've taken care of eight to 14 residents, you're pooped and sometimes you're unable to complete all the care provided on that day. The next day, when you come in, if they're not replacing staff, obviously your workload has increased, the staff-patient ratio has increased. We have said in the past, "Then prioritize for us, because you know what? Yesterday I was hardly able to complete the care, and you're asking me to provide it for another eight people. It's impossible. So you prioritize what is priority and what's not." But nobody will do that, so corners are cut.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: Thank you for your presentation today. We've heard a lot of discussion about the minimum standard and the 3.5 that you talked about in the final part of your presentation. I just wondered what you would include in a calculation of a minimum standard. Would you include the director of care, the RN on call, the RPNs, the personal support workers, the bathing people

in some homes, the dietary, the activation? Which organizations or groups would you include in that number?

Ms. MacInnis: That is a really good question. I have no background or experience in dealing with budgets, but the 3.5 hours of care that I believe is needed as a minimum staffing standard is specifically for the hands-on care providers.

Ms. Smith: And how would you define hands-on care providers?

Ms. MacInnis: PSWs, health care aides, PCAs. There are several different names for the care.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 146

The Vice-Chair: Now we'll move to the next presentation, by the Canadian Union of Public Employees, Local 146.

Mr. Henri Giroux: Sit anywhere?

The Vice-Chair: Yes, and you can start whenever you're ready.

Mr. Giroux: Good afternoon. My name is Henri Giroux and I'm from North Bay. This is Brian Blakeley, from CUPE research.

I work in a 240-resident home for the aged, and have been there since 1979, which is 28 years ago. I'm also the president of CUPE Local 146 and we have approximately 185 workers. I'm also the North Bay and district CUPE Local 9126 president. We have approximately 11 long-term-care facilities. We are all proud workers of long-term-care facilities, but we also see that there are some things missing in this legislation and that it needs some amendments. In addition, CUPE members are residents and users of Ontario's health system. Many of us have family members, colleagues and friends living in Ontario's nursing homes.

The continued movement of heavier-care patients out of hospitals and mental health facilities into long-term-care homes has created mounting care needs that remain unmet.

In its present form, the proposed legislation fails to provide the statutory and regulatory framework that would achieve the safety of our residents and staff in Ontario's homes. It fails to ensure even minimal accountability for meeting the residents' assessed needs and improving government accountability:

—It provides no rights to access any level of care at all.

—It abandons promises to re-establish care standards and compliance regimes to ensure these are met.

—It fails to protect residents, staff, family members and visitors from an inexcusable increase in violence, illness, accident and injury in our homes.

Local 146 and other locals in our area believe that the key focus of any long-term-care reform must be the provision of a minimum staffing standard to ensure adequate care levels, a mechanism to measure and provide adequate funding to reach these staffing standards, and a compliance regime to ensure they are respected.

Staffing levels are the key to providing sound care, to preventing abuse and neglect, to ensuring the safety of residents and care workers, and to improving the quality of life of the residents. The government must recognize that the homes are also a workplace where the current levels of care are inadequate and unsafe and that the rate of illness, injury and violence in facilities must be recognized and prevented.

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To ensure that the care needs of residents are met and to fulfill its obligations to provide sound oversight and accountability for the use of public funds, we recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day per resident of nursing and personal care. This is to reach the goal of risk prevention. It is not an optimum.

In addition, 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.

Heavy workloads mean that there is not enough time to complete tasks in a way that complies with standards. Nearly one in five workers reported that they are able to complete their tasks to established standards less than half of the time. An additional 14.3% report that they are never able to do so. Nearly 60% of the time, workers don't have time to provide emotional support. More than 50% report that work caused illness or injury more than 11 times during this time period.

The proposed legislation must tackle the serious issues of understaffing, illness and injury revealed in the research. It is unconscionable for the government to knowingly allow the continuation of inadequate regulation that has created understaffed workplaces in which caregivers are punched, kicked, spat on, pinched, bitten, slapped, injured and made ill while attending to provide care. Long-term-care facilities are workplaces where workers are entitled to health and safety, freedom from violence and abuse, proper work supplies, sufficient staff resources and support.

While the proposed legislation includes provisions to deal with the mandatory reporting of abuse and undefined neglect, it fails to address the serious problem of violence in long-term-care homes. The goal should be prevention of violence, not simply reporting of incidents of violence. There is an urgent need for the new legislation to explicitly recognize increased violence in facilities. Neil Boyd, a criminology professor at Simon Fraser University, who is studying physical abuse in the health care sector, says that the main reason for increasing violence is the aging population. He says that abuse of workers occurs most frequently in long-term-care facilities where residents have disabilities such as brain injuries, age-related dementia and chronic progressive disease.

We recommend that section 5 of the proposed legislation be amended to require that homes be safe and secure for residents and staff.

In addition, the safety of residents, our members, family members, volunteers and visitors require that the new legislation provide access to all standards for special-care units or facilities; clear, appropriate training guidelines and improved training opportunity; the establishment of care plans for those with a history of violence prior to admission; and stop the inappropriate downloading of patients from mental health facilities and acute care facilities into long-term-care homes. More care must be allocated to those with dementia and other cognitive impairments that result in agitation and aggression.

On a personal note and closer to home, in our facility we have a staff ratio of one worker for every group of 13 to l4 on a day shift and a ratio of one worker for 19 on the evening shift. Imagine how much care we can give with these figures.

Violence in the workplace occurs almost every day but it is sometimes left unreported because the residents are like family to us. Would you report your grandmother if she happened to slap, kick or spit at you?

Health and safety: We had almost eight to 10 health care workers with 10 to 20 years of experience who had to leave their employment to re-enter the labour market because they had hurt their back, spine or neck because of the workload and there is not enough modified work for them to stay at the workplace. Being in the labour market is a price to pay for an employer and also causes a lot of stress on families. An injury to one is an injury to all.

Please make the proper amendments to this legislation so that we can have a safe environment for our residents and staff.

The Vice-Chair: Thank you very much. We have six minutes left which we're going to divide equally. We'll start with Ms. Martel.

Ms. Martel: Thank you for driving here today. I appreciate your participation.

When you talk about eight to 10 health care workers having to leave their employment, what was the time period for that?

Mr. Giroux: In the last five years.

Ms. Martel: Okay. Let me talk about the staff ratio of one worker for every 13 to 14 on the day shift and one to 19 on the evening shift. How long has that been in place? That's a very high proportion, higher than we've heard in terms of responsibilities of staff to residents.

Mr. Giroux: It's been a couple of years now. We try to staff them, but the problem is that if the case mix index goes down, staff get laid off and then you're back to square one. We have experienced that in the past and we're hoping it doesn't happen again, because we heard the case mix index might have gone down again.

Ms. Martel: So that one for 13 to 14 and 19 has been in place for two years, three years?

Mr. Giroux: Two years.

Ms. Martel: And that's directly as a result of the case mix index declining and staff being let go?

Mr. Giroux: Yes.

Ms. Martel: How many staff were let go?

Mr. Giroux: We had two RPNs and one health care aide. They were later rehired, but the work was still there for them to—

Ms. Martel: But you're in a municipal home for the aged, right?

Mr. Giroux: Yes.

Ms. Martel: What's the top-up? Do you have any idea what the top-up might be from the municipality to help in the operation of the home, and what the money's going towards?

Mr. Blakeley: We don't have any information on that.

Ms. Martel: Because normally you would see that top-up replacing those staff, at least in a municipal home for the aged.

Mr. Blakeley: That's still driven by council decisions in the area. So I'll find out for you.

Ms. Martel: That would be helpful; thank you. That's it. Thank you very much.

The Vice-Chair: Parliamentary assistant.

