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Wednesday 24 January 2007

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Mercredi 24 janvier 2007

**Standing committee on
social policy**

Long-Term Care
Homes Act, 2007

**Comité permanent de
la politique sociale**

Loi de 2007 sur les foyers de
soins de longue durée

Chair: Ernie Parsons
Clerk: Trevor Day

Président : Ernie Parsons
Greffier : Trevor Day

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 24 January 2007

Mercredi 24 janvier 2007

The committee met at 0904 in the Four Points by Sheraton Hotel, London.

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 Chair (Mr. Ernie Parsons): Good morning. I would like to call the meeting to order. Welcome to the standing committee on social policy, here to receive input from you on Bill 140, An Act respecting long-term care homes.

Just as a general announcement, each presentation will have 15 minutes. You're free to speak for up to the 15 minutes, but if you stop prior to that, it will provide an opportunity for questions from all three parties, which will rotate, and the question time will be distributed evenly between the three.

OXFORD HEALTH COALITION

The Chair: The first presentation registered is Oxford Health Coalition.

Welcome. If you would come forward. I would ask that when you come forward, you state your name to enter it into Hansard.

Mr. Shawn Rouse: Good morning. My name is Shawn Rouse and I am here as a representative of the Oxford Health Coalition.

Ms. Janice Courtney: My name is Janice Courtney and I am here as a family member from Oxford.

Mr. Rouse: Good morning, distinguished Chair and honourable members of the standing committee on social policy. My thanks to the committee for this opportunity to speak on Bill 140, An Act respecting long-term care homes. As I said, my name is Shawn Rouse and I am a chairperson of the Oxford Health Coalition. I know that many groups and individuals have requested standing here today, and I will do my best to present a submission that is reflective of the concerns that are front and centre here in Oxford county of long-term-care front-line staff, residents, and community.

The drafting of this act has been a good first step. The inclusion of the residents' bill of rights, the proposed

intent to limit casual and agency staff, the increased powers of inspectors and continuing surprise inspections are all very good new initiatives. They are indicative of a real willingness to change for the better and not just change for change's sake.

Where the act does fail the residents and their families is in what is missing in the act. What we see as a root issue in many of the continuing problems plaguing resident care is the missing language surrounding a minimum care standard. An interesting issue has arisen in the presentation of an actual regulation reported on the long-term-care website that speaks to a minimum requirement for staffing levels in the dietary department of 0.42 hours per resident meal day. There is a formula to amend the number if the dietary department is shared with a retirement home or a hospital. Imagine that there are no minimum staffing levels in nursing, but there are in dietary. Compliance staff will be enforcing this and may request staffing schedules, records of resident meal days and duty rosters, among other things. Dietary standards are outlined in seven pages, and nursing standards are outlined in four.

We are insisting that the key component is the re-installation of a minimum care standard. We recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours of nursing and personal care per day per resident. This is to reach the goal of prevention of risk; it is not an optimum. 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. This is a defined number of hours of care that is attached to a particular level of assessed need. We are proposing that Ontario adopt a 3.5-hour minimum care standard of hands-on care. This means that a facility with the average case mix would receive resources for nursing and personal support care specifically to provide 3.5 hours of personal care per resident. Those facilities with lower acuity levels would receive less; those with higher acuity levels would receive more.

In 1996, the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. Since then, care levels have dropped below the previous standard. Since then, the average acuity of

residents in long-term care has increased dramatically. We are insisting that the government reinstate a care standard to improve the quality of life in long-term-care homes. Since the level of acuity has increased with the downloading of heavier-care patients from hospitals and mental health facilities and with the aging of residents, the standard must be modernized to meet today's care needs

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Based on research of standards in other jurisdictions across Canada and the US, we believe that 3.5 hours of care would be the minimum required to reach the goal of prevention of risk. This does not, as Minister Smitherman was saying the other day, promote assembly line care; this prevents it from continuing. This brings dignity back to the care of our parents and grandparents. This should be adopted as an interim measure while the government undertakes the research necessary to define the care levels associated with the current assessed levels of need.

I have received many first-hand reports from front-line staff in some of our largest long-term-care facilities in Oxford. Staff routinely give more than eight hours' work per day. They miss their breaks and lunches, they come in early and they stay late to ensure that the residents are provided with proper care. These people come in on their days off and visit with residents' families. They pick up residents' spouses who no longer have the ability to drive so that they may visit with their life partner.

In 1995 and 2002, the Provincial Auditor noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor has criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PricewaterhouseCoopers report, and inadequate tracking of contagious disease outbreaks. In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. The ministry has never updated, nor has it addressed, the findings of the 2001 PricewaterhouseCoopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs, including depression, cognitive impairment and behavioural problems.

The government uses an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool in 70 long-term-care homes. The tool allows facilities and the government to determine the case mix. The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity and those with heavier needs are deemed to have higher acuity.

However, there is no expected amount of care that is attached to the average level of acuity. An array of reports, media exposés, and testimony of families and care staff have shown that there are serious inadequacies

in care provision. In Oxford, there has been a pandemic of direct front-line care hours being reduced by management in the past year. There is not enough staff to provide the needed care.

Staff are unable to get their care work done to expected standards within the time they have on their shifts. Bathing, repositioning, referrals to medical care and even feeding are left undone because there is not enough care time. This results in residents being transferred to acute care through emergency departments. This shortfall has serious health and quality-of-life implications for residents and staff, and results in increased injuries to staff as well as to the residents. Some staff have reported that four minutes to wake and dress a resident is the norm. If the resident is not able to help, then sometimes two staff are needed. This takes time away from other residents, and some end up losing their personal care. A loss in care one day cannot be made up the next day without further penalties on those residents. All of this wears very heavily on the staff and especially on the residents. Some residents who have lost their ability to speak lash out physically. Documented cases of staff abuse by residents are almost a regular occurrence.

A care standard would set an expected level of care, weighted by the assessed acuity of the resident. This would provide one of the most important tools in assessment of appropriate funding and provide greatly improved opportunities for accountability.

What does the research show about minimum care standards?

—The province of Alberta has set a policy direction to bring care to 3.6 hours, and funding is at 3.6 hours as of the latest budget.

—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 its previous 2.25-hour guideline to 3.25 hours.

—PricewaterhouseCoopers found that Saskatchewan was at 3.1 hours in 2001.

—Thirty-seven US states have established minimum staffing standards either in statute or in regulation. While Ontario dumped its care standard, 13 US states increased their staffing standards between 1999 and 2001.

—The US Health Care Financing Administration conducted major research to deliver two phases in its report to Congress, entitled *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*. Their findings yielded a strong link between staffing and quality. They found that preferred minimum levels exist, above which quality was improved across the board. The total preferred minimum level was 3.45 hours of care, with a staffing mix of aides, RPNs or equivalents, and RNs. They also found that residents in understaffed homes are at greater risk of preventable health conditions, including pneumonia, urinary tract infections, sepsis, congestive heart failure and dehydration.

—The coroner's jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.

—A recent study published in the American Journal of Public Health, on July 1, 2005, by researchers from the University of Toronto and the University of Maryland found that for each hour of care, injury rates for nurses and nurses' aides fall by nearly 16%. For every unit increase in staffing, worker injury rates decrease by two injuries per 100 full-time workers. The study authors concluded that the more hours of care provided per patient, the fewer the workplace caregiver injuries, which leads to better care.

The bill should be amended to require cabinet to reinstate a minimum staffing standard by regulation. The regulation should require a minimum standard of 3.5 hours of hands-on nursing and personal care per day. There should be clear standards, special care units, and improved training requirements and opportunities to provide appropriate care for residents with behavioural problems or cognitive impairment, and especially those with a history of aggression.

The Ministry of Health and Long-Term Care must immediately update to the comparative work done by PricewaterhouseCoopers in 2001. The review must include, at a minimum, the current levels of acuity and the current actual levels of care. The review must also include an assessment of the evidence-based appropriate minimum staffing standard—to be weighted by assessed need—that is required. This information must be made public.

In addition to the requirement for cabinet to set a minimum staffing standard, there should be a process to require a regular three-year review by the standing committee covering the same information to ensure that care needs and standards are being met. This information must be made public.

There must be a clear requirement for a provincial funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding for the required staffing standard and strong accountability as to how money is spent.

There needs to be a clear standard to prevent the off-loading of patients from acute care facilities to long-term-care homes that are inadequately staffed to provide appropriate care.

With this research and these recommendations, one might think you have heard this before. I hope you have. I bring this information to you to ensure that you hear it as many times as necessary for you to believe that it is the best course of action in defending our parents and grandparents in their days that require the best level of care in their most vulnerable years. This is about dignity and respect. Front-line staff are the best source of information, not only because it's their job but because they care for residents. They speak up for many who don't have their own voice and strengthen those who do. Many other issues are connected to this, but without minimum standards connected to front-line direct resident care, nothing else can build the foundations needed to keep our

long-term-care beds safe and respectful of those who need them.

I turn it over to Janice.

Ms. Courtney: My name is Janice Courtney. I am a CAW chairperson at a long-term-care facility in Woodstock, down the 401 there near Toyota. As an employee for over 20 years at this facility, things are not good. As a daughter of parents and numerous relatives who need assisted living, I am outraged. Conditions have to improve, and quickly. How? Well, listen up.

Start to make informed choices. Become involved to make a positive change. I did not say that these parents and close relatives are all elderly. The residents of these facilities may be 38 with Lou Gehrig's disease or 49 years young afflicted with MS and only able to pull the call bell with his or her teeth. All residents require constant, reliable quality care.

If anyone thinks they'll be immune from having to have an affiliation with a long-term-care facility, think again. In the blink of an eye, a spouse, son or daughter is forced to make urgent alternative living arrangements for a loved one after a hospital stay expires. The loved one can no longer live independently, so the caregiver scrambles to try to secure a facility within the community.

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Super-soaker products are the ideal remedy to fix staffing shortages. Toileting is an option. Bathing maybe twice a week is a luxury. Going for a walk becomes a hazard because no one is available to accompany you for a breath of fresh air. Meal service is an assembly line because asking for personal assistance is an inconvenience.

When a resident hears "Wait just a minute" after a call bell has been answered, it turns into a half-hour wait because someone else has been deemed an urgent priority. Who decided this?

Regulations are implemented for a reason and a necessity. Usually regulations are to protect society from harm.

I urge you to make a generous, guaranteed standard of care, allotted for each and every resident. Society cannot ignore long-term-care residents. A 3.5-hour-per-day standard would be what politicians need to include in Bill 140, and it should be clearly enforced and guaranteed.

Bill 140 can be made even better.

The Chair: You've used the entire 15 minutes, so unfortunately there will be no opportunity for questions. Thank you.

CANADIAN AUTO WORKERS, LOCAL 27 RETIREE CHAPTER

The Chair: The next presentation is by the Canadian Auto Workers, Local 27.

Welcome. Please state your name for Hansard. You have a total of 15 minutes.

Mr. Hector McLellan: I'm from the retiree chapter. I would suggest that we speak a bit louder, because I've

got a whole story to tell you about my hearing aid which disappeared. It became doggie kibble, so I can't hear too well. I'd appreciate it if we could raise our voices a few decibels so that I can hear.

Roland Parris from the retiree chapter is here with me. He's my interpreter.

Mr. Roland Parris: I think we should emphasize the fact that we are with Local 27, but we are a retiree chapter, which is a separate body within the local. So we are here representing people who will be using those nursing homes. I'll tell you, we have 100 people coming to our monthly meetings. They'll be very, very eager to see what sort of response we get from you guys—because, remember, we vote.

Mr. McLellan: The submission I am presenting today is to generate some feedback from the committee—because it won't be too long until all of you are going to be retirees. All of you may be finishing up in a long-term-care home. I hope not, but it does happen.

Thanks to the committee for the opportunity to make this presentation on behalf of senior citizens affiliated with the Canadian Auto Workers, Local 27 retiree chapter, and also on behalf of senior citizens affiliated with the Ontario Federation of Union Retirees.

I am vice-chair of our retiree chapter in London and I am second vice-chair of the Ontario Federation of Union Retirees, and between the two organizations, we speak on behalf of thousands upon thousands of unionized retirees and their families.

I would like to ensure that this committee is focused on the true stakeholders, our senior citizens, who will be affected by the final outcome of this legislation once it has had third reading and final royal assent. As a social society, our responsibility is to ensure that the welfare and dignity of our senior citizens is uppermost in the passing of this bill.

As a senior, I dread the thought of having to go into care and being separated from the members of my community. My research shows that most of our older citizens share the same view.

Our seniors' community has a great sense of pride in looking after their own needs and not depending on others to care for them. When care is needed, our first priority should be care in our own home and in our community.

On the reading of this bill, my first thoughts were, "It's a well-written piece of legislation—long legislation." I suppose that's part of the job of government. They have to look into what's going on within these homes. But on reflection, I find that some of the provisions missing or not stated in this bill could have a profound negative impact on the care of our senior citizens who are in long-term-care homes.

Before this bill is passed, there has to be more consultation on private long-term-care facilities versus public and non-profit long-term-care facilities. Private facilities must make a profit, and the profit has become the priority over the care and protection of residents.

University Ph.D. candidate Michael Hillmer's recent report noted that non-profit care performed better than for-profit care. His study found that non-profit performed better than for-profit, especially in the measure of patient care. Findings in the for-profits included higher rates of pressure ulcers—bed sores—and the use of psychoactive medication to subdue patients. Can you imagine your loved ones being subdued because the nursing staff doesn't have the time to look after them because of the pressures of understaffing? These conclusions were echoed in the June 2005 study conducted by the University of Toronto on caregiver injuries and staffing levels. Lead researcher Dr. Carles Muntuner states, "Reduction in staffing ratios and number of staff hours lead to a lower level of care."

The current practice of tendering non-profit beds to for-profit beds has to end. Senior citizens' needs in long-term health care facilities should not be subject to the whims of the marketplace. Status of Women Canada found that home care recipients and their families are paying out of pocket for many services, including drugs, equipment and housekeeping. The same services provided in a hospital would be free. The money-making potential in home care is huge and the private sector has taken sharp note.

My information has said that globally, health care is a \$5-trillion business. Business is looking at this very carefully. Business wants to get as much of this five—I don't even know what a trillion is, and I'm sure most of us don't know what a trillion looks like. But the business community and corporations, especially in private home care, are really looking at this business.

Standard of care: We must address this issue and establish a minimum of 3.5 hours per patient per day as a minimum standard. At present, the government uses an assessment tool to figure out how much care a resident needs. It has been suggested that this method is flawed. The government is piloting a new assessment tool in 70 long-term-care homes based on case mix. This approach makes it very difficult to assess the average needs of residents and in turn makes it difficult to determine staffing and funding to ensure adequate care. In 1996, there was a minimum level of 2.5 hours' care per day per resident. It was removed by the Conservative government, and to this day no standard has been set, as per my research.

The provinces of Alberta, New Brunswick, Nova Scotia and Saskatchewan are all looking to set a minimum standard of between 3.1 to 3.6 hours of daily resident care. A minimum of 3.5 hours per patient can be measured, and staffing and funding would be better able to be assessed. Until this has been established, there needs to be more consultation before the bill is proclaimed.

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Staffing and qualifications: This is another area that needs further consultation, as it has been recognized that underqualified and understaffed long-term nursing homes have led to staff and residents being assaulted. In the last

five years, violence in nursing homes has shown a sharp increase. In the year 2004, violent residents attacked other residents 864 times and attacked staff 264 times—a 10-fold increase in five years. This statistic came from CBC news, April 10, 2005. There have been 11 homicides in Ontario and 3,000 reported attacks. This came from the Ontario Nurses' Association's submission to a coroner's inquest into the deaths of three residents at Casa Verde Health Centre. I have not been able to find out if any of the coroner's recommendations have been implemented. Maybe the committee can share that information with me, if they have it.

In conclusion, the new act will impact millions of Ontarians who are at their most vulnerable time ever in their life—and we all get there; we all become part of that. It's up to our legislators and citizens of Ontario that, before Bill 140 is proclaimed, it be written to ensure that senior citizens of Ontario are cared for with dignity and respect. Thank you very much.

The Chair: There are about four minutes left. If there are questions, I will start with the official opposition.

Mr. Ernie Hardeman (Oxford): Thank you very much for the presentation. I noticed that there were a number of concerns expressed with the bill that you would like improved.

I'd just like to ask: If there was one thing you could recommend that should be changed in the bill, as it seems evident that the government is not going to hold further public hearings and public consultation on it, that would make it better for the people whom you're here today to represent, what would it be?

Mr. McLellan: I would say staffing levels.