Ms. Smith: Thanks, Henri. It's nice to see you today. You stated in your presentation that the legislation "provides no rights to access any level of care at all." I would just take exception to that because, if you look at section 6, we set out how the plan of care for each resident is to be determined. It's to be based on the assessed needs of the resident, and every licensee is to provide the care that's required in a plan of care for residents. So there is a requirement that every licensee or every home provide the level of care that the resident requires, as assessed. I just wanted to point that out to you.

You also in your presentation were looking for "clear, appropriate training guidelines and improved training opportunity." I would just direct you to subsection 74(6), where we outline the type of training that we believe front-line workers should be receiving in all of our long-term-care homes across the province.

You also were looking for a requirement for "care plans for those with a history of violence prior to admission." I would just note that in subsection 41(4) we have extended the requirements for assessment prior to placement in homes and we include as one of the assessments the applicant's functional capacity, requirements for personal care, current behaviour, and behaviour during the year preceding assessment so that we have a better assessment overall of the resident's needs, both behavioural and physical, and can ensure that the placement is appropriate for that resident. So we have taken some of those considerations into account in this piece of legislation. I just wanted to point that out to you.

Thank you for coming.

The Vice-Chair: Mr. Ouellette?

Mr. Ouellette: You mentioned staff and the ratios of one to 13 and 14, and one to 19, and that individuals were laid off. When that took place, were they replaced with part-time individuals or not? Or do you know?

Mr. Giroux: No, they weren't replaced.

Mr. Ouellette: So no replacements took place at all to make sure that the level of care was maintained.

Mr. Giroux: No.

Mr. Ouellette: The other thing is, on that same page, page 6, you mentioned to stop the "inappropriate downloading of patients from mental health facilities and acute care facilities into long-term-care homes." Do you know what kind of a percentage relates to the individuals who you feel are in the homes now who shouldn't be there?

Mr. Giroux: I don't have the percentage right now; I could get you that. But the problem with that, we feel, is we have long-term staff and they're not well trained for that kind of patient. So that's what makes it a lot harder to work with that kind of patient compared to when people started there 20 years ago and they had old people and that's it.

Mr. Ouellette: Those are all my questions, Mr. Chair.

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

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BETTY MOSELEY-WILLIAMS

The Vice-Chair: We move to the next presentation. It will be by Betty Moseley-Williams. Welcome. You can start whenever you're ready.

Mrs. Betty Moseley-Williams: Good afternoon and thank you for the opportunity to share some of my thoughts and concerns with you regarding long-term care.

I do not believe there is a bottomless pit of money, but the shortfalls are too evident and it will take money to ensure the care provided in Ontario long-term-care facilities is, at the very least, adequate. But the aim should be excellent and equal care for all the residents, and it's not.

My name is Betty Moseley-Williams. I am 73 years young, and I worked as a nurse for over 50 years. I do not represent any group or organization. My comments are personal and they're with respect to the dealings I've had with long-term care over the past while.

I want to start by telling you a story of a conversation, and it's a true one. About 11 years ago, I was sitting with my sister, who was dying; we were planning her funeral. Being a sister, I was kind of teary. She put her hand over and said, "Betty, don't cry. I know where I'm going. You don't have any idea; my worst nightmare is that I will sit with paper panties in the hallway with a blanket half covering me, tied in a chair." I've thought of that a great deal over the last 11 years, most especially over the last year. I have to say that Mary's worst nightmare became reality for all of us.

Over the past 12 years, our family has dealt with a loved one suffering with dementia and Alzheimer's disease. The final year of his life was in three long-term-care facilities. He was lucky that his wife became his strong and vocal advocate. She is a very caring, but tough lady. She also spent $1,000 a month over and above everything else to help him so that he would have fresh fruit every day, that somebody would be there to help him and that he didn't have to be tied into a chair. She bought the chairs that were required—I think the two of them were around $5,000—so that he could be in comfort and with all of the dignity that he should have.

I'd like to make my comments and suggestions on parts of this bill. I'd like to talk to the mission statement, the family councils, the daily care and the inspection and assessment.

I believe the mission statement should be developed with input from the patients, residents, families of patients, staff and some people from outside any part of the long-term-care facility. The statement should have clarity regarding the purpose and objectives of the facility. I believe the statement should include that this is the home of residents and that all will be cared for with respect, they will be treated with dignity and their pride will remain intact. I personally would like to see the words "loving care," but I expect that would offend some people because of what we have done to the word "love"; so I will be satisfied with "caring," "respect," "dignity" and "pride." I think it should be at the entrance of every home, well displayed on every unit, well framed, attractive and it should say, "Look at me. This is who we are." It should be read by everybody.

It would be helpful if there was a bulletin board. I didn't realize there were that many statements that had to be posted. However, I think there are places in Ontario that could teach people how to do a bulletin board that wouldn't scare you to death.

I think the mission statement should be examined with the policies of the facility, and if the policy does not compliment the mission statement—if they don't complement each other—then the policies need to be looked at. They should blend and they should be married.

When we talk about physician care, I believe that all of the patients being admitted to the facility should be physically examined by the facility physician, regardless of what other documents come forward. The family member who has been the caregiver should be present at that examination. Usually that caregiver would know the patient's reaction to taking meds, and the doctor needs to know what works best for the patient.

While at home, the caregiver has been working with the family doctor and they can share the experiences that work. The orders can be written at the time of admission to allow the med nurse or the nurse in charge to use some discretion in dispensing medicine or other treatments. They react so badly if things are not done just the way they're used to them being done.

Very often, this information would help the attending staff when difficulties arise. We know that anger in these patients can be very quick. Caregivers have lived with the patient during the progress of the disease and their experience has given them some expertise in the care—what works and what will not. The caregiver wants to know the days the doctor comes to the facility and they want to know how they can speak to that doctor. There is

a terrible feeling of frustration—and I think "despair" is not too strong a word—when there are questions and no one will take the time to answer them. The caregivers need to be respected, and if they knew their knowledge of the patient was listened to, the respect would be reciprocated.

I think every facility should have a family council. Perhaps the proposed office of the long-term-care homes could make this part of their mandate, but look at the present councils and prepare a report on best practices which could be used for new councils to get started. I believe that family councils could and would assist the facility in its provision of care. Families know the problems they had in being providers of care. They have to appreciate that the facility has problems also and that by working together, much good would happen for the patient.

Another suggestion would be to hire a volunteer coordinator. The last time I recommended that to anybody, I ducked all the eggs that came flying. However, I think they could be hired, either full- or part-time, to work with the family council and staff to build a volunteer group that will give the commitment and belong to it, and the home will know that they have this many volunteers coming in each day. They could help with the daily care. I know insurance would have to be a part of any volunteer program if volunteers are to help with actual care. I think that's possible. I think it can be done; it just takes a little negotiation and work. There would need to be some training in the areas the volunteer would be working in.

In the matter of daily care, there's just too much to look at—unless you want to stay for a week.

I believe the bill of rights must be posted with the mission statement on the bulletin board and again on every unit. The fact that a patient has only three diapers allowed for a 24-hour period is scandalous. Toileting is a problem for some of the patients, but there has to be a better solution. When a person sits in their own urine or feces for long periods of time, the resulting skin breakdown should not surprise anyone, and it raises the question: Is this abuse, and abuse by whom?

Bathing patients using anybody's soap or deodorant is a great way to spread bacterial infections. Patients have their own toilet articles, to be used by them. We talk a great deal and we put up signs in every public building about washing hands, about cleanliness and about spreading bacteria. In facilities, the protocols for all personal care, including bathing, must be clear.

I think skin problems will be observed soon enough without daily washing. I find it difficult to comprehend how adequate cleansing is accomplished if the diaper is changed where the patient is standing, and there is not much dignity in that process. Record-keeping for patients' skin breakdown treatment and progress should be charted and updated daily. Bedsores are often the result of poor care, insufficient diaper change and patients left for long periods in soiled diapers.

Taking patients out of their rooms when they are not properly dressed, either in night clothes or day wear, cannot be allowed. There is no pride or dignity allowed when a patient is paraded or taken through public hallways in their underwear. Patients with hearing and/or vision loss should be approached appropriately. In our family, a hard-of-hearing dementia patient was repeatedly approached from behind for diaper change. Done while he was standing, the patient could not hear or see the staff approach, and often—every time—reacted negatively, as would anyone whose pants would just be pulled down without any warning. Again I ask: Is it abuse? If it's abuse, who is it by?

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I know how hard the staff who are doing the daily routine work. It's tough work. It is obvious to me that they need help and special training, and I don't believe this legislation is going to go far enough for that.

I don't know what the training or qualifications required for LTC staff are. I looked at the programs that are being taught for health care workers or health aide workers, and as far as dementia and Alzheimer's, I wasn't really impressed. I think all of that has to be examined. The training needs to address attitudes and it needs to be ongoing in the facilities. When students in any training or learning program or any type of career college are going into long-term care for their on-duty work, I think the supervision has to be with the people from the college who are teaching them. I don't think it's just turning them in there with a uniform and saying, "Now you're learning." It might make the professional development more meaningful if all of the staff were expected to be involved in presenting to their colleagues.

I worked in an emergency department for many years and when they told us that everybody in the department was going to do professional development, I thought, "If that custodian is going to teach me something when I've been here 25 years, we're going to have a little bit of thinking here." Well, he did. We learned a lot from each other. We learned what worked and we learned what made work difficult for other people and we made the emergency department work better.

I believe the staff of the long-term-care homes should be full-time, with a minimum of part-time people. Most of these patients do not deal well with change, and different staff every day is unsettling for them. The staffing must recognize that there are both male and female patients, and the staff has to reflect this. Too often we accept that it is not the best to have a male attendant looking after a female, and I agree with that, but I think it works the other way. In the term our family dealt with, there was never a male attendant looking after this male patient.

I agree with the proposed annual inspections and assessments. I believe the resulting report, with recognition of all the positive practices and any recommendations for change, should be available to all residents and family, as well as to prospective residents. This report might be a good time for the administrator to be invited to a meeting with the family council to discuss the report and to listen. I know there are many good things

happening in our long-term-care facilities, but even one bad accepted practice is too many.

I do thank the men and women who work so hard to care for these very vulnerable patients, but help in the form of ongoing in-service training is needed and I hope your committee will see the need for changes in the system. You need to be visionaries about what could be the norm in long-term care. You need to make us take risks and try things that would make life better for all of our residents in our facilities.

I have felt a great deal of anger and a large measure of frustration over the past year. Thank you for this opportunity to share some of this with you, and thank you for caring enough to sit on this committee. We are counting on you.

In the last years I've spent a lot of time with a severely handicapped person. We went out for coffee and walks—well, I ran and he drove his chair. At first, when he had to be admitted to a facility, we cried the whole morning. Actually, he prayed that he'd die; he didn't. And then we laughed a lot and he made the best of a not-so-great deal. We used Louis Armstrong's song "Prayer of Thanksgiving" for what we were able to share.

I see skies of blue
and clouds of white,
the bright blessed day
the dark sacred night,
and I think to myself
what a wonderful world.

And then we said amen.

I believe that all long-term-care facilities, with more help, such as better funding and realistic support, can help all of our resident patients and their families see the possibility of a caring, wonderful world. Thank you.

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

BELVEDERE HEIGHTS HOME FOR THE AGED

The Vice-Chair: We'll move to the next presentation. It will be by Belvedere Heights Home for the Aged. Welcome, sir.

Mr. Peter Spadzinski: Good afternoon. From the outset, I must confess a bias. My bias comes from having spent 18 years on municipal council, 15 years as mayor. I retired in 2003—voluntarily, I should say. Within about six months I was asked to join the board of our long-term-care facility. Within another three months, I found myself as chair. Last year at this time, we had an annual municipal meeting, at which time I announced to the assembled former colleagues that we were raising their municipal levy by 63%. We had another session with these municipal representatives last Thursday night in Parry Sound and we announced to them that we were raising their municipal levy by 55% this year. And that did not take into account a drop in the CMI from 89 to 83, which was announced after we finished our budget process.

So when I come and speak to you about Bill 140, I can tell you I bring a bias. It is very difficult for me to consider this bill seriously in light of the gross underfunding of our long-term-care facilities. There's a saying that it's easy to talk the talk. What I want to suggest to the province is that if you want us to take Bill 140 seriously, you must begin to pay for the walk.

One of the things that concerns us as a board is that we are dealing with declining resources, but the care must continue. Because people no longer need quite as much medical attention, and it seems to me that most of our funding is determined by that, that does not mean that we turn down the heat, we turn off the lights, we stop feeding them good food. Yet the funding formula, the funding provisions, the way funding is determined to a great extent seems to have that as a mindset. The CMI system does not recognize all of the realities of funding a long-term-care facility. In light of that, when we are told now by someone that we must increase our administrative functions, my question is—and this was my response to one of the mayors last Thursday night when he said, "You're not doing well enough. You go back and you sit down with your budget and you reduce it from 9%," which is what the increase was of our actual budget, "down to 3%. What are the things you're going to cut out?" I said, "That's a very simple thing for me to say to you tonight. You tell me whether we should heat the place, have lights on, feed the residents, have nurses on staff. Which one of those do you think we should eliminate?"

So when someone says to me, "By the way, in order for better care for our seniors, you're going to be doing more recording," I say, "There's nothing wrong with recording, but if people are recording—to use an old army cliché, if you're marching, you're not fighting. If you're recording, if you're writing on paper, you're not providing care."

If you want, as Bill 140 suggests, more recording, more accountability, it's time that the province put its money where its mouth is. If you want us to take Bill 140 seriously—and we ought to—you must understand that homes like Belvedere Heights have declining resources, and we cannot take seriously a lot of the suggestions—not the suggestions; the proposals—that are in Bill 140 until you make it clear as to how these things will be funded.

Municipalities will no longer accept the kind of increases that we announced last week. I live in a municipality that has just informed me that I will be paying over $5,000 more for a water system that came as a result of Walkerton. That's my own share of the costs. At the same time, I was told that my water costs would be over $100 a month. For me then to go to those same municipal councillors and say to them, "And by the way, we have now more than doubled your municipal levy over the last two years," you can well understand the kind of reaction that we are getting.

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Again, I know I perhaps bring a different perspective on a lot of these things. I've been around for a while, and I'm not naive when it comes to certain things.

I would suggest to you that with regard to some of the proposals within the legislation concerning the penalties for board members like myself—I'm a volunteer. I do not need to do this to get my jollies. I do it because I care about seniors—I'm getting close to that age myself—and I want to provide a good home for our seniors. For someone to suggest to me that I could be imprisoned, incarcerated, that I could be fined up to $25,000 for not exercising due diligence—I would suggest to you that the people who are underfunding our current system perhaps are the ones who ought to face that kind of penalty. It's like me saying to my child, "You must eat vegetables. You must eat fruit. You must wash your hands. And now, here's a piece of paper, and I want you to record how often you eat those vegetables and fruits, but I'm sorry, there's no money for the fruits or vegetables or the paper on which you're going to record what you are doing."

If you want us as a board, the municipalities as an entity, as owners of a long-term-care facility, to take seriously what you are proposing in Bill 140, as I said at the beginning, you can't just talk the talk; it's time that you started to fund the walk adequately. Otherwise, it'll only be seen as hypocrisy. Eventually, hypocrisy leads to a lot of contempt and neglect.