Mr. Hardeman: If I could go a little further with that: I noticed you mentioned in your presentation that the case mix requirements—the pilot projects—are not meeting the needs of the people. How would you say that the 3.5 hours per resident would serve all the residents in all the homes differently, recognizing that we have different levels of needs in different homes? We have some that have a lot of patients who need a lot of care and some that have patients who don't need as much care. Without some kind of case mix identification, how would you deal with that?

Mr. McLellan: It would be a matter of budgeting. Once you know how much time your staff has within a 24-hour/seven-day-a week facility, then once you have a standard set, a particular standard of 3.5 hours or even more—the standard of 3.5 hours is minimum. The RNs, I believe, have maybe less than an hour to look after patients. That's an RN. There are, especially in private facilities, other people who are looking after patients and who are sometimes not adequately trained. But trained 3.5-hour nursing staff can be budgeted. You can put a number on that and submit that.

The Chair: We need to move on to the third party.

Ms. Shelley Martel (Nickel Belt): Thank you, Hector and Roland. I'm sorry to hear about your hearing aid, Hector. I hope you get that sorted out soon.

Mr. McLellan: This is my new hearing aid. I put my hand over my ear to hear you.

Ms. Martel: Just with respect to the responses to the Casa Verde inquest: You can get a copy of the government's response to the recommendations from the Office of the Chief Coroner. They were released this summer. I got one for free, so hopefully you will too. If not, you can let me know.

I want to focus on the staffing standards, though. It's clear that if you have a minimum standard—and you should; I have been pushing for a minimum of 3.5 hours—it also requires an increased investment by the government to fund the staff necessary to put that in place. The government made two promises: first, that they would reinstate a minimum standard; secondly, that they would fund each resident and increase funding for direct care by \$6,000. So if you actually provide that \$6,000, you can hire the staff. Unfortunately, the government has only provided about \$2,000 of that \$6,000, so they have a long way to go.

You've talked about some of the studies, but in a more direct observation, what is it about minimum standards? Why is it necessary to have minimum standards if you're trying to provide the care that is needed for the residents in our homes?

Mr. McLellan: I can answer that, but I'll give Roland a chance.

Mr. Parris: No, go ahead.

Mr. McLellan: Okay. Just as I said to my friend—I can't even see your names now.

Interjection.

Mr. McLellan: No, you're not Elizabeth.

Mr. Hardeman: Ernie Hardeman.

Mr. McLellan: It's all a matter of accountability and budgeting. Just as I said to Ernie, if you have a standard you can budget on, I think it's plain accounting. We have to get this bill right, and once we get it right and it satisfies the needs of the seniors, then we can talk about monies. If the people of Ontario know that their taxes are going to a worthwhile project, like minimum standards for health care within nursing homes and long-term care, I don't think you'll have much trouble selling that. I don't know if that answers your question.

The Chair: I need to move on to the government side.

Ms. Monique M. Smith (Nipissing): Just to remind Mr. Hardeman, there was all-party agreement as to how many days of hearings we had on this. It wasn't the government that decided.

I want to respond to a couple of the concerns you raised. You talked about the continuity of care or the spectrum of care and that people want to age at home. Certainly I heard a great deal about that, and our government has tried to address that with some investments in home care to ensure that people can stay in their homes as long as possible.

You raised a concern about psychoactive medication and the use of medication and restraints. We've put some limitations in the legislation around minimum use of restraints, so we're only using them in rare circum-

stances. And around medication, it can only be prescribed by doctors, and those orders are reviewed on a regular basis. So we have put controls around that.

You asked about the Casa Verde inquest. One of the recommendations in the inquest was that we do broader assessments of our residents prior to them coming to a home. You'll see in the legislation where we've got quite a system of assessment presented. It includes a behavioural assessment not just of the recent past of the potential resident but of one year prior, so we get a better sense of what their behaviours have been so that the home can best address the resident's needs when they arrive.

On minimum standards, you talked about the RN time. We've had a lot of input from different people about who should be included in that 3.5 number. Who would you include in the number? What caregivers would you include in the calculation of 3.5?

Mr. McLellan: To start with, a trained professional, and that would be the RN. That's who I would have there. There are other facilities that have to have—

The Chair: I'm sorry, but we're over. Thank you.

COUNTRY TERRACE

The Chair: The next presentation is from Country Terrace. While they're coming forward, I would note that there are beverages—water, coffee and juice. If you wish to partake of them, just quietly come forward and grab what you would like.

Welcome. If you would state your names for Hansard, please.

Ms. Mary Raithby: Good morning to each of you. My name is Mary Raithby and I am the executive director of Country Terrace long-term-care home. With me is Kevin Concannon, chairperson of our family council. We are here representing Country Terrace, which is the best long-term-care home in Middlesex Centre. Country Terrace is home to 120 residents and employs approximately 110 staff, many of whom have worked here for over 20 years. We are a charitable, non-profit home in a rural community.

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My background is in nursing, as I am a registered nurse. I have worked in long-term care for over 20 years, starting as a charge nurse, becoming director of nursing, and then executive director for the last 14 years. As well, I am actively engaged with the South West LHIN and the identified priorities in the integrated health service plan.

Kevin and I are here to speak for our frailest and most vulnerable citizens: our seniors. We are asking you to remove the uncertainty that Bill 140 creates for our residents, their family members and our staff.

We support the bill's strengthened provisions for resident safety, abuse prevention and whistle-blower protection. We are disappointed, however, that while the legislation took three years to write, it will introduce limited-term operating licences linked solely to a building's structure. There is no plan to reassure Country

Terrace, our residents, families, staff and volunteers that we will be here or able to meet increasing demands, or that our home can meet resident expectations for privacy and dignity.

Without a plan, Country Terrace, like other families, staff and 27,500 residents in C homes, will be left wondering on what day in the next seven years the ministry will decide to reveal our future. The options for us in this bill include: close the home; close some of our beds; rebuild—which is impossible without a capital renewal program; invest millions in upgrades and still leave us with three- and four-bed wards; or renew our licence with no changes, again perpetuating three- and four-bed ward accommodation. All of this without an appeal process.

The worst option is hearing nothing in seven years. Ministry silence means our home will close, and subsection 101(5) allows them to not explain their decision to anyone. This is hardly reassuring for our residents, families and staff over the future of their home, their care or their job.

In addition to this uncertainty, there is subsection 103(9). It states that "a non-profit entity may not transfer a licence or beds to a for-profit entity except in the limited circumstances provided for in the regulations." This places non-profit homes like ours at an unnecessary disadvantage with regard to sales and will affect the value of our homes.

Mr. Kevin Concannon: Bill 140 states that "a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort." The preamble of this bill states that "The people of Ontario and their government... Affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term-care homes." Amendments are needed to ensure that this is met.

My family and I chose Country Terrace because of its history of excellence in care. Its structural classification is C, which means that we are paying the same amount each month as others in A homes and are receiving much less in accommodation. Where does this bill address this issue?

Country Terrace has three- and four-bed ward rooms. It does not have smaller resident home areas. It does not have on-unit dining areas. My mother eats in a dining room with over 60 other people every day, for every meal. The issue of privacy in shared rooms is apparent to us each day. You and I would not find this acceptable. Why should we subject our seniors to a lack of privacy?

Bill 140 does not even address these issues. These are the things that matter to us and our families. What assurance does this bill provide? If this bill is going to guide long-term-care decision-making for the next 30 years or more, we expected much more. Government must be empowered to fund a capital renewal and retrofit program and act on its support for Elizabeth Witmer's recent motion.

For a bill that took three years to write and, during that time, did not have wide stakeholder engagement, it is no wonder so many issues exist and are being questioned. For example, does it really make any sense to communicate the zero-tolerance-of-abuse policy to everyone attending or visiting the home? Does the person delivering flowers really need to know this policy? Would it make my mother's care better in any way, or will it compromise her care because the very staff needed to provide care for her will be communicating a policy and not available to our family members?

Bill 140 obviously does not meet the commitment stated in its preamble. Our seniors must not be forgotten. They are the very people who built our province for us and those who follow us. Your bill must support the future viability of long-term care now and in the future. We can do better for those who will depend on this type of care. We ask that your report include the necessary amendments to strengthen this piece of legislation in practical terms in order to meet our commitment to the people of this province now and in the years to come. Our seniors and their families are depending on your committee to make sure the government gets it right. This bill is not good enough.

Ms. Raithby: Country Terrace is a vital part of the social and economic fabric of Middlesex county. We deserve reassurance that there will be homes available for our most elderly, frail and vulnerable citizens and that, structurally, these homes meet resident expectations for physical comfort and privacy.

The government now has the opportunity to take the critically important first step to foster the successful and sustained renewal of Ontario's remaining 300 older homes. You can amend Bill 140 to remove the existing uncertainty and articulate your commitment to develop a comprehensive and appropriate capital renewal and asset management program.

The Ontario Long Term Care Association has worked within the government's proposed fixed-term licensing framework and presented a solution that removes Bill 140's uncertainty, provides a clear plan for the future and addresses the key bed-planning and structural-renewal questions. This solution recognizes that licences should not be perpetual but should be linked to criteria that support care and service needs.

For the licence to be renewed, the operator must demonstrate that there is continued demand for the beds in the community; the home does not have ongoing, unresolved compliance issues; and the home is structurally fit to meet the needs of the residents. This is a workable solution, and we ask you to refer to the submitted proposal.

We are at a time when long-term care is desperate for the government's support. We are at a time when staff is leaving us because the workload, standards and regulations place them in no-win situations. When all staff wants to do is provide care and services to our vulnerable residents, they are scrutinized, burdened and broken. Many managers can no longer take the pressure placed on them by the system and are leaving our industry.

It has been said that bad things happen when good people look away. We, the residents, families and staff in all C homes will not look away. We will look into your eyes and ask you to make a difference in the life of each of us. We will not look away today, this month or this year. You have been entrusted with an enormous responsibility and we need you to act. You have been given a chance to make a difference and we expect you to take it. We will not look away.

Thank you for your time.

The Chair: There are about four minutes left. I will start with the third party.

Ms. Martel: Thank you for your presentation here today. I want to focus on your page 2, at the middle of the page where it talks about the preamble of the bill and outlines the principles and then says at the end that amendments are needed to ensure that the principles in the preamble are met. Can you just reinforce or go over for the committee some of the amendments that you have in mind that are required to make sure that those principles can be met?

0950

Mr. Concannon: Yes, thank you. My mother has been in a nursing home for a year and a half, and I'm learning things every day. Specifically, I don't see—while I didn't expect the actual funding in this bill, I expected that the government would make some reference to a retro-build commitment. I don't see that here. Some of the amendments—in talking to Mary and other people at Country Terrace, I think the government is putting in far too much increase in administration and taking away from the actual care. It just doesn't make sense to me to explain a policy to a delivery person who probably doesn't care, to be quite honest, when they're just coming in and leaving something at the front desk and leaving.

The issue of care, 3.5: I have a problem with insisting on 3.5 for everybody because obviously some people will need more than that, and I don't think my mother needs that at this point. I think some of the amendments that I'm concerned about are increasing care and eliminating the administration, the paperwork that staff have to do. If it's necessary, that's fine. If it's not, let's not—as I mentioned in my comments, let's be practical. Let's run it with the emphasis on care. Yes, we have to have administration and paperwork, but let's keep that to a minimum.

The Chair: Questions from the government side?

Ms. Smith: Thank you for your presentation. I want to congratulate you on running such a great home. I know that you've had no "unmets" in the last few years, so you're doing a great job. And, Mr. Concannon, thank you for serving on the family council.

I did want to address one concern that you raised, and that was that there was a lack of consultation on this legislation. I personally caught my breath when you said that. I actually did a review of long-term care in 2004 and issued a report in the spring of 2004 called the Commitment to Care. During that time, I visited over 35 homes

across the province. We issued a white paper in the fall of 2004 and received 754 submissions in response to that white paper, which were fed into the process of drafting this legislation. We met with 35 stakeholder groups and subsequently received 57 briefs from stakeholders on the drafting of the legislation. We held public meetings in seven locations throughout the province, including in southwestern Ontario. And in this committee process we will have heard from about 120 more groups as we travel the province. So I think we have done our homework and certainly have a great deal of public consultation, as well as consultation with those front-line workers who are involved.

I did want to ask a question about the management of your home—

The Chair: A very brief question, a four-second question.

Ms. Smith: Very quickly. Do you presently have an approval or a licence, and if you have an approval, doesn't transferring over to the licence scheme give you at least more flexibility than you presently have?

Ms. Raithby: We are licensed.

Ms. Smith: You are licensed. Okay, thanks.

The Chair: Thank you. Mr. Hardeman.

Mr. Hardeman: Thank you very much for the presentation. I do want to say, in response to the government side's lack of consultation, the part that I want to ask a question about is "had no discussion in the process," which was the limiting of the licences. I don't believe that was part of the parliamentary discussion paper or subsequent consultation. In your presentation, you mentioned the fact that the licences have to be renewed in a maximum of 10 years down the road. In your report you also say that they should be renewed based on "the home is structurally fit to meet the needs of the residents." My understanding is that the reason for the limit on the licence is because the government doesn't believe that the standard that you presently have will be sufficient to renew the licence; they'll look for progress in the system. How would you envision that your non-profit home would deal with that process without some type of government program to help the capital funding?

Ms. Raithby: We can't. It would cost us \$15 million. We are run by a volunteer board; we have a \$6-million mortgage. We would not be able to do this without a capital renewal program. And in addition, the other residents in the province got that, the ones who are in the A homes. So we're asking for our residents the same as was given by the province to the other residents.

The Chair: I'm sorry; we're out of time. Thank you very much for presenting to the committee.

SARNIA HEALTH COALITION

The Chair: I'll call now for the Sarnia Health Coalition.

Please state your name for Hansard.

Ms. Helen Havlik: Good morning. My name is Helen Havlik. I'm with the Sarnia Health Coalition. This is

Arlene Patterson, who is the chair of that group. Thank you for having us here this morning. We have provided you with 20 copies of our presentation. It's fairly lengthy. I don't intend to read it all. I know you've heard quite a bit of it already, so I'm just going to emphasize certain parts of the presentation.

I'm going to page 7 of our presentation, the paragraph that starts with "Inaction on the Provincial Auditor's recommendations."

The Provincial Auditor, in 1995 and 2002, noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PricewaterhouseCoopers report and inadequate tracking of contagious disease outbreaks.

In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. In the minutes of the standing committee on public accounts, it is reported that the government has been collecting actual staffing data for several years. However, we have not been able to obtain these data. If the auditor's complaint that there is no assessment to determine the adequacy of funding to meet assessed need has been addressed, that report is not available publicly. No staffing standards have been created. The ministry has never updated or addressed the findings of the 2001 PricewaterhouseCoopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies, while having significantly older residents with complex care needs, including depression, cognitive impairment and behavioural problems.

How does our proposed minimum standard work? The government uses an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool in 70 long-term-care homes. The tool allows facilities and the government to determine the case mix. The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity. Those with heavier care needs are deemed to have higher acuity. The funding the home receives for nursing and personal support care such as feeding, bathing, nursing, etc., is based on the level of acuity in the home.

However, there is no expected amount of care that is attached to the average level of acuity. An array of reports and media exposés and testimony of families and care staff have shown that there are serious inadequacies in care provision. There are not enough staff to provide the needed care. Staff are unable to get their care work done to expected standards within the time they have on their shifts. Bathing, repositioning, referrals to medical care, even feeding, are left undone.

A care standard would set an expected level of care, weighted by the assessed acuity of the resident. This

would provide one of the most important tools in the assessment of appropriate funding and provide greatly improved opportunities for accountability.

Now I'm going to go to page 9: support for public and non-profit care. This is another issue that we have a lot of problems with. For-profit nursing homes are required by investors to maximize the profit and growth potentials of their companies. The investors in Diversicare, Extendicare, Chartwell or the others seek to maximize the rate of return on their investment and to pursue a growth strategy that maximizes return down the road. That means profit has to be found from the mix of government—public—funding and private fees that residents pay.

1000

In Ontario's nursing homes there are several funding envelopes, including nursing and personal care, programs and support services and accommodation. Only in the accommodation envelope do facilities keep funding if they do not spend it all. In the nursing and personal care and programs and services envelopes, the homes must return funding received from the government if it exceeds what they spend. In the for-profit facilities, this means that the accommodation envelope is the one from which they can take profits. This is also the envelope into which go premiums charged for private and semi-private beds.

Over the years, the operators have done a number of things to shift costs from the accommodation envelope into the nursing and personal support envelope, including moving incontinence supplies, moving costs for building cameras and surveillance equipment, and shifting the work of accommodation staff to personal support staff. The fewer the costs in the accommodation envelope, the more room for profit-taking. In recent years, it has been reported that the government is directing the operators to move incontinence supplies and surveillance and security costs back into the accommodation envelope so that nursing and personal care funds are not siphoned off into these other items. We are now hearing reports that this has not yet been done.