I would suggest to you that it is time that the province took seriously the care of senior citizens, as was promised in the last election. Since that election, the funding has gone down disproportionately. For some residents and for some homes, it has gone down dramatically, and the levies to municipalities have gone up in an incredible way. It's time that we took long-term care seriously and paid the price as a society.

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

Ms. Smith: Belvedere Heights in Parry Sound is a new home. Is that correct?

Mr. Spadzinski: Yes, it is. It opened in 2004.

Ms. Smith: Prior to that, was there a previous incarnation of Belvedere?

Mr. Spadzinski: Yes, there was. It was a D facility, as a matter of fact, so it was replaced. The old building is still standing, and the board is dealing with what to do with that old portion of the building. But there is a new facility, yes.

Ms. Smith: Do you run other programs at Belvedere other than long-term care? Do you run a day program for Alzheimer's or Meals on Wheels?

Mr. Spadzinski: Yes, we do. We have Meals on Wheels. We have a hospice program. We do run other programs in conjunction with our own operation.

Ms. Smith: As do a lot of municipal homes. But those don't come under the long-term-care mandate, so we appreciate that you're doing that.

We have invested, as I've said a number of times today—I don't know if you were here earlier—$740 million more in the system. I know that in 2004 the municipal sector specifically received about $100 million more in their per diem in order to redress some historical problems that we had in the funding model.

Certainly we recognize that long-term care is a work in progress, and while this is legislation, we know that there are funding issues. We've heard from a lot of presenters, and I'll certainly make sure the Minister of Finance hears your point of view on this as we continue our budget deliberations.

I wanted to ask you a question on your compliance history. Belvedere has had a great compliance history, with very few "unmets" in the last few years. One of the things that we've talked about with some of our stakeholders is, how do we recognize good homes? Short of more money, which I know is going to be your first answer, are there ways that you, as the chair at Belvedere, would appreciate being recognized for running a great home in Parry Sound?

Mr. Spadzinski: I think the recognition that I find very rewarding is hearing at our monthly meetings some of the comments that family members make about the care of their parents, their relatives. I believe what we need to do is create a culture, and the culture that you create within a facility like Belvedere Heights has a lot to do with some intangibles. The intangibles that I believe make the difference in a long-term-care facility are staff knowing that they are appreciated, and the board being aware of the requirements and the needs and providing the tools to staff to take care of the things that they've been asked to do. It took Belvedere a little bit of time to develop that culture. We were actually in some difficulty in the late 1990s, and things have turned around dramatically. But I believe it's a culture.

I have to commend the province for addressing some of the issues that have been addressed in Bill 140. I may have been a little bit too off-handish or off the cuff in saying that it's hard to take those things seriously, but quite honestly, we are fighting a war now, waging a war, in a sense, over funding with our municipalities, and we haven't heard the last of it. I fired the opening salvo when I announced the 55% increase last Thursday night, and I can tell you that there's more coming.

The Vice-Chair: Mr. Ouellette?

Mr. Ouellette: Just a quick question: You mentioned that the level of funding needs to be stepped up, and we've regularly heard about the $6,000 commitment. Do you think achieving that $6,000 will satisfy the funding requirements?

Mr. Spadzinski: In our case, it won't. We're well beyond the $6,000, but it will certainly help. We have some factors that we hope will be rectified, including an old building that isn't being utilized but that we still have to maintain. I can tell you that our municipal levy—I just did the rough calculations—is about $12,000 over and above what we get from the residents and from the province per resident. And of the $6,000 that was

promised, I think we have received about $2,300. So an additional $3,700 won't cover the total $12,000 per resident per year, but I believe it will certainly make life a little easier for the board.

I believe the municipalities understand. They want to provide a good facility, and they're on board with us on that. But they are dealing with a lot of other issues, as you know, real problems with their infrastructure and the soft services. I always said, when I was the mayor of our municipality, that there are some things you just shouldn't pay for through property taxes because they don't fully recognize your ability to pay. I believe that some of the soft services that have been downloaded—I think municipalities are really stretched now to try to do all the things that we're requiring them to do.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you for your presentation. I appreciate you've said that even $6,000 per resident is not going to get you over the hump. It might for some, so I'd like to see the government at least live up to that promise.

Let me follow up on you saying that that's not going to get you over the hump, because that's the current situation. The legislation, for example, mandates the licensee to ensure that the plan of care that's developed for each resident is provided. Then, in section 74, it talks about additional training to those staff who provide direct care. So you're going to have an obligation to provide increased training, especially around patients with dementia etc., all of which I agree with. You already have a serious financial problem that's not even going to be fixed if the government lives up to its promise. What are you going to do with the rest of this?

Mr. Spadzinski: As I said, we're in a very difficult bind. For example, we've talked about computerization. We are partially computerized, but even to find $60,000 to complete that, and the staff training that goes along with that, is a stretch. So when you add additional requirements—and of course I listened to the last speaker. We can't do enough to take care of people who are so vulnerable and we want to do the very best. I believe that we're doing a great job in Parry Sound, but at the same time I'm at the point of frustration where I'm ready to resign. I have to tell you I'm not a quitter, but I almost feel overwhelmed. So when these new requirements come on board and there's no corresponding funding that's announced with it, it may come. I don't know, but the way things have been going, I'm a little suspicious about that.

1410

So here are these additional requirements, and we can't even meet the mandate now. That's why I'm saying it's very difficult for us to then take these new mandates seriously, the new requirements, when we haven't even been able to fulfill our current obligations without this incredible pressure that we're passing on to the municipalities. There are seven board members; two are provincial appointees and five are appointed by the area municipalities in the Parry Sound area. I can tell you that we're going to be hard-pressed to find lay people who will serve on the board. Municipal councillors will come, but when they come, I can tell you there will be a different approach. They're not going to introduce 55% levy increases to their own councils. There's going to be a different approach.

I really appreciate the opportunity to speak to you and I wish you very well. Remember us out in the boonies, those of us who actually deliver the services to the seniors.

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

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2368

The Vice-Chair: We'll move to our next presentation, which will be by the Canadian Union of Public Employees Local 2368. Welcome back again. You can start whenever you're ready.

Mr. Leo Orford: Good afternoon. Thank you for allowing me this time to present to you issues of concern regarding Bill 140. My name is Leo Orford. I'm president of CUPE Local 2368. With me are Maxine Middaugh, vice-president of CUPE Local 2368, and Brian Blakeley, research rep with CUPE Ontario. I am a personal support worker and have worked for the past 10 years at Manitoulin Lodge nursing home in Gore Bay.

I would like to start by congratulating the Liberal government on taking the initiative to address long-term care in this province. I believe that Bill 140 is a step in the right direction in consolidating three older pieces of legislation. However, if we are going to tackle the issue of long-term care, then let's make sure we completely address the issue and make this piece of legislation perfect.

Today I will address two areas of concern with this bill for my local and myself personally. Those two areas of concern are that Bill 140 does not address the need of a minimum standard of care, and also section 155, the appointment of an interim manager and the continuance of a collective agreement.

First, let me address the minimum standard of care.

CUPE Ontario has submitted to you in earlier briefs in Toronto a request for a standard of 3.5 hours, equal to the province of Alberta, and I support that proposal fully. A copy of this proposal is with my attachments. Let me explain why I support this recommendation by giving you a brief overview of my place of employment, Manitoulin Lodge nursing home.

Manitoulin Lodge nursing home is a 61-bed licensed and accredited facility with three additional beds: one short-stay and two respite. This facility is privately owned by Jarlette Health Services. This facility has both no-restraint and no-lift policies in place. Currently, this facility has an approximate 2.2-hour level of care per resident per day. Remember that this total includes not only care from the personal support workers, health care aides and nurse aides but also from the registered nurses

and registered practical nurses. I have provided in my summary a breakdown that shows the calculations and allotment of these hours of care per 24-hour period per shift.

From these hours of care per resident per day, my membership must care for these 64 people. I use the word "people" because I want you to remember that when we refer to residents in long-term-care facilities, we are speaking about real people. Out of these 64 people, 92% suffer from some form of cognitive impairment, be it psychiatric or dementia-related. Out of these 64 people, only four do not suffer from some form of incontinence. With ambulation and transferring, 30 of these 64 people are wheelchair-bound or -dependent. Twelve of the remaining 34 people are dependent on walkers or canes and require staff assistance or supervision with mobility. Five of the remaining 22 people require staff assistance with ambulation. Of the 17 remaining people, only three do not suffer from an unsteady gait. For transferring, there are nine that require a mechanical lift and 14 that require a two-person transfer.

With activities of daily living, 55 of these people require total care with washing and dressing. Of the other nine, five require constant assistance from staff in washing and dressing and four require minimal assistance. With feeding and meal consumption, there are 13 who are complete feedings and 15 who are constant encouragement and assistance. These are just some of the facts that I thought might help paint a picture for the members of this committee as to the care levels that currently exist within nursing homes.

Also in my submission, I included a copy of the duty guidelines for Manitoulin Lodge to help give a breakdown of how care tasks are distributed or assigned. If you review these guidelines, you will note that this is a very time-regimented process and that it leaves no room for unusual occurrences. Let me explain in a little more detail what I mean by unusual occurrences. This can entail, but is not limited to, explosive diarrhea, vomiting, excessive behaviours or aggression, illness, palliative care measures, falls and injuries etc.

I am sorry, but with limited time and hands-on care, the people are impacted and their quality of life suffers the consequences. I am sorry, but promotion of self-sufficiency is overlooked because, for example, a caregiver can wash a person's hands and face faster than letting the individual do the task, and then touch it up if they did not do a good job. I am sorry, but episodes of incontinence are not avoided because a caregiver cannot be at two places at once and cannot attend to the toileting requests of four or five people all at the same time. I am sorry, but residents' choices are reduced because staff do not have the time to search through a closet if the first choice of clothing provided is not satisfactory to the resident. I am sorry, but residents must wait for their needs to be met, which can lead to an increase in behaviours, which in turn leads to an increased workload. I am sorry, but an increase in staff workload can lead to an increase in staff stress levels, which impacts on our care and ultimately impacts on the people we are caring for. I am sorry, but without the hours and staffing, charting and documentation are placed second to care. Thus, behaviours go undocumented or just become accepted as the norm for that individual, effectively resulting in a loss of funding. I am sorry, but without more time and staff, standards will go unmet. Currently, it is now a task to get our people to breakfast on time or have an extra minute to encourage fluid intake so the 48-ounce fluid standard is met.

This is a vicious cycle, because if we do not meet standards and complete the documentation, our funding is affected and, ultimately, the hands-on care is affected or reduced and the workload becomes more impossible. A minimum standard of care, as suggested by CUPE Ontario, of 3.5 hours would help to resolve this cycle and provide the front-line staff with the extra time that is needed to give the people that little extra and make their lives a little more enjoyable.

Please remember that the people of Ontario's long-term-care facilities helped make this province what it is, so let us make this piece of legislation what it needs to be. Address the issue of a minimum standard of care and give these people the care and respect they deserve. For myself, I hope that it is a while before I need the services of Ontario's long-term-care sector, but for some on this committee and for a lot of this province's voters, it is a reality of the near future. Please consider this as you contemplate this piece of legislation.

Now let me address my second concern: section 155. This section deals with the interim manager appointments under section 154 of this bill. Currently, this section of the bill will lead to labour relations instability and ultimately impact resident care. If an interim manager is appointed, then I see no reason why the employees' current collective agreement could not and should not stay binding. If the faults leading up to the appointment of an interim manager lie with the owner, why should the employee suffer? Therefore, I and my local support CUPE Ontario's submission that Bill 140 should be amended to provide for as little disturbance or disruption as possible when an interim manager is appointed by deleting subsections 155(7) and (9).

Thank you again for allowing me this time to present on Bill 140. I again ask that you consider the submissions you hear at these limited public hearings before finalizing this piece of legislation. This bill has the potential to truly address and fix long-term care in this province. All this committee needs to do is listen to the people, listen to the caregivers, listen to the families, and listen to the people within the long-term-care sector who know first-hand what this bill needs to be perfect.

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

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Mr. Ouellette: Just a quick question: You mentioned that you had a no-restraint, no-lift policy in place, yet on the next page you mention that nine require mechanical lifts and 14 require two-person transfers.

Mr. Orford: Yes, a two-person transfer not in lifting but in stabilizing the transfer so that they don't—

The Vice-Chair: Would you mind getting closer to the microphone?

Mr. Orford: It's to stabilize them and make sure that they don't fall. They still are able to weight-bear, it's just that they need a slight lift. Someone who cannot weight-bear we're not lifting entirely with our body. We have machines for that.

Mr. Ouellette: Okay. Thank you.

Ms. Martel: Thank you for your presentation. I want to focus on section 155. I think I understand what you want in subsection 155(7). If I read it correctly, there shouldn't be any changes to the terms and conditions, even if there is an interim manager. If a collective agreement is in place, everything should stay the same.

Mr. Orford: Yes.

Ms. Martel: Okay, I get that one. It's subsection 155(9) I'm not quite certain about. Do you mean, then, that if there is a change, it should be considered a sale of business so that successor rights apply? I apologize if I'm getting this wrong.

Mr. Orford: I'll refer this to Brian.

Mr. Blakeley: Ms. Martel, it is handled as a sale of business and we have no problem with that. The problem we have is that currently during the period of time of the interim manager's presence, the collective agreement is not continued by legislation; in fact, it's stopped. So we would ask that the act be amended so that the collective agreement continues to apply. We note and we're pleased to see that the act provides some financial security to employees of the departed, if I can say that, employer. We'd just like to see these two sections dealt with so that the collective agreement applies, the sale of business would carry through, and people wouldn't suffer because of the conduct of their previous employer.

The Vice-Chair: Ms. Smith?

Ms. Smith: Just to clarify, though, after an interim manager, if someone else is coming in, then that transfer is considered a sale of business and everything applies yet again. So it's just for that short period of time where there may be an interim manager in place, and even in that situation, we have made provisions in the legislation so that the financial implications that could result are covered off by the government or the interim manager.

Mr. Blakeley: Yes, and we believe that what we're asking for is a very minor adjustment. The reality of our experience is that in most cases the collective agreements are de facto continued; they're just not legally binding. It seems to be a relatively minor change that we think is a good step to protect people's rights.

Ms. Smith: Just to follow up on Mr. Ouellette's point, the "no lifts" is no physical lifts; you can use mechanical lifts. Is that right?

Mr. Orford: Yes.

Ms. Smith: Okay. And your 2.2 hours of care—this is the calculation that you have attached?

Mr. Orford: Yes.

Ms. Smith: And that's what's happening presently at your home on Manitoulin. So you're including in that number the RN, the RPN—sorry, in some places it says "RN" and in some places it says "day shift." Those are personal support workers or health care aides?

Mr. Orford: Yes. That's off to the side in pen. I put "PSW" and "health care aide." Sorry.

Ms. Smith: Okay. That's great. Thank you very much.

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

DAVID CHESLOCK
CATHY LABRASH

The Vice-Chair: I believe the District Municipality of Muskoka is not here. Are they here? No. So we are going to move to the following presentation, by David Cheslock. Is he here? Okay. Welcome to the standing committee on social policy. You can start whenever you're ready. You have 15 minutes. You can divide it between presentation and questions.

Mr. David Cheslock: First of all, thank you to the Chair and the members of the committee for allowing us to make a presentation to you today. My name is David Cheslock. I'm a registered practical nurse with over 13 years in the long-term-care industry. Joining me today is Cathy Labrash, also a registered practical nurse, with over 15 years of service in long-term care. I'm a former employee of Extendicare Falconbridge and Ms. Labrash is currently employed in a full-time position at Extendicare Falconbridge in Sudbury.