The operators have also conducted public campaigns and lobbying to increase the amount of funding in the accommodation envelope. The fee increases for residents adopted by the Harris-Eves Conservative government go into the accommodation envelope.

The for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing home industry are in direct conflict with the public interest in accessible and affordable care. I'm not talking here about those nursing homes that are run by a sole operator; I'm talking about the large for-profit groups.

Beds for care or revenue streams for investors? Ontario's non-profit and public facilities have always had approved beds, which means that the number of beds

they operate is approved by the provincial government. The for-profits have licensed beds, which have a value on the open market. Thus, for-profits can buy and sell bed licences as revenue streams for their companies. Nursing home beds are places of care for vulnerable seniors. Most Ontarians would be appalled to realize that the for-profits see them as commodities to be bought and sold for investor revenue streams.

The mission of a non-profit or public long-term-care home is to provide care. This is incorporated into the agency's bylaw and letters patent as the reason the home exists. The mission of a for-profit nursing home is to maximize profit and growth for its shareholders. So a non-profit is founded on the principle of putting the most it can into the home. The for-profit requirement to deliver maximum rate of return and growth means that it must take the most it can out of the home.

To a for-profit, long-term-care homes are an investment. They move from jurisdiction to jurisdiction, depending on the market conditions. For example, after Extendicare was sued in Florida for deaths in their homes due to dehydration and bed sores, which the court ruled as neglect, they sold off their facilities in the state and moved shop. Ironically, while Extendicare was given the largest penalty in a civil suit in history in Florida for the deaths of residents in its nursing homes, Ontario is awarding the company the single largest share of our new beds. While we think of nursing homes as a place to live for our aging parents, spouses or friends, Extendicare Canada sees these homes as one part of its portfolio, providing a revenue stream to investors as follows: "Today, the company is focused on growing its business in both the assisted-living and nursing home sectors of senior care. The company expects to continue making selective acquisitions to increase the size and scale of its portfolio." You can see that on this website, where it has been since December 19, 2006: www.extendicare.com/aboutus/history.html.

Research from well over a decade of experience in the United States shows that care in non-profit and public long-term-care homes is superior to that of for-profit homes. When releasing his recent study showing better performance in non-profit versus for-profit nursing homes, University of Toronto Ph.D. candidate Michael Hillmer noted that the differences "could be as simple as them being required to put any profits back into the homes." His study found that non-profits performed better, especially in measures of patient care, than for-profits. Findings in the for-profits included higher rates of pressure ulcers—that's bed sores—and use of psychoactive medications to subdue patients, and more use of restraints.

His conclusions were echoed in the June 2005 release of the University of Toronto/University of Maryland study on caregiver injuries and staffing levels in nursing homes. Lead researcher Dr. Carles Muntaner stated, "Reductions in staffing ratios and numbers of staff hours lead to lower quality of care. At the end of the day, it's a policy option, but the consequences are clear. If you try

to squeeze the budget to maximize profits, it creates the dangerous situation we see in the United States.”

In his investigative report on Ontario’s long-term-care homes, Ottawa Citizen reporter Paul McKay reports on the claims of the for-profit lobby group the Ontario Long Term Care Association as follows: “Karen Sullivan contends her members make no profit on the provincial subsidies. Instead, she says, they earn their profits by charging higher fees to wealthier residents who can afford private rooms, and by buying food and other supplies in bulk and setting lower wage scales for staff.” Despite the spin, even the for-profit association admits that cutting on food and staff costs and charging higher fees is the practice for maximizing profit-taking from the homes.

Conversely, municipalities are pouring funding into the operational budgets of the facilities to improve care. Non-profits fundraise to provide activities and amenities. They act to levy additional resources to put into the homes.

I won’t read the next section; I’ll just go down to subsection 103(9).

The Chair: About one minute left.

Ms. Havlik: Subsection 103(9) of the proposed legislation allows non-profits to transfer to for-profits as per regulations—unspecified. There is no requirement that homes be rolled back into non-profit or public control. We have expressly opposed non-profit to for-profit transfers. Later in the “Transition” section it is specified that non-profits with licences will continue to have licences; those with approved beds will continue as such. Currently there is a mix of approved and licensed non-profits. In the fall of 2006, the government put out to tender new beds in southeastern Ontario, following the tender process established by the Harris-Eves Conservative government, which is weighted towards the large for-profit chains, with their superior access to capital. These policies, combined, mean that the current majority of for-profit beds will continue, with provisions that new beds can be tendered to the for-profit sector, and more of the non-profit could be transferred—

The Chair: I’m sorry.

Ms. Havlik: Okay. That’s it.

The Chair: Thank you. I assure you that the entire document will be read by the committee. There is no time for questions. Thank you.

SAINT LUKE’S PLACE

The Chair: The next presentation is by Saint Luke’s Place.

If you would state your name for Hansard, please, and you have 15 minutes.

Ms. Rita Soluk: My name is Rita Soluk. I’m the administrator for Saint Luke’s Place. Thank you for the opportunity to present this morning to the standing committee on social policy on Bill 140.

Located in Cambridge, Saint Luke’s Place provides 114 nursing home beds, 40 retirement home beds and

129 independent-living apartments for seniors. We are a fully accredited, not-for-profit long-term-care home committed to promoting resident-centredness, advocacy and the residents’ bill of rights. We value and support the principles of resident choice, dignity and respect, and are committed to the provision of quality of service in all of our initiatives.

As a not-for-profit charitable organization, we depend upon private donations, our foundation, and in-memoriam gifts to fund the acquisition of furnishings and equipment and to assist with the financing of our nursing home restructuring initiatives.

We support the fundamental principle of Bill 140; that is, to create a place where seniors “may live with dignity and in security, safety and comfort.” We support the need for clear standards and for accountability.

1010

That said, we have major concerns with Bill 140. We believe that in its present form, Bill 140 will have serious consequences for Ontario’s seniors and, equally important, our health care system as a whole. We are concerned that Bill 140 permits our government to abdicate its responsibilities for ensuring a resident-centred, responsive long-term-care system now and into the future.

Standards and compliance requirements without the necessary financial support from our government are a recipe for disaster. Rather than providing a plan to address current and future needs of Ontario’s seniors, Bill 140 promises to erode care and services to our seniors, fails to recognize the already demanding workload of staff and fosters the institutionalization of seniors.

Fixed licensing terms threaten to exacerbate the current problem of insufficient long-term-care beds and create a situation where seniors’ access to nursing home accommodation is seriously limited. Bill 140 provides the government with the ability to unilaterally close and relocate long-term-care beds without any requirement to explain or be accountable for this decision.

As evidenced by our structural upgrades in recent years, Saint Luke’s Place recognizes and is committed to undertaking the structural changes that will enable us to meet the changing needs of our seniors. However, the government’s ability to arbitrarily close those beds may cause us to hesitate to undertake future capital upgrades.

As is the case for all long-term-care homes, lenders will be hesitant to invest in our restructuring initiatives when there is no guarantee of re-licensing. Loans will come with higher premiums and shorter repayment terms, and donors may be hesitant to donate towards restructuring initiatives when re-licensing is not assured.

An equally important aspect of the fixed licensing term is the impact any reduction of long-term-care beds will have on access to hospital beds. Long-term-care homes are an integral component of the health care continuum and they play an important role in the hospitals’ bed management system. Any reduction to long-term-care beds will result in an increased number of seniors awaiting placement in hospital beds. As a result, the potential exists for longer waiting lists and wait times for

medical and surgical intervention, further stress on our already overcrowded emergency departments and so forth. Fixed licensing terms affect the health care continuum as a whole, not long-term-care homes alone.

We believe fixed-term licensing is unnecessary if the government's goal is to control long-term-care bed numbers or to ensure compliance with standards. Section 102 provides the government with the ability to reduce bed numbers based on utilization rates in the community. Section 154 provides the government with the ability to revoke a home's licence and/or appoint an interim manager where a home is noncompliant with standards.

We strongly encourage this government to reconsider the need for fixed licensing term provisions in Bill 140. Additionally, we encourage the government to recommit to a capital renewal program. Without a recommitment to capital renewal, renewal of the long-term-care sector is not affordable, the current double standard for seniors' accommodation is perpetuated, and the fundamental right of seniors to live in comfort with the privacy and dignity they deserve is undermined.

Rather than heeding parliamentary assistant Monique Smith's recommendation that "strategic efforts need to be developed to promote the long-term-care sector as a desirable career option as staff shortages and pay inequities are constant challenges," Bill 140 in fact creates additional barriers to recruitment and retention of staff in long-term care. The fixed licensing term eliminates job security for staff, thereby discouraging employment in long-term care, and the increased documentation and reporting requirements result in an increased workload for already overworked staff. Job insecurity and excessive workload are cited consistently in the research as having a negative impact on recruitment and retention of staff. From the resident care perspective, increased documentation and reporting demands will erode the time available for staff to provide resident care, increased recruitment and retention costs will reduce the funds available for direct care provision, and staff turnover will undermine the ability of long-term-care homes to build skilled and knowledgeable health care teams capable of meeting the complex care needs of our seniors.

While we support the need for standards and accountability, we support OANHSS's recommendation for this government to analyze the financial burden of the new administrative demands and, at a minimum, increase operating funding to offset the related costs.

Bill 140 introduces an additional and significant source of personal liability for board officers. Board officers will be held personally liable for any breach in the act by anyone in the nursing home. For a first-time offence, officers will be subject to a fine of \$25,000 and/or imprisonment for up to one year. Not-for-profit nursing home board officers are volunteers. They donate their time, knowledge and expertise, with the end goal being that of enhancing the quality of life for seniors.

The additional obligations and penalty provisions are a major concern for our board members. We have been advised that our board's directors' and liability insurance

will not cover anything to do with this law. The introduction of personal liability will make recruitment and retention of board members extremely difficult.

We recommend that board officer liability provisions in Bill 140 be amended to mirror the provisions set out for board officer liability in the Public Hospitals Act.

Finally, the government is well aware of the fact that Ontario's long-term-care sector's funding is less than the Canadian standard of three to 3.5 hours per resident per day. Long-term-care underfunding, along with the additional demands created by Bill 140, will compromise the ability of long-term-care homes to meet the standards set out in this legislation. Equally important, the ability of long-term-care homes to sustain the current levels of care and support to seniors will be compromised.

Bill 140 demands that long-term-care homes do the impossible; there is no requirement for the government to be accountable for funding the changes. While current legislation states that the government "shall" fund long-term care, Bill 140 states that the government "may" fund long-term care. While we appreciate the health care funding challenges of our government, our government must commit to financing the current care and service needs of long-term care and the additional funding requirements that result from the demands created by Bill 140.

In conclusion, we request that you give consideration to the concerns that we've expressed regarding Bill 140. While changes are required in long-term care, we are concerned that the proposed legislation includes provisions that will seriously undermine the rights of seniors for accommodation and for quality, responsive resident care.

We believe that Bill 140 in its present form will create undue hardship for long-term-care homes and compromise the care and support provided to our seniors. While we support the need for standards and accountability, the proposed legislation will serve to redirect our already scarce resources away from direct care provision toward meeting the administrative requirements set out in the act. Additional funding is required to support the current and evolving health care needs of our seniors, ensure compliance with proposed standards and facilitate the needed structural renewal of long-term-care homes.

The Chair: Thank you. We have about one minute each for questions, starting with the government side.

Ms. Smith: Thank you for your presentation. I wanted to ask you a couple of questions about the funding that you raised. You talked about Ontario's long-term-care sector's funding being less than Canadian standards. We've actually invested over \$740 million in the last three years, and I understand at Saint Luke's you've been able to hire about 10 full-time equivalents with the funding that you've received over the last couple of years from our investments. Which staff members have you been able to include in your staff complement?

Ms. Soluk: All those additional staff members who have been hired have been hired for direct care provision, which is also the requirement set out in the funding,

which is not a problem. We're focusing on the direct care needs of our residents, and it's appropriate that's where the funds would go.

Ms. Smith: Absolutely, and I totally agree. We've seen an increase of about 4,800 staff across the province—front-line workers. Are there particular tasks that the 10 or 11 new staff at Saint Luke's have been assigned to?

Ms. Soluk: I would say that they would assume the same sorts of direct care responsibilities as any other individual, whether it's providing personal care, assisting with their activities of daily living. A number of the residents—and I know from your report you're well aware of the fact that we have an increased number of dementia or cognitively impaired residents across the sector. That dementia increases during the time they're there. You're well aware of the increased complexity; you cited examples when you talked about dialysis, catheter care, all sorts of things. You also recognized the increased dependency for transfer mobility, etc. All of those sorts of dollars that were provided have in fact gone towards doing that.

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Ms. Smith: That's great.

The Chair: We need to move on to the official opposition.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): Thank you very much, Rita. I know from personal experience that Saint Luke's is a much-beloved place. You've got a dedicated staff, and I appreciate your leadership. You emphasize the fact that a lot of this new documentation paperwork is going to take time away from the personal care, and we've heard that wherever we've gone.

You talked about the fixed licensing term. This is a move where the government didn't do any consultation, but it has the potential to create a lot of uncertainty for the sector in the reconstruction and renovation of their homes, and also for staff and what have you.

You mentioned that it's hard to recruit staff right now. Can you just explain why it is so difficult to recruit staff and why this will just further exacerbate the problem?

Ms. Soluk: Sure. I think Monique Smith talked a bit about it in her document Commitment to Care.

First off the bat, long-term care is not an attractive health care sector for people to work in. It's not seen as a flagship per se. If you look at something like cardiac transplants, that sort of thing, it's just not in that same ballpark.

Second, it's well acknowledged across the industry that the workload demands are significant. On any given day, if you take a health care aide, for example, they have an assignment of anywhere between nine, 11 and sometimes 12 residents for whom they're responsible for giving direct care. That means baths, feeding, dealing with behaviour problems for those who have cognitive impairment, and so forth. The registered staff support the front-line staff in that work and do those sorts of things. They also carry the bulk of the responsibility for the

documentation, medication distribution, treatment requirements. As I talked about a second ago, the treatment needs have certainly shifted. If you look at dialysis, the kinds of skin care that are required, it's not just about complex care needs; it's about the multiple systems that are involved. So the demands are significant. And it's probably the poorest-paid sector across health care.

The Chair: We need to move on.

Mrs. Witmer: Thanks, Rita.

Ms. Martel: Thank you for your presentation here today. I just want to focus in on the fact that Ontario's funding is not even reaching the Canadian standard of three hours per resident per day. The government has put out a number of about 2.8; I'm not sure what that's based on because I don't know that anything was released publicly to back that up. But even 2.8 is less than the 3.06 that was recommended in the Casa Verde inquest as what was absolutely necessary as hands-on care per resident per day. I suspect that if the government provided the remaining \$4,000 per resident that it promised, we would be able to get up to a higher standard and you would be able to hire more people to provide the personal care that you want to.

I'm also really concerned about the licensing. Given the consultations that apparently went on, we are in a situation where neither the for-profit sector nor the not-for-profit sector agree with the government's proposals on the licensing section. So I'm puzzled as to how we managed to get to that situation. What do you think needs to happen around licensing that would protect or aid your home and also allow you to do the redevelopment that you want to do?

The Chair: In four words or less.

Ms. Soluk: Okay. The bottom line is, I think it has to be eliminated. I pointed out that you can deal with bed numbers and failure to comply with standards under the other sections. Take away the licensing requirement and we'll be able to borrow money to move forward. People will have confidence in what we're looking to do. We'll have donors that support us, we'll still get our in-memoriam gifts, and we'll be able to move forward with a multi-pronged approach to funding those sorts of restructuring needs.

The Chair: Thank you.

VERSA-CARE CENTRE HAMILTON

The Chair: The next presentation is Versa-Care Hamilton.

Grab a seat and please state your name for Hansard.

Mr. Sean Weylie: Good morning. I'm Sean Weylie. I'm a concerned family member of three residents living in long-term care currently in the Hamilton area. I've worked for 11 years in the long-term-care sector in various management roles. I began my long-term-care career as a recreation manager and moved on to do some recreation consulting. I am also a past president of the Activity Professionals of Ontario, which has received a grant from the Liberal government to prepare a best-

practices manual for the recreation professionals in long-term care. I have been involved with the redevelopment of a D-class facility, and currently I am the executive director of Versa-Care Hamilton, which is a C-class long-term-care home.

Our home in Hamilton serves a unique population of younger seniors and people who normally would live on the streets or in psychiatric settings. With the downsizing of the psychiatric beds, we are now charged with the responsibility to care for these individuals. I am here today to ask the committee to make amendments to the proposed Bill 140 to ensure a superior quality of life for my relatives, for the residents of long-term-care homes and for a sustainable system, believe it or not, for me in the future.

The Commitment to Care report developed by Monique Smith was a good foundation for legislation to be developed on. However, during the development of this legislation, the true essence of the report was lost. Instead of creating a sustainable long-term-care system, the legislation has created uncertainty and an increased workload for professionals in the field.

The new act has many positive attributes that further support the residents' quality of life. Enshrining the residents' bill of rights and legislating zero tolerance for abuse are just two examples of the many positive resident safeguards in the legislation. The new Long-Term Care Homes Act, Bill 140, however, has serious flaws. The most glaring is the absence of the government's responsibility for funding long-term-care homes. Subsection 88(1) states, "The minister may provide funding for a long-term-care home." The government has a responsibility to all Ontarians to fund health care in the province. Section 88 clearly absolves the government of any financial responsibility for funding the long-term-care system.

Current funding levels continue to fall below those of similar demographic and geographic locations. This section of the legislation, as described in the OLTCA's Key Amendments to Bill 140 document, "allows for the withdrawal of the government's commitment to a publicly funded universal long-term-care program." According to an Ipsos Reid poll that was released on February 20, 2003, "Seven in 10 ... of Ontarians believe that funding for long-term care in the province should be a priority for the Ontario government," and "Nine in 10 ... Ontarians express agreement with the view that 'a government program should be put in place to allow existing long-term-care homes to be redeveloped to higher standards' that are in place for" the newly built homes in the province. This bill does not address either of these public opinions and does not make a clear and definite commitment to supporting the quality of life of our seniors.

Another Ipsos Reid poll, released on January 18, 2006, entitled *Canadians on Healthcare*, reported that "Canadians believe in equal access to health care: 90% of Canadians agree that access to health care should be exactly the same for everyone, regardless of their income." Without a commitment in the legislation to a

government-funded system, the seniors on reduced incomes face an uncertain future. Many of my residents are in a lower income bracket. They are concerned about whether they will be able to pay for the service if the government does not commit to funding levels that are appropriate to their care needs.

On a regular basis, our nursing staff are run off their feet. Many nurses have stated to me that they would love to be able to take the time to stop and get to know their residents better, but there just isn't time. My grandmother, who is in a long-term-care facility, has raised concerns about how rushed the staff are to deliver care. She is frequently encouraged to sit in a wheelchair to go down to the dining room instead of being encouraged to walk. My grandmother is capable of walking, but the staff on many occasions say they don't have time to walk everyone to the dining room.

1030

This brings me to another section of the act that requires attention. Subsections 8(1) and (2) are of great concern. This would lead one to believe that restorative care is someone's job. Restorative care—and I have to stress this—is not a discrete and separate program but is a philosophy that every home should embrace. The funding model currently in use does not support the improvement of a resident's well-being. It penalizes homes that have taken on a restorative philosophy and a commitment to quality of life. The inadequate funding in the program and support services envelope does not allow the professionals the opportunity to adequately meet the legislative requirements. The government currently provides \$6.82 per resident per day to fund recreation, social programming, social work, dietitian, physiotherapy, occupational therapy, speech language pathology, etc. This translates into seven minutes of recreation or rehab care per resident per day. In seven minutes, the staff is expected to assist the residents to programs, provide the necessary services and then document the care provided to the resident.

The government is commended for their inclusion of recreation and social activities under section 9 of the legislation. This inclusion acknowledges that recreation and social activities are an essential service and therefore need to be funded accordingly. This section of the act speaks to the resident's quality of life. Recreation and social programming are activities that help normalize the life of a resident in a long-term-care home. In our own homes we do not have personal nurses, dietitians to develop our menus, cooks to prepare our meals and people to do our chores. We do have the ability to participate in leisure pursuits that interest us. Without ongoing government commitment to funding, residents' quality of life will be negatively impacted.

The care hours shortfall is not only applicable to the programs envelope but across all the funding envelopes. The residents in long-term care are requiring more care than before, as evidenced in the 3.15% increase in the provincial case mix measure over last year's results. Since 1992, there has been a 27.35% increase in the

provincial CMM. We can only expect that this trend will continue to increase with the growing number of Ontarians requiring long-term care over the next 15 years.

Furthermore, I have a concern about legislation that is so prescriptive that it restricts an operator's ability to be innovative and expand their services to residents. As an example, nursing staff diligently record the volumes of food and drink a resident consumes in a day. Is this really a dignified way to live out the rest of your years—having someone monitoring your consumption like a child? Why not use the weight loss and weight gain indicators to determine if a resident is at risk nutritionally? The legislation micromanages the long-term-care sector to the point where failure is almost certain. No operator will be able to meet every detailed section of the act 100% of the time. Registered staff are already moving out of the long-term-care sector, stating that the workload is overbearing and the focus on professional judgment and resident outcomes is being lost. Other examples of this prescriptive approach are clauses 4(1)(a) and (b) about mission statements—this restricts an organization's ability to develop a personalized mission that reflects the values of the home—and subsection 18(3), about communication of zero-tolerance policy—this section cannot reasonably be met 100% of the time. Under the proposed legislation every individual, including the plumber and the paper delivery person, would require this information even if they had no resident contact. Is this really reasonable to expect?

Prescriptive legislation makes these homes more like institutions, but the purpose of the legislation was presumably to encourage a more homelike environment.

The issue of licensing is also of real concern to my residents. Many of my residents have been asking me what they will do in seven years if we can no longer operate as a long-term-care home. Many of my residents are younger and do not have anywhere else to go. If the licensing scheme is not amended, the uncertainty my residents face is a reality. Some may argue that losing one home in an urban area like Hamilton or Toronto is not an issue because of the availability of long-term-care homes. But what about those who cannot afford to pay for a private room in a new long-term-care home? Most new homes have a two-to-three-year waiting list for their ward accommodations and they usually fill those internally before allowing the general public access to those beds. Versa-Care Hamilton has been extremely fortunate that our company had the vision three years ago to downsize our long-term-care home from 248 beds to 128 beds, and we created two-bed ward rooms. This is not the case with other homes in our area. Three- and four-bed ward accommodations are still a reality in our province and this is not a dignified way to live. The premise of this bill was to promote quality of life. The fundamental principle even states "that a long-term-care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort." The licensing scheme does not

provide any of the residents in B- or C-class homes with any security of knowing that they will have a place to live. I'm not very comfortable with the thought that not only could our residents be out on the street, but that my staff may not have jobs in seven to 10 years. I will find it very difficult to tell my employee, who has 30 years of service with our organization, that she no longer has a job. We employ over 190 staff and volunteers. This would have a significant impact on our community.

The government has the opportunity to make a commitment to the quality of life of our seniors and to allow them the opportunity to live in dignity. After careful review of the amendments put forth by the Ontario Long Term Care Association, as a family member and as an executive director, I urge the committee to support these amendments. We have the opportunity to create a bill that will be "the pride of Canada," as announced by Minister Smitherman. We cannot be "care less" and have our seniors forgotten.

Thank you for your time. If you have any questions, I'll gladly answer them.

The Chair: Thank you. We have 40 seconds per question, I believe, for rotation.

Mrs. Witmer: Thank you very much, Sean. I guess what I find absolutely astounding as I continue to listen day after day, ever since the legislation has been introduced, is that this government has introduced the limited term "licensing" and created such uncertainty for staff and residents. I am appalled that there was no consultation and, furthermore, I am appalled that there has been no indication on the part of the government that they're prepared to make some accommodations and to introduce some recommendations. It just astounds me that they would put these people and the staff at that type of disadvantage, risk and uncertainty. I will tell you that I can't believe it.

Mr. Weylie: Neither can I.

Mrs. Witmer: I'm just overwhelmed. Thank you.

The Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation. You focused on section 18, where you talked about having to communicate the zero tolerance policy. There's a similar provision under section 75 which goes even further, for those who are performing work at the home that's not defined, where you have to talk about residents' bill of rights:

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

"4. Fire prevention," etc.

What do you think this is going to do if you're in a position to have to talk to all these people about all of these things before they come to do work in the home—"work" which is undefined in the bill?

Mr. Weylie: In the bill, when it doesn't define what work is—and we're assuming that that's a contractor or somebody along those lines—that means that the average volunteer—being a former volunteer coordinator as well, it takes about an hour to orient a staff member or a volunteer to just the basics of a home. So if you have five

or six contractors come in in a day and you have to orient every single one of them, there's six hours of my day or a manager's day or a staff member's day used towards orienting those individuals.

The Chair: Ms. Smith.

Ms. Smith: Thank you for your presentation today. I feel compelled to respond to Ms. Witmer and Mr. Hardeman, who've been harping on this point today, and I don't know why, because their government wasn't exactly famous for consultation.

In our Future Directions document, our white paper that we put out before we started drafting legislation—I think you're familiar with it—we had the following questions: What factors should the ministry consider when designing a new licensing and bed approval system? What factors should the ministry consider when setting terms, time limits, on the licence or approval of a particular home—i.e., the physical structure? What criteria should the ministry use when deciding whether to renew a licence or approval? What criteria should the ministry use when deciding whether to revoke a licence or approval? Should the public have any opportunity to comment on the applications for a licence or approval, what methods should be used to allow the public to make such comments?

So, while I know this doesn't address your concerns, I did want to set their minds to rest, and I will provide you with a copy of the white paper this afternoon.

The Chair: Thank you.

Mr. Weylie: Actually, can I say one other thing to that issue?

Ms. Smith: Sure.

1040

Mr. Weylie: Even though the licensing scheme was put forth, the responses to the white paper were not addressed in this legislation. I did fill that out and I was a part of that whole process, and those comments and recommendations were not reflected in this legislation.

Ms. Smith: Well, there were 750.

The Chair: Thank you.

PEOPLECARE

The Chair: The next presentation is by PeopleCare.

Thank you for joining us. Please state your names for Hansard.

Interjections.

The Chair: Please, save it for lunch. PeopleCare.

Mr. Brent Gingerich: Thank you for your time today. My name is Brent Gingerich. I'm owner-operator of PeopleCare. I'm here today with a valuable 22-year veteran staff member, Kathy Dingwell, who is PeopleCare's director of programming and support services.

PeopleCare is a family-owned and -operated group of three long-term-care homes: in Tavistock, with 100 residents; in Stratford, with 60 residents; and in Cambridge, with 90 residents. PeopleCare was founded by my grandfather 40 years ago, so I represent the third generation in this successful organization. We're extremely

proud of our reputation in the community for providing high-quality care in a home-like setting and treating our staff like they're part of the family. We're also proud of our innovations and achievements: PeopleCare was the first long-term-care home in Ontario to be accredited by the Canadian Council on Health Services Accreditation; we've been on the leading edge of medical practices and treatments for residents with Alzheimer's; and we've always had an outstanding compliance record with the Ministry of Health and Long-Term Care.

We have three points for your consideration today: (1) creating a win-win Long-Term Care Homes Act; (2) enhancing the licensing provisions in Bill 140 with a plan; and (3) enhancing the programming provisions, which Kathy will talk about.

(1) Creating a win-win act: In my family's experience, in every generation there has been a major event in long-term care that has paved the way for the next. This is one such event.

The challenge in developing this act is to build on the positive progress and to enhance what's working and to attempt to address what's not working without destroying things that are working well. There are staff and operators out there who are doing fantastic work in this sector. Each and every article in Bill 140 has its own effect on this complex system, so one needs to be aware of those effects in order to make this act something really great and positive all around for the sector.

How do we do this? We need to have an in-depth dialogue with the experts in this sector. By doing that, we can create an act that is win-win. That in-depth dialogue has not happened.

This act could be win-win for the government, could be win-win for the clients and public, could be win-win for the staff and operators and could be win-win for owners and financiers. This is why the Ontario Long Term Care Association has proposed some 95 in-depth and detailed amendments. I'd encourage you to adopt these amendments as presented.

(2) Licensing: PeopleCare's three homes are classified as C by the Ministry of Health, which means the physical structures, the bricks and mortar, comply with 1972 nursing home standards but do not meet the newly introduced 1998 standards. My colleagues in the OLTCA and I have been advocating the government since the 1998 standards were introduced to develop a workable plan to get these 1972 C homes, which represent about 50% of the homes in the province, to standards more acceptable to today's residents and their families. Unfortunately, a plan has never been introduced.

With Bill 140, there's still no workable plan for the future. According to Bill 140, I may get notification by the ministry informing me if I'll get to remain open after seven years. In the absence of such notification, I can expect to be closed. That's the level of planning for capital in this act. For a long-term-care organization with an outstanding reputation that has been a model provider of long-term-care services for 40 years, this has caused a tremendous amount of uncertainty regarding our future existence.

The worst thing is, Bill 140 does not even identify what we need to do in order to keep our licence after seven years. My bank is not optimistic. My banker calls this cloud of uncertainty “risk,” and he indicates that banks don’t like risk. Unfortunately, I have to worry a lot about what my banker thinks, because part of our extended family’s succession and transition plan for me required that I take out a mortgage. Now, because Bill 140 does not outline a workable plan for C homes, our mortgage rates have gone up—my payments have gone up considerably. There is less money in the budget to do the cosmetic upgrades and repairs to our home. But the worst thing—the absolute worst thing—is that we may not be able to renew our mortgage in four years—bottom line. Talk about uncertainty. Is it acceptable to create that type of environment in this sector?

The OLTC’s proposed amendments to the licensing scheme in Bill 140 would not only address the issues I have presented, but they would give the sector back the confidence and stability to move forward with a renewal strategy that’s great for the government, great for the residents and public, great for the staff and operators, and great for owners and financiers. It’s a win-win.

Ms. Kathy Dingwell: My name is Kathy Dingwell and I work at PeopleCare, as already mentioned by Brent Gingerich. It is a good home, one that Brent should be proud of and one where all of the staff, residents and volunteers are proud to work and live.

We have had some meetings with residents, staff and families too about this legislation. Do you know that one of the biggest questions voiced by the residents is, “Why are C homes not funded to renovate to the level of the A homes or new builds?” The residents feel that they shouldn’t have to move to another home to take advantage of sharing their room with only one other person. So we encourage and ask you to consider a plan that includes support and funding to allow C homes to move ahead and to renovate in keeping with today’s standards.

I am also a past president of the Activity Professionals of Ontario and am currently working on the best-practices initiative for recreation in long-term care, which is funded by the Minister of Health and Long-Term Care and supported by the Commitment to Care paper. This process has confirmed something that many of us already working in the field know: Recreation programs are important, essential and a must in the delivery and provision of quality care to the residents who make long-term-care homes their home. Maslow says it best when he says that once basic needs are met, individuals can strive to meet higher needs. If you have safety, shelter and are not hungry, then you can look to fulfilling social-belonging needs or your creative needs and to achieving success.

As staff members who work in the field of recreation, it is our job to assist the residents to find other things to do: leisure pastimes of their choice that are meaningful, creative and fulfilling and which help them achieve success. Did you know that lack of activity is linked with distressed mood, frustration and problematic behaviours?

So when you come to our home, any home, wouldn’t you like to see a variety of activities and recreation programs that reflect what is needed and wanted by the residents?

Currently, at our very best we would like to design programs that are structured to use the creativity and strengths of the residents that can build on these feelings of self-worth, give a sense of control as well as choice and match their interests and abilities.

Bill 140 does require homes to provide restorative care, recreational programs and social activities that meet individual-assessed resident needs. However, at our very best, with the current ratio of 1 to 60, we are able to encourage residents to attend already existing programs. We would prefer to develop programs for the individual, but how can we do this with our existing resources? Wouldn’t you like to be doing something that you want to do? To do this, time is needed for assessment, planning and the implementation of programs.

1050

The needs of our clients are changing. They are cognitively impaired, they are young adults, they have wide age ranges—from 26 to 107 in our home. As I have said in the past and will say again, without funding to go hand in hand with these legislative changes, many long-term-care homes will have to decide how and what will be continued and what will not.

We realize and appreciate what an opportunity this is to be part of this process, but we ask you to consider not only the recommendations of the Ontario Long Term Care Association but what we have shared with you today. We ask you this not only as workers who have “worked on the floor,” as we like to say, but as advocates who work daily with staff, residents, families, volunteers, community members and friends—the people who make, live and work in long-term-care homes in Ontario. Thank you.

The Chair: Thank you. We have about one minute per party for questions. Ms. Martel?

Ms. Martel: Thank you for your presentation here today. I want to focus on your banker. You’ve said that because the bill doesn’t outline a workable plan, your mortgage rates and your payments have gone up. So even though the legislation hasn’t passed, just based on what he sees, he has done those things?