We're here today to raise our concerns regarding the new Long-Term Care Homes Act, as it has been proposed, and its effects on resident care. It seems that only a few short years ago Mr. Smitherman promised us a revolution in the long-term-care industry and proposed to fix the problems that plagued this industry for over a decade.

In a response to a Local 204 SEIU questionnaire that was sent out on June 11, 2003, Mr. McGuinty's government promised to reinstate the minimum-hours-of-care standard that was removed by the Harris government. This included 2.25 hours of nursing care daily. Furthermore, they promised they would instate a three-baths-per-week standard. The reality is that we have seen no standard of three baths; instead, we have seen two baths. And we have seen no standard hours of care. My question is, what happened?

The staff who care for our family members every day in long-term-care homes used to pour their hearts into providing this care and they used to be a surrogate family, filling in for us when we were not there due to our work and other obligations. I say they used to, because with the increasing workloads caused by government regulations and more medically complex cases, the staff have simply run out of time.

In regard to the bathing issue, let me say that what I learned in school was that three does not equal two.

Giving every resident two baths per week is a great improvement, but it is definitely not three. The only problem with the two baths is that there was no increase in the staffing to accommodate the change in workload. At Extendicare Falconbridge in Sudbury, they put in the two baths without any increase to the number of care hours being provided. This means that the same number of staff must now give approximately 234 additional baths every week. My mother always said that I would never be an accountant and that I'd never be a mathematician, but I know bad math when I see it, and that is bad math.

I think when we discuss hours of care, there is often a misconception of what that actually means to a resident's life. If we look at the hours of care at Extendicare Falconbridge, based on SEIU calculations, there was an average 2.12 hours of care per resident per day. When you take RNs into consideration and realize that they typically do not provide hands-on care and you take them out of that equation, it reduces it to 1.93. It sounds like a lot of hours—1.93 hours per resident per day. However, when you look at it in reality, what does the number really mean?

Let me point out a few things that no one takes into consideration when looking at hours of care. Of that 1.93 hours there are tasks that need to be performed that do not provide direct interaction with a resident. For a PSW, this will include 20 to 30 minutes of charting each and every shift that must be done. This used to be much shorter, but over the years government regulations designed to ensure proper resident care increased the amount of charting required. Other tasks include loading linen and supply carts to take to your rooms on your rounds, cleaning every piece of equipment that you need to perform your duties, and for infection-control purposes, frequently cleaning them in between each resident.

It includes putting away personal laundry, cleaning bedside tables, dressers and closets. It includes checking every item in a room to ensure that a resident's name is properly identified on each and every item; serving dinner plates at all meals, including beverages; hauling away dirty laundry; in-servicing to ensure people are properly educated and updated on all aspects of their duties; serving refreshments three times a day; and let's not forget, going room to room to get equipment. Walking actually takes a lot of time in some of these big buildings. All of these things cut into the time of the 1.93 hours.

Let us not forget that the RPN role is critical to care of the client as well, but they surely spend much less time with a resident than the PSW does. Much of their time is spent preparing medication for the resident, as it usually takes more time to prepare than it does to actually administer that medication. An RPN can take on average two and a half to three hours for morning medications, one to two hours for noon medications, one to two hours at dinnertime for medications and another three hours for bedtime medications. This does not include what are called PRN medications—as-needed medications—such as analgesics for pain.

An RPN must further chart all PRN medication given. This means that a simple Tylenol can take up to five minutes to prepare and chart, not including the time to actually administer that medication. Charting can take several hours each shift when you include the charting for PRNs, resident quarterly reviews, doctor orders, signing in medication from pharmacies and other tasks.

I could spend an hour just running on about those individual things that cut into that time. We should also consider that RPNs must address family concerns and answer repeated phone calls to the units. None of these tasks provide interaction with a resident, but they all become part of that 1.93 hours.

1430

Based on this information, I think it is fair to say that hands-on care can actually be measured in minutes, not hours. I am not saying the tasks are not important; I'm not saying they don't have their place. However, they do not provide hands-on, human interaction, the missing component of the formula for quality resident care. I could bore you with a lot of numbers and studies that show that Ontario is at the bottom end of the care hours, but I'm sure you all know these numbers already. I ask the government to reinstate the standard hours of care into the act and increase it to 3.5 hours, thus bringing Ontario in line with the rest of North America. Ontario residents deserve better.

Ms. Cathy Labrash: Thank you for allowing me the opportunity to speak to you today. I would like to address the staffing issues challenging the long-term-care industry.

Almost every day that staff report to work, one of the shifts is working short-staffed. The shortage of staff is a result of the employees leaving the industry to go to hospitals, where the workload is substantially decreased and the wages are much higher. This makes it nearly impossible to recruit and retain staff.

Allow me to provide some examples of recent events at Extendicare. Saturday, I was asked to work a double shift. Sunday, I received the same request. No sooner had I arrived at home than I received a phone call asking me to come back to work a night shift as a responsible RPN. "Responsible" means there is no RN available to work the shift, and the RPN assumes the responsibilities in his or her place. This means that there is no RN in the facility on that particular night.

The employer's response to a situation like this is an on-call list. If I need a medical directive for a resident who may be having pain, I must call the manager who is on call. This does not allow for proper coverage during an emergency situation. The employer is increasing the training for RPNs who are willing to work as a responsible person. How does this address the fact that there is still frequently no RN in our facility?

To further the problem, if no one is willing to come into work and the RPNs are already working short that night, they are told that they are responsible for their own floors. This reduces the number of professional staff in a building from the regular four to three. One can only

hope that we are not already working short on one of those floors—RPN or PSWs.

The best-case scenario is that all staff show up on a night shift and we have 10 people in our building to spread over our three floors. What will happen should there be a large-scale emergency in this facility?

The staffing in general in our facility has reached critical proportions. We continually work short, which ultimately impacts our residents. The only way to address the shortage is to address our workloads and the hours of care. No staff member wants to go to work and tell a resident that they don't have time to assist with some task of daily living, but what is the choice? Telling a resident that you do not have time right now is a totally unacceptable response.

There are insufficient people to provide care as mandated by the Ministry of Health and Long-Term Care. The employer regularly reminds staff that work has to get done even if we're working short. The employers have developed staffing plans, frequently called "plan Bs," which is one staff member short on a unit, and sometimes we've been "plan C," which is two staff members short on a unit. When all else fails, they'll tell us to pass it on to the next shift. The question is, where does this overflow ever get picked up? The other shift is already running to capacity and often they are working short as well.

Regardless if it is a PSW, an RPN or an RN, the end result is that we are working short. It seems to be a never-ending circle. The real surprise occurs when staff come to work and find out we are actually working full-staffed.

Insufficient staffing puts residents' safety at risk. Even at full staffing levels, there are not enough bodies to monitor the residents. On my unit there are nine PSWs, two RPNs and one RN on a day shift. There are approximately 78 residents with numerous health and care issues. Although it looks good on paper, the truth is that we are constantly pulled away from resident care for many different reasons, such as:

—in-servicing, which reduces staffing to half. These in-services are usually held for 15 to 30 minutes and occur before a break. This means that half the staff could possibly be off our unit for the better part of an hour. Most of this in-servicing is mandated under the Ministry of Health standards; and

—professional staff meetings. These meetings take all our professional staff off all units for approximately one hour, give or take 15 minutes.

The level of burnout among long-term-care staff is increasing every day. The staff are emotionally drained by the demands put on them by all parties. Residents are not blind to human emotion and easily detect the tension and fatigue of the staff. This does not lend itself to a therapeutic relationship. Ultimately, staff pays the final price for the stresses by injuring themselves trying to get an unreasonable workload completed. The end result is another short-staff situation that will result in lower resident care.