Mr. Gingerich: That’s right. As I said, bankers don’t like risk. Because there’s no workable plan for C homes after the seven- and 10-year fixed-term licensing, he doesn’t know if he’s going to get his mortgage paid off, so they have changed underwriting criteria, which negatively affects our cash flow and our ability to do the simple renovations and structural enhancements that we need to do in our home every day—not to mention that it would be completely impossible for us to upgrade to the new 1998 standards without a funding program.

The Chair: Ms. Smith?

Ms. Smith: Thank you both for being here. Kathy, we’ve talked about the importance of activity coordinators. You’ll see in this legislation, I think for the first time, that recreation and social activities are mandated in the home. I think that’s an important improvement.

I wanted to touch on what Ms. Martel was talking about with Brent for a moment, the financial uncertainty. We've heard in Kingston that OMNI has been sold. Being on the board of the OLTCA, I'm sure you're familiar with Fraser and his group. He indicated that the bankers and the investors in that sector were not fussed by the legislation. That may not be his language, but he certainly indicated it hadn't affected the sale. You're probably also aware that Versa-Care is being sold and that there's been no underlying concern there, as far as we're aware, or any public discussion about concerns around the sale of that business. I'm interested to note what your reaction would be to that when you're telling us that the financial sector is jittery.

Mr. Gingerich: I can't speak for the speculation of some people out there in the sector, some large institutions that make moves that I don't quite understand. What I'm concerned about is our home, our sector and my ability to stay in this community. I don't want to sell to a big chain. I have no intention of selling to a large institution like OMNI has done. I don't think it's your intent in this legislation to force people to do that. I want to keep our organization in the town where it is and keep PeopleCare a family operation. What I'm saying to you is, it's very difficult for a small organization like us to finance these homes and to finance the minor—

The Chair: We need to move on. Thank you. Mrs. Witmer?

Mrs. Witmer: Thank you very much, Brent and Kathy. I know that you do give outstanding care to the residents. I am very concerned that the unintended consequence of this legislation, with its limited-term licensing, might be to force small homes like yourself—we've heard from people throughout the province of Ontario who have been in the family business for 50, 40 years, well loved in their community. People have put up with the B and C homes and the three- and four-bed ward accommodation because of the dedicated staff and everything else that happens there. It's time now that there be a plan developed in order that we get rid of those three- and four-bed wards and people have homes that are totally wheelchair-accessible.

I am very perplexed and very concerned. I don't think the government is listening. They don't hear about the uncertainty they've created for you, your residents, the people in your communities and the need to make some changes. I thank you and I regret that already your bank has recognized that you've become more of a liability than you were before the introduction of Bill 140.

The Chair: We're out of time. Thank you very much.

LUCY BUTTERY

The Chair: The next presentation is Lucy Buttery.

I know I've just used your name, but the procedure requires that you state your name for Hansard, please.

Ms. Lucy Buttery: Hi. My name is Lucy Buttery. Thank you for letting me speak. I am an SEIU member. I

work in the dietary department of a nursing home with 63 residents.

My concerns about Bill 140 are the lack of hours that we have to care for our residents. We need to put more funding into long-term-care facilities so that we can raise the hours of care to 3.5 per resident per day. At our home, we have a level of 2.03 per resident per day.

In the dietary department at our home, we have lost five hours per day since I started there 18 years ago. We currently have 0.4 hours per resident per day in the kitchen. The ministry has made many changes in our department throughout these years. Whenever inspectors come in, the rules change and more and more duties get added to our job, but our hours never increase.

The meals used to be served from the kitchen, but it was decided that the residents should see the staff serving their meals, so a portable steam table was purchased. For the last few years we've had to take the cart out into the dining room. The cart goes out at 8:30 in the morning. We used to serve breakfast with two staff, but now we do it alone. One person must serve 63 residents in 30 minutes. This is less than 30 seconds per resident. It is very important that we make the residents' meals a relaxed dining experience. In our home, it is anything but.

I have heard that in many homes, the health care aides are doing a lot of dietary's jobs. At our nursing home, they come to our cart to get the food for the tables that have residents who need to be fed, and they do our snack cart. We are expected to serve just one table, four residents, at a time: pour their tea and coffee, smile, visit, wait for them to make up their minds on what they want, and get back to our cart, all in less than two minutes. Although we know all of the residents' diets, we were just given a binder that we have to flip through to make sure that we don't give the diabetics sugar and the "dislikes eggs," etc. When we are done, we are expected to go around and see if anyone wants seconds. All of these tasks take extra time out of our day—time that we don't have. Just imagine: 63 residents brought into a dining room. Some are walking on their own, some with help. Some are getting up just seconds after they've been seated, and some have to be persuaded to go in, because they don't feel like going in at all. All of these residents are served their food, fed, and taken out of the dining room in less than an hour. Does this sound relaxing? There are bells ringing. There are staff taking residents in and out of the dining room, and running trays to the rooms for the residents who aren't coming out because they aren't feeling well.

We are run off our feet in the kitchen. Every meal is just as rushed. We have 30 minutes to serve lunch and supper. Because we have a lot more food to serve, we have two dietary staff working during these two meals. It is still quite a job because we are still expected to show each resident the main meal and the alternate and we have to be polite as we stand there and wait for them to make up their minds.

Another new thing that has been added in the last while is that we now have to chart the amount of food

and fluids that each resident has at every meal. We chart the food we use, and the health care aides do the fluid and food intake that each resident has had.

I understand the importance of all the changes that have been made in the past few years, like food presentation, which uses a lot more dishes; charting food and fluid intake; allowing the residents to have the choice of an alternate; a relaxed dining experience; and more time spent with the residents in the dining room, but each change takes a few extra minutes, and we do not have any extra time.

With the price of food, it is very hard to stay on budget, so a lot more dishes and desserts have to be made from scratch. This also takes up a lot of the dietary staff's time.

The housekeeping staff have limited time to accomplish all of their tasks as well, which leaves us kitchen staff spending a lot of time trying to keep the kitchen's cleanliness up to ministry standards.

1100

When the health care aides are going to be working short on evenings, a staff member is taken off the bath shift to fill the evening shift. Sometimes they are unable to replace the bath shift, which leaves some residents not getting their bath. We had the Norwalk virus. Half of our residents were vomiting or had diarrhoea. The health care aides even had to work short one evening through this. Staff availability is just non-existent. It seems like no one wants to work in nursing homes because of the stress and workload.

The housekeeping department had to disinfect all of the doorknobs, railings and handles while the Norwalk virus was in our home. They were given an extra hour per day, but a five-hour shift was taken away so they could have that hour a day to disinfect.

The three housekeeping staff never get their work done, and a lot of days they even work through their breaks. They practically run all day long, and if a resident leaves or passes away, they are expected to clean up that room in their regularly scheduled shift without any extra time.

In the summer we get nursing students, but they only stay until they're done school and then they go elsewhere, where they can make more money and not have to run on the job.

Ours is a small facility in a small town where we often know the clients and their families. Staff try harder because of this. We want to make them comfortable. In our facility, wanderers are not segregated. When agitated or "sundowning," they will often go from room to room to room, which means that you end up having bell after bell ringing from cognitive residents because they are upset by being bothered. Some do not understand it is a disease; others know but they don't want these people in their space, which is understandable.

We are taught to encourage independence, to let residents do as much as possible so they don't lose their abilities. Often this is impossible. Health care aides are

rushed to get them washed, to the table and fed, all around a timetable.

If residents are ill, often the well ones are given limited attention. As an example, a resident has MS and also has a cold. She has almost no movement left in her body—maybe enough to pull the bell. Her nose is dripping but she has to wait and wait because her caregiver is busy somewhere else. Each time a little more dignity is lost. She has to be a patient woman but gets called "demanding" because she sometimes loses her temper or wants things done in a certain way, which is the only thing she has control of—all of this because she has to rely on others for total assistance. Extra hours and helpful staff would make a huge difference to help our residents maintain their dignity and quality of life.

I would like to share with you what it's like to be a resident in a nursing home, on behalf of my mother. When my mom became unable to take care of herself at home, we talked her into going into a nursing home. She was not too happy about this, but we told her that it would be better for her: Her medication would be given to her at the right times, they would give her her meals and they would help her bathe and dress. My mom was still walking with a walker with some help when she went into the home. I encouraged her to keep walking around as much as she could so that she would still be able to get around. It didn't take her very long to realize that the health care aides didn't really have the time to walk her all the way to the dining room, and that if she couldn't walk back to her room on her own she would likely stay in the dining room until it was her turn to be taken back. She realized that if she had a wheelchair she could get back and forth on her own, so we bought her a wheelchair. It wasn't too long before she didn't use her walker at all.

My mom went into the dining room for every meal. After every meal, the girls would take her back to her room, they would help her to the bathroom and put her into her La-Z-Boy chair. She would usually stay there until the next meal. The health care aides would bring her a drink or a snack off the snack cart at 10, at 2:30 and at 7 o'clock at night. She never dared to ask for too much because she knew that the girls were too busy and she didn't want to bother them. The health care aides never told my mom when they were working short, but she always knew because they were always in that extra big hurry to get her done. In the morning they would put my mom on the commode. Sometimes they would have problems in another room with another resident and they wouldn't get back to her for 10 or 15 minutes. She would tell me about it, and to her, it always felt like it was an hour. Imagine how helpless you would feel.

Like most seniors, my mother was very set in her ways and she did not like change at all. She suffered from osteoporosis and needed help getting dressed. Before she went to the home, she always liked to wear a buttoned-up shirt, a straight-cut skirt, a slip, panty hose and a girdle. After about two days of living in the home, the staff were at her about not wearing her girdle because

it took too long for them to put it on her and they didn't have time. She was pretty stubborn about this and would not hear of it, so she started at the family about it. After about two months, they finally just stopped putting it on her. I think that's when my mom finally realized that her independence was really gone. Next came the pantyhose. The girls just didn't have the time to struggle to try to get them on her. My mother was 86 years old and for the first time in 60 years she had to wear socks and jogging pants instead of pantyhose. To anyone else, this might seem like a minor thing, but it was a really big deal to my mom. This was one thing that always really upset her.

There were a few things that my mother just wouldn't give in on, like wearing her housecoat to the dining room so she would be ready for her bath right after breakfast; going to bed early because the health care aides started at the end of the hall and did one room at a time so they could get them all into bed before 9 o'clock, when one of the shifts would end. That meant that she would have to go to bed shortly after 8. Some staff approached me about buying mom some open-back nightgowns. They said that it would be much faster and much easier for them to change her. The next time the clothing company came to the home, I took mom to look at them. She wouldn't even look at them, but I bought her two, thinking that I would talk her into it later. After my mother passed away, I found the nightgowns in one of her dressers. They had never been worn.

Wandering residents were always a problem. They would just come into her room at all hours of the day and night and get into her belongings. This was very upsetting to her. There was just not enough staff to keep an eye on all of these residents. When any of our family members complained about this, they would tell her to keep her door shut, but my mom was afraid of being locked in a room all by herself. They put a six-inch-wide yellow band across her doorway. This didn't really work, but it was the best they could do for her. She spent many nights being afraid.

My mom was really lucky to have a big family who visited her a lot, and the staff from the activity department did their best to try to talk her into coming out to their activities. I see so many residents who have little or no family. It makes me feel very sad to think of how long their days must be, alone in their rooms with staff rushing in and rushing out to give them care, and push them back and forth to the dining room for their meals in a hurry because they have to get all 63 residents there in 10 minutes. No one has any extra time to just stop by and say to them, "How are you today? Is there anything I can do for you?" or "Would you like to go for a walk?" because we are all so busy trying to do our jobs and stay caught up on all our charting.

Current regulations require documentation and charting. This takes time away from staff being able to provide more hands-on hands. If the government wants more accountability, then they need to provide more money for staffing to complete documentation for the accountability. As the saying goes, if you don't chart, you haven't done it. By the time you get your work done

properly there is no time left to chart. It's always a balancing act. Which is more important—the resident or the charting?

Because we are a small facility, it is often difficult to obtain staff. Part-time hours are shorter and staff often work two jobs to make a living. Young people do not want to stay working in this environment long-term. After working in this kind of atmosphere, you just get tired, your patience runs thin and it is very hard to stay focused on why you really chose to work in a long-term-care facility.

The Chair: One minute, please.

Ms. Buttery: It is getting harder and harder to find anyone who wants to spend the rest of their career being a health care aide or a dietary aide in a long-term-care facility because the load is just too heavy. This is why so many homes have to work short. There is just no one to hire. It is our job as health care providers to give our residents the best care possible. Please help us help the residents.

The Chair: Thank you. There is no time for questions.

1110

ONTARIO RETIREMENT COMMUNITIES ASSOCIATION

The Chair: The next presenter is the Ontario Retirement Communities Association, if you would state your name. Those who have an agenda—I believe that Gord White is replacing the initial presenter.

Mr. Gord White: Yes, obviously I'm not Shelley Gould. I'm Gord White, CEO of the Ontario Retirement Communities Association. What I'd prefer to do today is make a very brief presentation on the one point that we have to make and leave some time to respond to questions. The issue we have, and you may want to turn to this page in the act, is with subsection 93(1). I'll explain a little bit about the retirement home sector. I really did not imagine that in the course of my responsibilities with the association I would end up speaking at a forum such as this, dealing with long-term-care homes. But subsection 93(1) requires that I be here today.

The retirement home sector in Ontario is about 38,000 beds across the province. It is a sector that also provides care and accommodations for seniors, but one where seniors pay 100% for the care and accommodations. Representing the Ontario Retirement Communities Association, we represent 60% of those 38,000 beds, so it's about 23,000 beds across the province that are members of our association. The principal role with our association is to be an accrediting body for the sector. We set standards, we inspect and we accredit retirement homes. Only retirement homes that have passed our accreditation and continue to meet our standards are allowed to be members in our association.

I've defined the sector a little bit and, if we're talking about numbers of beds, it's about half the size of the long-term-care sector in Ontario at the moment.

Now to the point: What brings me here today is subsection 93(1), and in that it says, "No person shall operate residential premises for persons requiring nursing care or in which nursing care is provided to two or more unrelated persons except under the authority of a licence under this part or an approval under part VIII." So it's an issue of the provision of nursing care and whether or not to license. The way this is written, it looks to our association and to operators of retirement homes in Ontario as if retirement homes would no longer be able to provide nursing care, depending on what the definition of what nursing care is. If it were to mean the distribution of medication, that would include just about everybody living in a retirement home in Ontario today. I would say that all 38,000 people living in retirement homes receive some sort of nursing care, and that's a primary driver for people wanting to live in a retirement home. So if we were to read this act in this way, it would suggest that if retirement homes were not licensed or given some sort of exception, then people living in retirement homes would be required to find their care elsewhere, and probably the only place they could find their care would be at long-term-care homes. It doesn't seem to make sense.

We would like to see as a solution to this problem that retirement homes be considered as an exemption, and that would appear under 93, and there's room for an exemption here under clause 93(2)(b). Under that is an allowance for other premises to be exempted from subsection 93(1). That's the point. Essentially, we're saying that if the province wants to have an act that's regulating care in retirement homes, that's another solution; there should be a specific act to get to that outcome to regulate care in retirement homes. It really shouldn't be done under 93(1). And, by the way, in our conversations with the province on this issue, the general response we've had each time is, "That's really not the intent of subsection 93(1)." We understand that. My purpose today is, I guess, to reiterate that point, to bring attention to it and to make sure that it is not an outcome that 38,000 people would no longer be allowed to receive care.

With respect to an act regulating care in retirement homes, the province has initiated a process to begin that. As a matter of fact, next week public consultations to discuss the issue of providing a regulatory framework for retirement homes begins in Sudbury. I believe there are 13 stops around the province. That's something that we are supportive of as an association and something that we are looking forward to. I believe I've made my point. I'll take questions.

The Chair: Good. We have eight minutes for questions. Ms. Smith.

Ms. Smith: Mr. Chair, you'll be delighted to know that I won't even take my share of the eight.

Gord, we've had a chance to discuss this previously. As you mentioned, there is a consultation going on. There's also a consultation backgrounder, a white paper, that has been sent out to various stakeholders, including a questionnaire. People are being asked for their points of view. The 13 consultations start next Tuesday in Sudbury

and are going to Thunder Bay, Windsor, London, Kitchener-Waterloo, Toronto, St. Catharines, Hamilton, Ottawa in both French and English, Kingston, Barrie and Brampton. From what I understand, these are working group discussions on looking at the retirement home industry and how we can best regulate it.

As we discussed, section 93 is actually what already exists in our long-term-care home legislation. It was determined that we would stay with the status quo until the consultation on the retirement home sector is complete and that clause 93(2)(b) gives us the regulation-making ability to address whatever come out of the consultation. We don't want to prejudge what happens in the consultation, so we've given ourselves the ability through that regulation-making authority to address your concerns. I thank you for bringing them forward today. I think that we'll be able to address this once that consultation is complete.

The Chair: Mr. Hardeman.

Mr. Hardeman: Thank you very much for the presentation. I appreciate the comments from the parliamentary assistant, recognizing that we do have an answer for the question. As I looked at the section when you started your presentation, I too would have concerns. I want to quickly go just one step further, beyond the consultations that are presently going on, not prejudging what those consultations will direct. Your suggestion of an amendment for an exemption: If there is not a regulatory regime put in place for retirement homes—I suppose one always has to remember that consultation could lead to any conclusion if it's full and open consultation—if there is no act coming forward with an exemption to this, how would you identify retirement homes as being exempt? How would you suggest that that be done?

Mr. White: That's an excellent question. It's very difficult to identify retirement homes without having a definition set in legislation. Retirement homes are covered under the "care homes" section of the current Tenant Protection Act, which we know is going to be the Residential Tenancies Act at the end of this month, but really that's a fairly broad net that's covering retirement homes, plus other types of housing. So it would be difficult, I think, to use "care homes" as a definition to really meet our need. That is a concern for our association.

Mr. Hardeman: In going on, then, you just mentioned care homes. Would the exemption you're suggesting that you could put in as number 5 in the list of exemptions then also include care homes?

Mr. White: No. I'm certainly only here to speak to the issues that are facing retirement homes. "Care homes" is really a very broad definition and it's covering different types of housing. It's also including rooming houses and boarding lodges and things like that with things that really aren't dealing specifically with seniors in the type of environment that they experience in a retirement home.

Mr. Hardeman: I'm just trying to get it straight here. Wouldn't care homes also be covered in this section and have the same problem as retirement homes?

Mr. White: At the moment, I guess a care home, if there was no legislation that was really affecting this sort of specific—probably could be affected by this particular act the way it is written.

Mr. Hardeman: So it's reasonable to assume that not only should government be looking at whether there should be an exemption for different accommodations, including retirement homes and care homes and so forth, even if the legislation on retirement homes comes forward to legislate retirement homes, something more needs to be done for some of these others because this is quite prescriptive.

Mr. White: Correct. I would presume that if "care homes" were to be applied to retirement homes, it would also be applied to other homes that are covered under the "care homes" section.

Mr. Hardeman: Thank you very much.

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The Chair: Ms. Martel?

Ms. Martel: Thank you for being here today and for bringing this to our attention.

The conversations that you've had with the ministry about this: Have they been verbal conversations to say that retirement homes are not included?

Mr. White: Essentially, it's indicated that retirement homes could be dealt with as a possible exemption under the regulations, and there certainly is room in the legislation for that to happen. The trick is, if there's no act defining what a retirement home is, how do we get into that exemption? Certainly it's not in anyone's best interests across Ontario to preclude the provision of care in retirement homes.

Ms. Martel: You've heard what the parliamentary assistant has had to say. Does that respond to your concerns?

Mr. White: It's close to responding to our concerns, and it certainly makes our membership feel a bit more confident, yes.

Ms. Martel: So perhaps if you could get something in writing from the ministry to reinforce what she has said and that you could give to your members, that would be helpful.

Ms. White: Of course, we would look favourably upon that, yes.

Ms. Martel: Perhaps we'll make that suggestion to the ministry or to the parliamentary assistant as a follow-up: putting something in writing that can be shared with members of your association so that everyone understands the rules under which we're operating right now and that you're not affected.

Mr. White: Right. Thank you.

The Chair: Thank you.

COUNTY OF ESSEX

The Chair: We move now to the county of Essex.

Welcome. If you would state your names for Hansard, please.

Mr. Brian Gregg: Thank you, Mr. Chair and members of the standing committee on social policy. We represent the county of Essex, which owns and operates the Sun Parlor Home and the Victoria Street Manor. I am Brian Gregg, chief administrative officer for the county of Essex, and with me is Bill MacDonald, the administrator of both homes. We appreciate the opportunity to be here this morning and offer comments on this important legislation.

For over 100 years, the Sun Parlor Home, located in Leamington, has proudly offered its services to the community of Essex county. As a not-for-profit long-term-care home, municipally owned and subsidized by the county of Essex, all our resources are dedicated to the residents. County ratepayers currently contribute more than \$5 million towards the operation of our two facilities.

Our mission statement is, "To serve our community, providing supportive resident-focused care that promotes quality of life." This pertains to the 206 long-term-care beds at the Sun Parlor Home, as well as 14 beds in our supportive housing group home, the Victoria Street Manor, which operates in Amherstburg.

We believe that the quality of life, safety and well-being of long-term-care-home residents in Ontario is a priority, and we demonstrate this by providing excellent-quality care to our residents which continually exceeds minimum standards. We also believe that all agencies, profit and not-for-profit, must be accountable for the care and services they provide. To this end, the county of Essex supports the spirit of Bill 140.

Essex county does wholeheartedly endorse the government's goal of building a strong, accountable and resident-centred long-term-care system. We also feel that our home is there to serve our community, and has been doing so for many years now. We can understand the desire to consolidate the three existing pieces of legislation into one. The goal of adequately training all contracted staff and volunteers is generally supported.

There are, however, many measures in the proposed legislation that we believe have no direct impact on our residents' quality of life, safety or well-being. We are also greatly concerned from a municipal perspective about the tone of the legislation, which is more punitive and prescriptive in nature. We understand the need to address the small percentage of poor performers in our industry. However, we believe that the great percentage of homes that exceed the minimum ministry standards, particularly through municipal and charitable assistance, should be recognized and rewarded for doing so. In this manner, we are more likely to achieve the desirable "home" environment. Accordingly, it is important that we get the legislation right at the outset, as it will affect the lives of our residents in long-term-care homes for many years to come.

The warden of Essex county wrote to the Minister of Health on November 29, 2006, regarding Bill 140. In that letter, we endorsed the positions taken by the Association of Municipalities of Ontario, AMO, and the Ontario

Association of Non-Profit Homes and Services for Seniors, OANHSS. The purpose of our presentation today is to further elaborate on these issues. We know the committee will be hearing much more from our associations about their detailed recommendations to alter the act.

I wish to turn the presentation over to Bill MacDonald, the administrator of Sun Parlor Home, to present in our own way some particular concerns.

Mr. Bill MacDonald: We have six concerns, the first being doing more without the resources to do so. The legislation does propose to do more in a number of ways: more documentation, more compliance, more administrative requirements, etc., all of which we believe would shift resources from where they are needed most—at the bedside.

Municipalities have seen both increasing complexity of resident care needs and the cost of new standards without the corresponding provincial funding support for many years now. The legislation changes the government's funding obligation from "shall" to "may" fund our requirements. We are concerned that this ambiguity may, in the future, provide the ministry with the legislative authority to further erode funding envelopes. The government's pre-election commitment to increase operating funding to \$6,000 per resident is only one third achieved prior to these new legislated requirements. If left unaddressed, this results in another downloading of funding responsibility to the municipal sector and/or redirecting funds from resident care needs.

Our second concern is not-for-profit support. In many ways and in many places the current government has, in words, supported the not-for-profit health care delivery model. It is disappointing then that there is no strong and explicit statement in this legislation's preamble. We believe that the government should commit to preserving and promoting the not-for-profit long-term-care sector by means of an explicit statement. We feel that this is appropriate given that 65% of the new 20,000 long-term-care beds in Ontario were awarded to the for-profit sector.

Our third concern is about the personal liability for directors. Essex county council is greatly concerned with the increased personal liability proposed for directors for failing to take all reasonable care to ensure their homes meet all requirements of the act. The implications of this appear to be particularly harsh, especially when compared with other legislation, such as that governing hospitals and the new LHINs. One of our councillors did ask whether the minister would be subjected to the same personal liability exposure. Why such a heavy-handed approach is necessary for municipalities that have shown leadership and significant contribution in the provision of long-term care in Ontario is a mystery to us.

Our fourth concern relates to individual rights versus collective rights of all residents, which is best illustrated in this question of secure units. We welcomed the review of long-term care done by Monique Smith—we mean that sincerely. It emphasized that we are homes where

residents are partners in care to be treated with dignity and respect. At the Sun Parlor Home, we have certainly taken pride in doing precisely that. We have also taken great care to balance the needs and rights of individual residents with those needs and rights of all residents.

Thus, the sections referring to secure units are of particular concern. We do support minimizing the use of restraints throughout the home and in secure units. We understand that in our secure unit residents can have forms of dementia and other behavioural difficulties which may present safety risks not only to themselves but to other residents and staff. We need to be able to provide the special care that these residents need.

So section 43, relating to the CCAC's authority for admission to these secure units, seems to define these special-care units as a restraint. Applicants may need a special-care unit, but may not be able to place the resident in one because the substitute decision-maker has not consented to this placement. This would present a risk to all other residents throughout the home. As a result, homes may be eliminating secure units entirely rather than present such a risk to so many other residents. These matters are particularly sensitive in all homes, as we await the government's actions arising from the recommendations of the jury in the Casa Verde nursing home inquest.

1130

Our fifth concern is related to capital funding. We realize the ongoing need to maintain and upgrade the physical plant in our homes and have done so in Essex county. We take exception to having no legislated funding obligation on the part of the province to assist us in doing so. In particular, section 133, which can order renovations without any reference to funding assistance, is troubling. There should be commitment by government to a capital renewal strategy.

Our sixth concern is funding for training. As we did state earlier, we do feel it appropriate that orientation and training for all contracted staff and volunteers be conducted. Generally, we feel that homes can do more to serve the needs of our elderly residents if our staff are appropriately trained. However, again, we must state with some dismay the lack of government funding to do so. These requirements, along with numerous others, as legislated and negotiated, are creating a burden on municipalities which is becoming increasingly difficult to absorb.

I would like to turn it back to Mr. Gregg for our concluding remarks.

Mr. Gregg: As stated in the warden's letter to the minister that we referenced earlier, we do strongly support AMO and OANHSS, who have eloquently stated the following:

"The not-for-profit sector has a long and proud history of 'going the extra mile' for the residents—providing more than is required, topping up provincial funding with municipal and charitable contributions, creating home-like environments, serving the distinct needs of our communities, and working closely with local volunteers.

“We want to continue to play a leadership role in providing quality care, and we want to work with government to make lasting improvements to the system. Unfortunately, Bill 140, as it is now drafted, does not encourage a true partnership between providers and the government. The bill is adversarial in nature, and it places almost all of the obligations on the homes.”

Thank you for the opportunity to present these concerns to the committee. We look forward to seeing these addressed in further iterations of Bill 140. In particular, we ask that you pay close attention to the detailed recommendations being provided to the committee by OANHSS and AMO during this consultation process.

We in Essex county continue to be committed to the provision of long-term care to our most frail and vulnerable residents in a spirit of true partnership with the province of Ontario.

The Chair: Thank you. There are about two minutes for questions, starting with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation and for the care that you provide to your residents. You say that the legislation is going to mean more documentation, more compliance, more administrative requirements, which means less money available at the bedside. I wonder if you could articulate for us what impact that is going to have on the level of personal care.

Mr. MacDonald: Thank you for the question. First, I would say that our industry is one of the most highly regulated, highly accountable industries in the health care sector. We sign a facility service agreement each year which basically commits us to live up to every single standard—even standards that haven’t been thought of yet, which is kind of hard to do. So all of the additional requirements of the legislation, albeit well-intended or not—it’s really about resourcing them. If the county didn’t contribute to our organization to pay for those extras, then it would come from the bedside, and it’s a difficult equation to say precisely when the county has had enough. But in reality every single administrative extra, even the training, which we welcome—it’s a good idea to train our consultants and volunteers, but it’s an extra. It all requires more and, if not resourced, it will take away from the bedside.

Mrs. Witmer: I guess you are in a fortunate position—I say “fortunate” because you’ve got taxpayers who can—but we have many homes throughout the province who are going to be subject to the same documentation and what have you, and obviously there is no taxpayer there able and willing to help, so that is of real concern. I guess the bottom line is that if you’re going to impose this onerous documentation and administrative workload, you need the resources—financial and human.

The Chair: We need to move on. Ms. Martel.

Ms. Martel: Thank you for your presentation today. I acknowledge that’s a very significant contribution by the taxpayers and the county to support these two homes.

I just wanted to focus on the two concerns you raised: one with respect to secure units, the second with respect

to an order around capital funding. Can you just give me a sense of what you’d like to see in those two sections that might minimize or take away your concerns?

Mr. MacDonald: Let me start with the second and say that the ministry has had support for capital funding and a fund to keep facilities up to date, and I think a continuation of that type of capital funding support will keep even the brand new homes up to the standards that we’d like to see. That’s the kind of capital funding commitment that we have in mind.

With respect to the secure units, that’s a different question, and it does relate to a rather tricky, for those who aren’t in the business—but the idea of treating the secure unit as a restraint and thus requiring this consent. If a resident who needs to be in the secure unit doesn’t have that consent, all of a sudden throughout the home this does create quite a hazard. You’re probably well aware of the deaths that occurred in the Casa Verde nursing home. This is the type of aggressive resident that we need to treat properly and put in the appropriate place in this province. So that’s a slightly different challenge.

The Chair: Thank you. Ms. Smith.

Ms. Smith: I just want to follow up on Ms. Martel’s point. I recognize that it is definitely a challenge and we do have a variety of behavioural issues in our homes, but putting someone in a secure unit, albeit for their safety or the safety of all the other residents, does mean limiting their movement. The secure unit means that they are not given the pass code and not allowed to leave. That’s a pretty big decision to make, and I know it’s not made lightly in our homes. We have heard from family members, the Alzheimer Society, the Advocacy Centre for the Elderly, that they really feel that consent is necessary in order to take away that right to mobility. I think you’re suggesting here that you don’t believe we should be seeking a consent from the resident or their substitute decision-maker to move into a secure unit. Is that what you’re proposing?

Mr. MacDonald: Obviously Monique is very knowledgeable and presents both sides of the argument very well. Having participated with OANHSS, our association, and the ministry in looking at this very challenging question of where are the most aggressive and the most difficult forms of dementia best handled so that we look after the needs of that resident as well as the needs of all our other frail and elderly residents, I would say that it’s a challenge. There are examples of good secure units in this province today that are doing precisely that, but they also are resourced to do so. They’re designed and resourced to do it a little bit differently.

We may have opportunities in our province. We’re about to open up some new homes, even in the Windsor-Essex area; thank you for acknowledging that. There may be opportunities to create units that are designed to truly house these residents. Frankly, today there’s not a good spot throughout our entire health system to put them in. It has been a challenge in prior governments and a challenge in the current government, and we need to do something about it. It’s probably the single biggest chal-

lenge the industry has. So there may be some opportunities.

Ms. Smith: Absolutely, and I know that there are discussions ongoing about that.

If I can sneak one quick one in, you said that there should be a recognition of good homes. Short of more funding—and I put the same point to the chair of Belvedere Heights in Parry Sound yesterday—do you have any quick suggestions on how we could recognize good homes?

The Chair: Really quick suggestions.

Mr. MacDonald: One quick one: In the accreditation process that health facilities are subjected to voluntarily, if you're a good performer, they only come around every three years, and if you need them to come around every year because you're average or less than average, they come around every year. I understand that's being considered. So that's a small form of reward that would recognize the good performance of some homes.

The Chair: Thank you.

1140

JOHN VAN BEEK

The Chair: The next presentation scheduled is by Margaret McClintock. We've been advised that she's unable to make it today, but John Van Beek has requested that he make a very short statement on her behalf. The Chair has ruled that that's acceptable; if the committee doesn't concur, I will probably storm out in a huff.

Mr. John Van Beek: Thank you very much. I'm going to be very brief, so it will put you back on schedule.

Nursing home workers who have made presentations here have been under the gun. They are very nervous, of course, in terms of presenting in front of this committee. I was informed late last night that a letter had been sent to one of our members who was going to make a presentation, and I just want to read the letter and put it on record. Of course, we will take the appropriate action. This is dated January 23, 2007.

"Ms. Marg McClintock

"c/o Caressant Care on Mary Bucke," which happens to be in St. Thomas.

"Dear Ms. McClintock:

"It has been brought to our attention that you will be speaking at the Bill 140 London public hearings meeting on Wednesday, January 24, 2007 at 11:30 a.m.

"This letter is to notify you that during this meeting you will in no way be representing Caressant Care Nursing and Retirement Homes Ltd. in your opinions and outlooks.

"If Caressant Care determines that you have represented them in any way, this could lead to your termination of employment.

"Sincerely,

"Cheryl MacDonald

"Manager, Human Resources," from their corporate offices in Woodstock.