The most recent demand on staff has come as a result of the MDS program developed by the Ministry of Health and Long-Term Care. This program alone has increased the amount of work required from every RPN in the facility. An annual assessment on a typical resident under the program will take an average of 30 minutes. The follow-up documentation required by this program can increase the charting on every RPN by several hours a week. The staff find it difficult to meet the deadlines in this program due to existing workloads, as evidenced by frequent reminders by RAI co-ordinators that assessments are due.

These are some of the challenges we face in regard to staffing levels.

I would like to thank the committee for allowing us to present to you today.

The Vice-Chair: Thank you very much for your presentation. We have two minutes left, which gives every party a chance for a quick question or comment. Ms. Martel.

Ms. Martel: Thank you, both of you, for being here today. Double shift: Does that become 12 hours?

Ms. Labrash: It's 16.

Ms. Martel: So, Saturday, 16; Sunday, 16. You got home and were called in for Sunday night to come in for a night shift?

Ms. Labrash: Had I accepted the shifts, it would have been a 16-hour shift on Saturday and a 16-hour shift on Sunday as well.

Ms. Martel: How often is there no RN in the home at night?

Ms. Labrash: I'm not really sure of the numbers, but it's quite frequent.

Ms. Martel: How often are you working short-staffed? Is that being monitored by the union at all, for example?

Ms. Labrash: Yes, it's reported to the union when we are working short, and we just keep track of it.

Ms. Martel: Do you have any idea, let's say, in the last six months, what those numbers might be? Sorry to catch you off guard. I'm just curious.

Mr. Cheslock: About 20 times every month, they're running staff-short.

Ms. Martel: And you're also monitoring if that's one short or two short? Should I assume that's usually one?

Mr. Cheslock: We are monitoring it, and we can pull it. You shouldn't assume it's one. Sometimes it's two. Sometimes it's one on every unit. Sometimes it's up to two per unit. So it's not uncommon.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: Thank you for being here. When you don't have a 24/7 RN, has that been reported to the ministry? Because there is a regulatory requirement now for 24/7 RNs in our homes.

Ms. Labrash: I'm not sure if it has been.

Ms. Smith: I wanted to ask you, when you did your calculations about the number of hours—and then I think you factored out the RN. We had other presenters factor out RPNs for the minimum standard number. We've had a variety of opinions on what should be included in the minimum standard number. I'd be interested to hear

which caregivers in the home you think should be included in the minimum standard number.

Mr. Cheslock: I believe it should include anyone who provides actual hands-on care or interaction with a resident. So we would say that would include RPNs, PSWs, and it could potentially include RNs, depending on the job description of that individual. It shouldn't include an RN who is a supervisor rather than an actual hands-on care provider.

Ms. Smith: Would you include in that number any of the activation people, the activities coordinators, the people who deal more in the secure units with those suffering from dementia, who may not have actual physical demands but may need more redirection and help—sundowning?

Mr. Cheslock: In the facility we were looking at, which is the one we come from, there is no one in that capacity. The activation department doesn't provide that type of care. They provide actual activities. So I would say, in that case, no.

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

The next presentation will be by the city of Greater Sudbury. I believe they're not here yet. Is anybody here from the city of Sudbury? We'll recess until 3 o'clock.

The committee recessed from 1440 to 1441.

CITY OF GREATER SUDBURY

The Vice-Chair: If it's okay with all members, the mayor of Sudbury is here, so we can start anytime. It's okay with you? From the city of Greater Sudbury we have a councillor with us, the deputy mayor.

Mr. Ron Dupuis: Good afternoon.

The Vice-Chair: Good afternoon. You can start whenever you're relaxed and ready.

Mr. Dupuis: We will be having Randy Hotta, who is the director of our city-owed facility.

As stated, my name is Ron Dupuis. I'm a deputy mayor with the city of Greater Sudbury. For the past six years, I have also represented city council on the management board of Pioneer Manor, which is a municipally owned and operated facility. As a sidebar, I just want you to know that both of my parents live at Pioneer Manor.

First and foremost, it's important that I thank the standing committee on social policy for allowing us this opportunity that ensures that Bill 140, the Long-Term Care Homes Act, 2006, will be amended so that it ensures that all residents who access accommodations and care in these facilities not only remain the focus of this proposed bill, but that long-term-care facilities will be accountable in a way that is realistic.

The city of Greater Sudbury, as you've probably heard today, has six long-term-care facilities with a total of 1,218 long-term-care beds. Due to the bed shortages in our acute-care system, there have been an additional 72 interim beds added. Of those 72, 70 are currently being managed by Pioneer Manor.

The demographics of our community critically indicate that the city of Greater Sudbury has a rapidly growing elderly population and that more and more older adults, seniors, will eventually require the care and services of a long-term-care facility. The Ministry of Health and Long-Term Care has recognized the needs of our community and has included Greater Sudbury in its recent call for applications for an additional 96 long-term-care beds that will then bring our long-term-care-bed capacity to over 1,300.

Since 1953, Pioneer Manor has been owned and operated by the city of Greater Sudbury. I am proud to say that for the past 53 years our facility has not only been home to thousands of residents, but it has been recognized as the facility of choice for many within our community. As well, for those 53 years the home has been financially operated in a very responsible and accountable manner.

Pioneer Manor is a member of the Ontario Long Term Care Association. Therefore, we strongly echo and support the amendments that they have brought forward to the standing committee on social policy. The city of Greater Sudbury is also a member of the Association of Municipalities of Ontario, and they have recommended amendments that are critical in ensuring that municipally owned and operated homes are recognized for their already significant contribution and accountability to their respective communities.

I recognize that there are a number of amendments that need to be made to Bill 140, but as the owner-operator of a municipally owned home for the aged long-term-care facility, the following issues are recognized by our board of management as having the most significant impact on our operations.

The first one of those is the duties of directors and officers of a corporation. Accountability is foremost the responsibility of any board of management. There is a need to ensure that those individuals in such a position remain credible and must answer to those who have put them in a position of trust. Municipally owned and operated facilities entrust their council members to this task. Section 67 certainly implies the need for accountability, but to an extreme that makes it unattractive to get involved on a board of directors or board of management and places a community in a very vulnerable position. Council members welcome the commitment they've made to represent their community on numerous boards, but we do so in a position where we feel we can make a significant contribution and in a manner of trust. If every board imposed the same penalty as is being proposed in Bill 140, many corporations would not recruit credible individuals. A board's role is to provide direction at the micro level and to make policy decisions. It is not their role to be involved in the day-to-day administration and operation of the homes. The board's role is to ensure the homes are well managed, not to manage them directly.

Licensing: In 2005, Pioneer Manor successfully completed a $22-million redevelopment plan whereby half of this 342-bed facility now meets the A standards. There

remain 154 beds which do not meet the new provincial standards but, according to this proposed bill, the ministry has the authority to enforce the upgrading of the facility as a condition of renewing their licence. The concern is not the fact that we should be ensuring that we provide residents with the accommodations and a lifestyle they deserve, but funding needs to be addressed in Bill 140 prior to the ministry's enforcement of such a matter.

As you're probably aware, on October 26, 2006, Pioneer Manor was the victim of an unfortunate fire that not only caused significant damage, but it also stripped 20 residents of their homes, and they lost the few cherished valuables that they owned. I hope that this bill will also recognize unfortunate incidents such as this and ensure that any restructuring that needs to take place will be done in a way that will only make a bad situation better.