It's a deplorable situation, of course. The union will attempt to correct this situation in terms of the ability of threatening people's right to speak out. In terms of that, it's just absolutely deplorable. I just want to put that on the record. Thank you.

CANADIAN UNION OF PUBLIC EMPLOYEES

The Chair: The next presentation is Pat Riedel.

Mrs. Witmer: I guess I have to ask why someone was able to make a presentation without being on the list of speakers. I do know that there are other people in the audience who actually spoke to me today and indicated that they would appreciate the opportunity to speak. So I don't know that we can arbitrarily allow different individuals to speak, at the whim or will of whom, but I think there has to be some fairness. There are other people who also would like to get on the record.

The Chair: The reason I concurred with the request was that the gentleman was speaking on behalf of someone who in fact had registered and had been assigned 15 minutes. If I erred, I apologize for that. But it was on her behalf and I accepted the request.

Would you state your names for Hansard, please.

Ms. Pat Riedel: Pat Riedel. Good morning. I am currently the area 1 representative for the health care workers coordinating committee of the Canadian Union of Public Employees, or what is known as CUPE.

I've worked as a health care aide in a municipally funded long-term-care setting for 30 years, 25 of which have been full-time, five days a week, every week, and I can attest to the fact that there have been a lot of changes in long-term care and not a whole lot of them have been positive. Just so you're aware, CUPE represents 24,000 members working in approximately 217 long-term-care facilities across the province of Ontario.

One of the key areas of concern that we have regarding this bill centres around the issue of staffing. Staffing levels in homes, and the one in which I work, can vary and, depending on the shift you work, the staffing ratios can change from as much as 12 to 1 and in some cases they can go as high as 30 to 1 or 35 to 1, depending on your shift. The midnight shift is usually the one that is least covered.

Research has shown that staffing levels in privately owned or for-profit homes have a much higher resident-to-staff ratio, as more staff ultimately means a lower profit margin for the home. A regulated minimum standard of 3.5 industry-wide would go a long way toward changing that problem. The legislation in Bill 140 fails to set out a minimum standard for resident care. A minimum level of 3.5 hours of hands-on care for each resident in all homes must be included in the legislation. Alberta already has 3.5 hours of care as their minimum, and New Brunswick and Saskatchewan are working toward achieving the same. I'd like to know why we're not, here in Ontario.

Staff changes and working short-staffed have become an almost expected part of our jobs. This is a chronic problem and is prevalent across the province. Employers are not always concerned about replacing staff who have booked off. Why would they be? They know that the staff who remain there are going to work their butts off to make sure that the work gets done and the residents get cared for because they care very deeply about these residents. Some of them are not just clients; some of them, who have no family, become family to us and we become family to them. So you're not going to allow that person not to be washed, not to be dressed, not to be fed because you're working short; you're going to do that. In the interim, the employer is saving the wages of this employee they have not replaced.

Residents have been mandated to have two baths a week. When you're working short, you have to decide what it is that you're going to give up, and quite often it's that resident's second bath. You have no idea how much it hurts a staff member to have to walk into a room and say to a resident, "I'm sorry, but you're not going to get your bath today because we're working short and I don't have the time to do it." It's the same if they ask you to do them a favour and you have to tell them, "I don't have the time right now. Maybe I'll get to it later," and you don't get to it, and you go home at night and you think, "I should have done that." It's too late by that point in time.

The other issue that's not addressed in this bill is violence in the workplace, and I'm not talking about violence just against staff. The problem the staff have, when they're working in a unit such as an Alzheimer's unit, is with residents who are suffering from some form of dementia or possibly brain damage. What happens is that quite often, because they are confused and unable to rationalize properly, they will strike out at you. I can tell you from experience that every time this happened to me—and I worked in an Alzheimer's unit for 25 years. Each and every time this happened to you, you were told by your employer, "What are you complaining about? It was part of the job. You knew it was part of the job when you took the job." When it happens, the first question out of their mouth is not, "What happened?" It's, "What did you do to provoke it?" We need to have more staff in the homes in order to protect not only our residents but our staff as well.

Part of the problem that we have as well nowadays—when I first started working in long-term care, the majority of the residents we had could do at least part of their own care. Now they're being kept in the home longer, and they're coming in requiring a lot more hands-on care and a lot more time, and we just don't have it to give with the staffing levels that we have at this point in time. We've been finding as well that, because of the closure of mental health facilities and facilities that used to handle the mentally challenged or developmentally challenged, we're getting those people in our homes, and it's a totally inappropriate setting for these kinds of people. They're put into the general population, with frail and elderly residents who cannot defend themselves.

1150

The timing for the gentleman who came before me to read the letter regarding the staff member who was told she would be terminated if she came here was almost a godsend. When it comes to the whistle-blower protection that's in this legislation, it's practically nonexistent. I think you've seen a perfect example this morning of what can happen if you make an attempt to report any kind of abuse or any problems within your facility. What happened this morning is a perfect example. The employers in the homes make it very well known that there is a process to go through to report abuse or suspected abuse or problems within the home. But what happens is that, even though the information is on the forms, quite often you can't get those forms unless you go to your employer and ask for them. This means that they know exactly who made the report, and you are then subject to disciplinary action up to and including termination, such as what this woman was just threatened with.

One of our other concerns is the fact that there were only four cities in the entire province that were given the opportunity to speak to this bill. Those were Toronto, Kingston, Sudbury and London. This effectively cuts out at least 73 groups we know of that have had no opportunity to address this issue. I do believe that it is necessary to demand that there be more hearings in more communities.

Our elderly citizens deserve better. They deserve to be treated with dignity and respect. All of us must realize that in the coming years we are probably going to be in that situation. Funding for homes affects not only the residents in the home; it's going to affect every member of our community at some point, because at some point we may very well find ourselves in the same boat.

What I find is happening in the homes, because we don't have the hands in the house, is that we're not able to get things done. I can fully sympathize with the woman who was up here before, talking about the dietary things. It's not just nursing departments, but every department is working short.

I want to be very clear on where this 3.5 hours that we're asking for is supposed to go. I understand that during some of the other hearings in some other areas, there was some confusion on what the 3.5 hours and the funding for that would go to. That is specifically for hands-on care: for RNs, RPNs and health care aides. That's for the people who do the washing, the dressing, the actual physical hands-on care.

I understand that there was some confusion. They were questioning whether or not this was to increase maintenance, the dietary departments and that kind of thing. I'm not saying that those departments are not important. I'm simply saying that I want it to be very clear that when we're asking for 3.5 hours, that is specifically for front-line workers and hands-on care. Thank you.

The Chair: We have about four minutes for questions. Ms. Martel.

Ms. Martel: Thank you for your presentation. You've spent 25 years working with—

Ms. Riedel: No, actually 30 years working; 25 were full-time.

Ms. Martel: Full-time for 25 years, but 25 years working with patients suffering from Alzheimer's. Is that correct?

Ms. Riedel: Actually, I did over 26 years on an Alzheimer's unit. It's only been in the last four that I have not been, and that's only because the employer has restructured our workplace and has done away with 20 Alzheimer's beds in our facility. We now only have one locked unit that addresses Alzheimer's clients. The other 20 were put back into what is commonly called ambulatory or independent care, which means that you have to be able to pretty much come and go on your own and be able to find your own room and your way around the home in order to be there. What's happening, not necessarily in my home, but because of the lack of beds for the cognitively impaired, is that they're ending up having to put them into the general population, and what happens there is that your frail elderly then become victims when these people have their episodes of violence, and you don't always have the staff to stop that.

Ms. Martel: How many of the staff have received training to deal with people with dementia?

Ms. Riedel: That's the problem: A lot of them don't. They are downloading people who have been in psychiatric institutions, who have a developmental problem. They are putting these people into the homes, but they are not providing any kind of training to the staff for them to know how to deal with them. This increases not only the possibility—the probability, rather—that a resident can be harmed, but staff can be harmed, because they don't know specifically how to deal with or defuse a specific situation.

When a resident—believe me, I've worked in Alzheimer's units for a long time, and when a resident looks at you, you know that he's going to hit you. A lot of the times you don't have that kind of warning with people—

The Chair: We need to move on.

Ms. Riedel: —who have psychological disorders. At least with an Alzheimer's client, you have some indication of warning, whether it be a change in the facial expression or the eyes.

The Chair: Ms. Smith?

Ms. Smith: Thank you for your presentation. There are a few things I just wanted to address.

Alberta has set a target of 3.5, but they actually don't have a minimum standard of 3.5. They do say that they're funding to 3.5, but there is no documentary evidence to that effect. As well, we don't have any Canadian jurisdictions that have a legislated minimum of 3.5.

I did want to ask you, though, about the 3.5. You say you would include the RN, RPN, health care aides, those doing bathing and dressing. If there were particular individuals in the home who were assisting with feeding, would you include that in your front-line, hands-on care?

Ms. Riedel: Feeding is specifically a health care aide function in the home that I work in. It's not dietary or anyone else.

Ms. Smith: In your home. But in other homes, they sometimes have them as different types of staff. I'm just saying, if within a home there were someone assisting with feeding, would you include that in your definition of hands-on care?

Ms. Riedel: That depends on whether they were staff or whether they were volunteers. You need to be a little more specific about "someone else" in order for me to answer that.

The Chair: We're out of time. Mr. Hardeman?

Mr. Hardeman: Thank you very much for the presentation. I too wanted to go a little bit into the 3.5 and who was included. We've had a number of concerns in my community where different homes have calculations as to what standard they're providing and then who is included in dividing the number of hours that are available to the number of patients in the facility, what standard we are meeting in doing that. I think it's very important to understand how you perceive the calculation needs to be done in order to say, regardless of whether it's 2.5 or 3.5, how you calculate and who you include in the calculation as to hours of care available per resident.

Ms. Riedel: The way we have done the calculation that you're talking about was, we were counting in how many RNs, how many RPNs, and how many health care aides we have within the home on each shift. You take the number of hours that are allotted to those people, how much they're actually paid for, and you add them all together and divide them by the number of residents that you have in your home. That should give you a fairly good idea of what the hours of care are that are available to the resident in that home. In—

The Chair: I'm sorry; we're out of time.

Ms. Riedel: In the one that I work in, that's actually 2.7 hours, not 3.5.

The Chair: Thank you very much.

Just some housekeeping: The committee will be meeting in the Manchester Room for lunch.

This room will be cleared and locked over the noon hour, so if you have possessions that you wish to have access to between 12 and 1, if you would take them with you.

The committee now stands recessed until 1 o'clock.

The committee recessed from 1200 to 1301.

The Chair: The committee is back in session. For those of you who are joining us this afternoon, each presentation will be a maximum of 15 minutes. Any time left over after you present is utilized for questions from the members of the committee. I would ask that when you come to your chair if you would state your name for the purposes of Hansard.

PARKVIEW NURSING CENTRE

The Chair: The first presentation is by Parkview Nursing Centre in Hamilton.

Welcome.

Mr. Kevin Baglole: I want to begin by thanking the committee for permitting me to present to you today.

The Chair: I don't know why, but the procedure requires that you state your name.

Mr. Baglole: That's my next sentence.

The Chair: I apologize. I will give you 20 extra seconds.

Mr. Baglole: My name is Kevin J. Baglole. I'm the administrator of Parkview Nursing Centre in Hamilton. Prior to taking on this role, I had the privilege of serving as the coordinator of pastoral care and social services in three long-term-care residences in Hamilton since 2002. Prior to that time, I was involved as a volunteer committee member and faith group representative in a number of long-term-care homes, first in Kitchener-Waterloo and then in south Niagara. I have a large concern for seniors in general, and specifically the health and well-being of the frail elderly living in long-term care.

When I review and read Bill 140 and consider its implications for all those involved in long-term care, especially our residents, I have a deep concern for what impact the various components of the bill will have on the spirits of those involved. I wonder if the uncertainty of the licensing renewal will impact the spirit of the residents, who may not know what their future holds. When hope, security and certainty are removed, the human spirit is unsettled and can become fearful. I wonder if the families of residents, who have placed them in a home to be cared for, will have disturbed spirits, because instead of caring for residents, staff might be required to complete onerous amounts of paperwork in order to satisfy compliance standards. I wonder too about the spirit of the front-line staff members who are faced with more and more complicated care issues of residents but do not have adequate support from additional staff to assist when most needed. I wonder about the spirit of the entire long-term-care sector, as it seems that instead of being committed to delivering the components of a life of quality to our residents, Bill 140 seems to create a spirit of suspicion, over-supervision and fear of non-compliance.

I am certain and I know that those who were involved in drafting this bill did not intend to harm those involved in long-term care, but I encourage the members of this committee to use this opportunity of sober second thought to point out the shortcomings and burdensome aspects of this bill that require change. We need to seize this opportunity to create a spirit of co-operation in putting the tools in place to enable all of us to build a life of quality for our residents.

But I want the committee to hear from one who is deeply involved in long-term care. To that end, today I'm accompanied by Mrs. Arlene Fitzpatrick from the family council of Parkview Nursing Centre. I will permit her now to outline her concerns and requests to you.

Mrs. Arlene Fitzpatrick: Thank you, Kevin. My name is Arlene Fitzpatrick from Parkview Nursing Centre in west Hamilton. I set up our family council and have been chairman for six years. I am also involved in Family Council Network Four, on the steering committee

and as an executive member. I volunteer at Parkview—nine years, averaging approximately 30 hours per week. My mother has been a resident there for eight and a half years. My father was also a resident for one and a half years.

Parkview Nursing Centre in Hamilton is home to 126 residents, employs 140 staff members and 50 volunteers, with volunteer hours averaging 300 per month to 550 in high-activity months; for example, December.

The location is within walking distance to all amenities: shopping; banking; dentists; medical offices; schools from which Junior Buddies integrate with our residents as well as university students who train to be volunteers at Parkview; and across from Victoria Park, where residents can participate in outdoor activities. Many residents' spouses and families reside in the area and are able to walk or use public transit, while some travel with scooters.

Parkview is a four-floor structure, three floors housing 42 residents each, with 60 residents dwelling in four-bed wards. Approximately 90 to 100 line up for transportation to the main floor dining room three times a day for meals. They do not have the luxury of wheelchair-accessible washrooms. The facility was built 28 years ago according to standards of that time. The atmosphere is very homey, warm, friendly and welcoming. In fact, many residents who have temporarily come there have chosen to stay.

The purpose of my presentation: I want to ask the standing committee to amend Bill 140 to support B- and C-class homes in providing the care, dignity and respect that all residents need and should be entitled to in a safe, comfortable, home-like environment now and in the future.

Fixed-term licensing: The proposed fixed-term licensing scheme based on structural conditions without taking into consideration the compliance record of a facility is not realistic. Nor is the fact that such proposals are being made without offering necessary funding assistance or an attainable plan. Legislation must go hand in hand with funding to meet resident needs both in accommodations and care. How can an operator of any facility who is willing to improve structural conditions to meet the standards receive consideration and approval for additional funding under the present proposal? Fixed-term licensing as it is being presented at this time is inflicting panic and uncertainty in an already vulnerable sector of society.

Quality accommodation: Why aren't all three- and four-bed ward rooms to be eliminated in Ontario, just as they have been reduced or eliminated in other provinces? I believe this needs to be a priority for our government.

My mother pays the same rate as those living in A-class homes, yet she lines up three times a day to go down the elevator to a crowded main dining room. Her wheelchair doesn't fit into her bathroom, and were she in a ward room, there would be little or no privacy for her. The greater majority of residents who are capable of functioning reasonably well when entering a facility most

certainly need and should be given more privacy in washrooms, personal space and sleeping areas.

Care: Living in beautiful surroundings does not necessarily mean residents are receiving the amount of care they should. Many who have come to our home have made definite improvements both mentally and physically with the therapy and the attention they receive. Volunteers are a vital part of residents' daily activities and well-being, especially with the workload that is expected of staff—2.5 hours of care per resident just doesn't cover it.

Taking into consideration what other provinces have accomplished to date, there are several concerns that still leave Ontario falling below the standards other provinces have in long-term care. In fact, even within our own province, standards of care and accommodations for residents in B- and C-class homes greatly differ from others in class A and newly restructured class Ds who pay the same rate. Every resident deserves equal treatment now and in the future.

Wheelchair-accessible washrooms: Wheelchair-accessible washrooms would not only give residents more dignity but would also be beneficial to staff, who at present have little or no space to work in when assisting in toiletry. This would also help to cut down on staff suffering from injuries and thus help reduce absenteeism.

1310

Changes and improvements to buildings of B- and C-class facilities: I want the government to make it feasible to have the owners of my mother's home make structural improvements to Parkview, with plans that are approved by a qualified team of architects and builders, to make Parkview an A-class home.