Regarding funding, the city of Greater Sudbury is a proud owner of a home for the aged. We are very concerned that, through this proposed bill, the province of Ontario is trying to get municipalities out of the business of operating long-term-care facilities. History has it that when homes for the aged were legislated to become long-term-care facilities, we faced a massive challenge to our daily operations. The dynamics of the level of care changed dramatically, making it necessary for municipalities to conform. The challenge was not in the need to change the way we did business, but in the way we had to secure funding in order to make this happen. With any new standards that the ministry imposes there needs to be adequate funding to ensure that the systems can be put into place without any disruption to the residents. Therefore, I cannot stress enough that adequate funding is the only way that we can ensure that the new standards are complied with.

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Another matter that is worth mentioning is the per diem for raw food. Residents of long-term-care facilities receive $5.46 per diem, while prisoners receive more than twice that amount.

As I have indicated before, there are many other amendments that we do support. As the city of Greater Sudbury council stated in its motion that was passed unanimously on January 17, 2007:

"Therefore, be it resolved that the city of Greater Sudbury supports the need to ensure that submissions being presented to the standing committee be reviewed for consideration and whereby the proposed amendments will ensure that the purpose of Bill 140—Long-Term Care Homes Act, 2006—will improve people's quality of life and protect residents in long-term-care homes; and

"That there be sufficient operating and capital funds for homes to meet the requirements and standards of the proposed legislation."

An effective and accountable Bill 140, the Long-Term Care Homes Act, 2006, should be a piece of legislation that will allow us—owner-operators, residents, families and staff—to work together at ensuring that the care, services and support we offer to residents be world-class, so that through this whole process we remember whom this bill is intended to protect and serve and that the end result will be one that will benefit our residents, who are our mothers, fathers, grandmothers, grandfathers—anyone we love. Thank you very much.

The Vice-Chair: Thank you very much for your presentation. We have five minutes left. We can give almost two minutes to each party. Parliamentary assistant?

Ms. Smith: Thank you for being here today and providing us with some insight into Pioneer Manor. We did hear a little bit about some of the programming that you have there through the Alzheimer Society this morning, which was very helpful.

I, first of all, wanted to just clarify on the food issue. There's a big myth out there that keeps getting propagated about the food. In fact, the number that is put out about inmates is the prepared food cost of $11.43 versus the raw food cost of $5.46 which we have in long-term care. Our prepared food cost is actually $18.10. So if you're going to compare apples to apples, we are actually investing more in our food preparation than they do in our prisons.

You talked about the renewal of licensing. Pioneer Manor is, I understand, a municipal home, and you don't fall under the licensing scheme in the legislation; you are an approved home. Isn't that correct?

Mr. Randy Hotta: That's correct, yes. But in the act, is that going to change?

Ms. Smith: No.

Mr. Hotta: Municipal homes will not be affected the same way?

Ms. Smith: In municipal homes, we are continuing the status quo of approvals, yes. There won't be a licence or a licence term on municipal homes. So I just wanted to clarify that.

Also, when you talked about a change in funding, I did note that in 2004, when the McGuinty government put a large influx of funding into long-term care, one of the sectors that we invested about $100 million in was the municipal sector, and that was in order to redress the historical anomaly that had existed for some time. We heard a lot from your association on that point, so I just wanted to note that that investment was made in order to assist the homes, and in that year the increase in your per diem was quite a bit higher than the rest of the sector.

I want to thank you, though, for coming today and providing us with your input, and I look forward to continuing to work with you in providing long-term care in Sudbury.

The Vice-Chair: Thank you very much. Mr. Ouellette, I guess, is going to get one minute extra because I missed him the last time. My apologies.

Mr. Ouellette: Thanks for your presentation. First of all, in light of yesterday's headlines in the Sudbury Star, it's good to see that the local council is getting involved in trying to resolve a lot of these health care issues, although I was a bit concerned with the way it was reported in the paper about the response and how you're

working together. Can you give us any insight as to how the ministry is working positively with you to resolve some of these issues, or are you working directly on that? Do you know?

Mr. Dupuis: That is not part of my portfolio, but I have to be quite honest with you that when it comes to the local newspaper, I just don't read it.

Mr. Ouellette: That's fine. We heard from another individual on council who reported to his council last Thursday that they are going to receive a 55% increase in their municipal contribution to municipal facilities. Are you seeing that sort of response, or locally here in the Sudbury area?

Mr. Hotta: No.

Mr. Dupuis: Randy tells me no, but all in all, I think, if we look at what has been happening as far as health care in our area, there's a lot of frustration out there with our hospital and the slow movement on that, but it's something that is certainly being addressed. We're so looking forward to seeing that project completed.

Mr. Ouellette: You mentioned the capital funding requirements. On average, what would you expect that the funding levels would need to be as a percentage of the operation in order to maintain the level that's going to be expected for the facilities locally?

Mr. Dupuis: I'll refer that to Randy.

Mr. Hotta: I think the answer is that when you look at the legislation, for example in your type of question, what happens, to give you a real example, is that when compliance comes to a home and they order you to—for the sake of the argument, get mag locks and keypads. Correct? So we look at the costs. In this case it was $35,000. In order to comply with the Ministry of Health, the standard is that we require it because it's an older part of the building, so this money has to come from somewhere. Usually we have to find the money within the budget. We call the program people and they have no money.

These are just practical questions that we have to deal with on a day-to-day basis. In essence, with the capital side, whether it be renovations or anything, we have to do it ourselves. Unless someone else can tell me differently, there are other monies available for capital funding. I know that we're trying to get our B and C beds upgraded at the same time as well. There's a concern that if we don't keep the beds upgraded, compliance would come in and say, "They don't meet the standards." So we're caught somewhere between a rock and a hard place in those situations.

Mr. Ouellette: Thank you. Those are all the questions I have.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for being here today. The story, Ron, was about Sudbury's ongoing crisis with alternate-level-of-care patients. It has gone on for three years now. The council is well aware of it, and so is Mr. Hotta, because he has been trying to cope with it at Pioneer Manor. Can you tell me: What's the top-up—I'm assuming there is; maybe there isn't—that the municipality provides to Pioneer Manor for operations?

Mr. Hotta: It's about 4% of our budget.

Ms. Martel: Can you give that to me in dollars, please, Randy?

Mr. Hotta: In dollars, in real program dollars, I would say around $963,000.

Ms. Martel: What does that go into? Is that paying for additional staff?

Mr. Hotta: It pays for any overruns from the provincial dollars that we have in the budget. So it covers other costs beyond our budget.

Ms. Martel: Would the overruns usually relate to—

Mr. Hotta: For example, nursing.

Ms. Martel: Okay. I have two. So care—nursing: What about PSWs, RPNs?

Mr. Hotta: It's all the same group.

Ms. Martel: All of the above?

Mr. Hotta: Yes.

Ms. Martel: What portion of that $900,000 would then be directed to staff? You are trying to have the staff you need to meet residents' needs.

Mr. Hotta: Probably, in our budget, most of it, 90% of it, would be front-line staff.

Ms. Martel: Is that $900,000 plus an increase over the last couple of years? Can you respond to that?

Mr. Hotta: I think it has been pretty close to that amount. It went up a bit last year. We're one of the lowest, I believe, in the province on a per diem basis from municipal contributions.

Ms. Martel: In terms of the requirements in the bill, because the bill says you should have to meet the level-of-care plan that's set out for every resident, that you should provide the extra training that's required, all of which I don't disagree with, do you have any sense of where the money is going to come from to allow you to do that?

Mr. Hotta: It either comes from the user fees or it comes from the province, and that's going to be difficult right now.

Ms. Martel: Because the municipal contribution is already over $900,000 to cover a shortfall?

Mr. Hotta: That's right. And if we raise it, then we have to go back to council, and there are issues regarding using property tax money more and more for that type of purpose.

The Vice-Chair: Thank you very much.

We're going to adjourn until tomorrow at 9 o'clock. I believe we'll be in London at the Four Points Sheraton.

The committee adjourned at 1459.

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