Relocating: I have heard assurances that beds will not be lost or closed, but under Bill 140, I understand that the licence can be transferred to another area. We need Parkview in the area that it is in, not somewhere else that is inaccessible. I don't want to see spouses and families of residents separated from their loved ones, especially if transportation is an issue, thus threatening the well-being of all parties.

The compliance program: Structural standards and care standards need to be established for all inspectors to abide by so that the compliance program has more uniformity and stability across the province. The proposal to withdraw funding for non-compliance threatens the safety and lives of the residents involved. I cringe at the fact that my mother or other loved ones could be subjected to such an ordeal.

In closing, I would like to commend all those who have been instrumental in compiling all the information to present the Long-Term Care Homes Act. Your efforts and your perseverance in promoting a better quality of life for seniors and long-term care are appreciated. I trust that the standing committee will strongly consider the issues we have concerns with and ensure that the necessary changes are made to Bill 140 so that the aging population that has contributed so much to Ontario as veterans, voters and taxpayers will not be forgotten by our government, now and in the future.

In addition to the needs referenced in our presentation, I urge the committee to support the detailed amendments submitted by the Ontario Long Term Care Association to address the issues we have raised. Thank you.

The Chair: Thank you. There's just over a minute for each party. Do any of us remember whose turn it is?

Ms. Smith: Mine, I think.

The Chair: That's what I thought. Ms. Smith.

Ms. Smith: Thank you, Mr. Chair. I know you didn't just forget me.

Thank you for your presentation. I know I'm coming to see you on February 6; I'll be there. I'm sorry that we had to change the date, but we were doing something special the day we had scheduled.

About the licensing being transferred outside the area: Actually, the structure that exists now around licensing allows for the transfer of licences to different areas, so in fact we are putting more restrictions around that than what already exists—just to address that.

Around the number of hours, and you talked about 2.5 hours of care: In fact, the government has recently released a number that averaged 2.86 in the province.

You talked about falling below the standards of other provinces. There's no other province that has a legislated standard, and there are few that have set targets. Some have set minimums—1.9, 2.1. No one has a minimum of 3.5. It's a real mixture of who has what requirements, but there are no minimum standards of 3.5.

I just wanted to ask you what you would include in that 3.5 number or in whatever number you're proposing as far as what you would see as being calculated for care for your residents. I'll ask both of you, if we have time.

Mr. Baglole: Certainly I think we're talking about direct resident care. We're not talking about maybe sick hours or when people are out of the building; it's direct resident care. I would even question whether an activation staff assisting with the dining of a resident should be considered as part of the hours or not, those kinds of issues. But I think we would like to see maybe not so much a cookie-cutter approach, but a real need-based one: Does the home need 2.5 hours or do they need 3.5 hours for that particular care that they're delivering?

The Chair: Thank you. We're out of time. Mrs. Witmer?

Mrs. Witmer: Thank you very much, Kevin and Arlene, for coming forward. Mention was made of the fact that you are a home that has four-bed wards, and obviously you need money for capital redevelopment. I did put forward a private member's motion. It was supported unanimously by all parties in the Legislature, and I am optimistic that the government will follow through on that commitment, as well as providing the additional \$6,000 that they had indicated they would make available for each individual. As you've pointed out, the demands today on staff are onerous. This will only increase the burden. Unfortunately, the needs of our residents are much more complex than they were in the past. I'm optimistic and I hope that the government will do so.

You mentioned that your mother pays the same rate as somebody in an A home. We continue to hear that it is a

bit of a double standard. Some people are almost second-class citizens. They're in the new, 1998-designed homes and they're in a homelike environment, with small dining rooms, etc. I hope the government recognizes that we have to treat all of our older population fairly and equally.

Ms. Martel: Thank you for your presentation. I want to ask you a question about volunteers, because you said that you were. Does the home have a paid staff person who coordinates volunteer activities?

Mrs. Fitzpatrick: Yes, we do. We have our activity director.

Ms. Martel: Full-time?

Mrs. Fitzpatrick: Full-time.

Ms. Martel: Okay. The legislation says that every home shall have an organized volunteer program, and I don't have a problem with that. But then it says, "To be included in program," and it lists the range of people who need to be contacted in order to see if they'll participate as volunteers: schools; spiritual and religious centres and organizations; businesses; service clubs; ethnic, cultural and linguistic organizations; and other organizations and institutions within the community. I'm just wondering, do you think that's a bit much? Do you think that the volunteer coordinator isn't already trying to do those kinds of things?

Mr. Baglole: Yes. I think it's slightly onerous because then she would have to keep track of all those places that she contacted. So it's another amount of her time taken up in documenting that she contacted spiritual, schools, those kinds of things. She does that anyway. That's one of her mandates and one of my expectations, one of the owner's expectations, that she would do that, and to great fruition for over 20 years. It seems onerous that she has to do that now to comply or to prove that she's done that.

The Chair: Thank you very much.

TRILLIUM VILLA NURSING HOME FAMILY COUNCIL

The Chair: The next presentation is Trillium Villa Nursing Home.

Welcome. If you would state your name for Hansard.

Ms. Brenda Marshall: Good afternoon. My name is Brenda Marshall. I am the chairperson for the family council of Trillium Villa Nursing Home in Sarnia, Ontario. I have been a member of this council for approximately one year, yet I have been associated with this nursing home for the past 17. This home is my home away from home, and the 152 seniors who reside there are my extended family.

This long-term-care home is one out of three nursing homes in our community classified as a class C home. There are 35,000 seniors living in class C homes. There are 75,000 seniors living in long-term care across Ontario. It is not hard to do the math; almost half of our seniors live in C homes. These are homes that do not meet the new design standards, as do the A homes, yet

the residents of these homes continue to pay the same fee as a resident of a newer home.

I have come here today to ask the committee to amend Bill 140 and improve the licensing portion of this bill. We need to include provisions that provide these residents with the certainty of knowing that their home will continue to be there for them. Our community needs to be reassured that when the time comes, they too will have long-term-care access that meets the current and future needs of our baby boomer society.

There are too many unanswered questions that this bill does not address. This act specifies that a licence be issued for a transitional term of not more than 10 years for a home classified as a C home. What then? Will our home be closed or downsized? Will our loved ones be transferred to a different community, where there is no family, because there are no beds left in their own community? What happens if the home needs the roof replaced in a few years? Will the owner be able to find financing for a new roof that will last years beyond the life of the licence or will they be forced to carry out temporary repairs using duct tape until the uncertainty has been removed? Once the licence has been renewed, how much longer then? Will we meet those years' standards? These are questions that are being brought to me by residents and family members of our home. These are questions that I'm unable to answer for them, and I should be able to answer them. I am part of family council, and the families of these residents look to us for answers.

1320

The government wants the licensees and families of these seniors to take more responsibility, yet you make it harder each and every day for us. Why have this bill if, in the end, there are not enough homes available for our most elderly, frail and vulnerable citizens because they have been closed? The seniors in our communities across Ontario deserve better than this.

Long-term-care homes need to stay open and the government needs to assist us with capital renewal like there was for the 20,000 new beds and the 16,000 rebuilt D beds. I am sure that we can all agree that the contents of this bill are to protect the residents in these facilities. Yes, the government is ensuring tougher inspections, prosecution for those who abuse and neglect our loved ones, ensuring that a nurse is on staff 24/7 and restricting the use of restraints, but this bill is far from being superior, and superior it should be before it is passed.

We need the government's commitment to provide more capital funding to upgrade or rebuild our older facilities. A rebuild program from this government is a must. The operator or licensee cannot do it on his or her own without financial backing. If you were a loans officer, and a client came into your office and asked you for X amount of dollars but could not ensure that the payment would be returned in full because of the uncertainty of the outlook for the business venture, what would you do? Grant the loan? I think not.

My mother-in-law is in the last few days of her life, as I speak here today. She has no privacy when family visits

because she shares her tiny room with another wonderful lady who must watch her die, knowing that one day it will be her turn. Should we ask her to leave her room because we would like some privacy? I think not. This is her home as well and she must be made to feel comfortable in it. We also need to give the residents of these facilities the comfort and dignity they so rightly deserve. There are three to four residents sharing a room as well as a washroom. Try going to the washroom in a wheelchair when you cannot get the chair through the bathroom door. These residents are living out their lives and dying without privacy and dignity, and it is incomprehensible. They call these the golden years? I'm not so sure anymore.

We have some wonderful staff at Trillium Villa and, believe me, I have watched them come and go over the years, but they can only do so much. We, as family members, can only do so much, and I must tell you that we are all burning out. Together we are caring and loving human beings and, if not for us, our loved ones would not live the fulfilling lives that they do. If you choose to close down these older homes, you and you alone are giving our seniors a death sentence. We need to work together, compromise and create a bill that will keep our long-term-care homes in existence. If anyone here has spent time in a long-term-care home like I have, parts of this bill would not be written up as such. It has taken three years to write this act, yet you want to pass it through as quickly as possible. Shame on you. Shame on all of you.

I beg you to take into consideration each and every one of the speakers who have presented their cases in the last two weeks. We are the ones who know the ins and outs of these homes. We are the ones who know what needs to be done and the help we need to accomplish the task.

I was asked by the president of resident council of our home to bring this letter that I hold and to read it to you. It is a promise that I intend to keep. I would like you to listen to their voices through mine.

“Dear members (standing committee of social policy):

“As residents of a long-term-care home in Ontario we would like to express concerns regarding Bill 140. We worry about the consequences of this bill and ask that you reconsider how it is written. We live in a home that is a C classification. Our care here is excellent considering the stressful conditions associated with this older building, and the lack of funding dollars for adequate staffing in long-term care. Both the insufficient Ministry of Health funds and the age of the building have an effect on the amount of staff time available to meet our comfort and needs. Older C buildings like ours are very challenged to meet ministry regulation/standards. After all, many of these standards were not in place when this home was built, or have changed. Residents coming into long-term care were not as disabled, dependent and in need of real care to the same degree as most residents in our home and other homes. It is frustrating to know residents in newer homes don't have to be concerned

about some of the day-to-day concerns we have in an older building. For example, hallways are too narrow for wheelchair traffic; most bathrooms are shared by four people, are too small for a wheelchair to fit through the doorway and don't allow staff to assist us safely; storage space is just not available so our hallways are cluttered; bedrooms are too small to allow free and safe movement; there is no room for a casual chair to sit in or for company; dining rooms have 60 to 80 residents (imagine the noise three meals a day)” in that room, no relaxation whatsoever; “dining rooms are too small for safe and free movement with so many using walkers and wheelchairs. These are only a few of the problems associated with an older home. All of these factors affect our care, our comfort, and the availability of staff to meet our needs. We watch as staff work twice as hard overcoming these challenges. The number of new residents we get in a year is by far more than in any A or B home because many come for such a short time and then move to a newer home. We barely get to know many of our neighbours. Again, staff time is taken from us to accommodate for this constant change in residents. We understand there is no additional ministry funding to help overcome these challenges. Something is very wrong with this picture.

“What has happened to the renewal projects initiated several years ago? The Ontario government started to replace older homes but is not committing to continue. We feel like we are in limbo. Will our home be licensed in a few years from now, or will it perhaps not be renewed? If Bill 140 passes, who is to say that homes in good standing like ours and other C and D homes will not all of a sudden be closed? How long will this home be left before upgrades or rebuilding take place? Why would the owners want to invest in long-term care without provincial support and funds? Is there any security for us as residents, for our families, families and residents of the future, the owners and the staff who work so hard? We, and the residents of the future, need reassurances that the government will continue their unfinished task and provide equal accommodations and funding support for all residents in long-term care. Policy-makers need to make policy in conjunction with those who make decisions regarding funding.

“Long-term care is already stressed. Our care needs are incredible. Our personal needs will not be met as you expect if this bill is not rewritten. It will add complications that will again take time away from direct care. We deserve better. We deserve comfort in our living arrangements and the dignity of having staff who actually have the time to meet our needs. That requires more direct care staffing hours, more funds for direct care staff, less paperwork that takes staff away, a building that meets ministry expectations and the knowledge that our home will be licensed annually if we meet standards.

“Our question to the provincial government is, who are you accountable to if you don't write this bill well? Who pays the consequences? As we see it, it will have a trickle effect down to the very people you think you are helping—us, the residents in long-term care and those of the future.

“Respectfully,

“On behalf of Trillium Villa Nursing Home Resident Council

“Al Muxlow (president)

“Mary Lindsay (vice-president).”

The residents of these homes are the heart and soul of Bill 140. If you do not want to listen to them, then what are we all doing here today?

I thank each and every one of you for the time you have given me here today, and I respect the job that you have at hand. Thank you.

1330

The Chair: Thank you. We have about 40 seconds per caucus.

Mrs. Witmer: Thank you very much for your presentation, Brenda. Over the course of the last couple of months, from when the bill was introduced to where we are today—I had grave concerns when the bill was introduced; I now have far beyond grave concerns. We’ve heard from people like you. I will tell you, this bill, with which probably the government intended to do good, is really going to have a dreadful impact on the people who live in the homes, the staff who work in the homes. We hear about the very stressful conditions. I think at this point in time—I had 300 amendments. I can’t possibly introduce all those amendments. It’s not humanly possible. I’m almost believing now that this bill needs to be rewritten. The government needs to understand that it’s a bad bill. It doesn’t meet the needs of the residents. As I said, it was probably well-intended, but I don’t even think you can improve it at this point.

Ms. Marshall: Thank you.

Ms. Martel: Thank you for your participation here today and the work that you do on the council. Because we’re so short on time, I’ll just make this statement. We’ve heard about the licence issue again and again over the past five days. Clearly it is a huge issue both financially for a number of homes and for the—I don’t want to say “security”—comfort of residents to know how this will be resolved. I’m hoping that the government is listening to the concerns that have been raised about this very particular issue and that we come to a resolution for it, because the anxiety that’s out there really cannot continue, either for the staff nor the operators. Thank you for your presentation.

Ms. Smith: Thank you for being here and for your involvement with the family council. I note that there has been a real improvement in the home over the last four years with respect to compliance. Now they’re doing a great job, so I want to commend you. I’m sure you’ve been involved in encouraging the staff and ensuring that that’s happening, so that’s just great. I also note that Trillium Villa has hired over 20 new staff since we’ve increased the funding. I just wondered if you could comment on what some of those new staff are doing for your residents in the Villa.

Ms. Marshall: If the staff has increased, I have not seen it. It is very understaffed. We need a lot more staff at that home. I know you have done a lot of research in

the past, Monique. I don’t know if you’ve ever shadowed a staff member in a long-term-care home for a whole day—not just a visit; I’m talking about a whole day.

Ms. Smith: An eight-hour shift.

Ms. Marshall: You would understand the problems that they have during the day.

Ms. Smith: So you’ve seen no substantial difference since they’ve hired 23, I think, new staff in your home?

Ms. Marshall: I have seen differences over that time, but we’re still talking shortages. There are differences, but there is still a shortage.

The Chair: Sorry; we’re out of time. Thank you.

GUELPH WELLINGTON HEALTH COALITION

The Chair: The next presentation is the Guelph Wellington Health Coalition.

If you would state your name.

Ms. Magee McGuire: I’m Magee McGuire. Before I begin, on behalf of the Guelph Wellington Health Coalition I would like to extend our appreciation for all of the hard work that you and your staff have obviously been putting into this new bill. But we’re not out of the woods yet.

I chair the Guelph Wellington Health Coalition. We have been under the umbrella of the Ontario Health Coalition since 2002 when the Romanow report was being developed. We endorse the principles of the Canada Health Act, especially universal medicare. As advocates, we provide a forum through media and events for public discussion on health delivery and funding when it affects our own community in LHIN 3. This presentation reflects the input of our members, who have come from the community, local hospital unions, chapters of the Council of Canadians and the Registered Nurses’ Association of Ontario, the district labour council, teachers’ federations and the student association of the University of Guelph, to name a few. My personal contribution is supported by my current studies in health care leadership and my past 36 years of experience in the field as an RN.

Clearly, Bill 140 has a dedicated team of engineers who have created minuscule avenues of scrutiny for issues that have not been attended to before. The most important feature of your effort has been exemplified by the great changes that your committee set itself on course to follow after the Red Tape Commission recommended replacing the three existing acts that govern elder care in Ontario. You have clearly denoted the importance of provision for the continuity of care in all facilities regardless of whether they are long-term care, homes for the aged or retirement homes. You have aimed for quality and are attempting to focus on the core of it. We have discovered that some facilities offer all three levels, which gives greater opportunity for spouses who want to be close to each other and their families.

There are some distinct challenges to this act, which has the characteristics of a transformational leadership,

and I will speak to these. Clearly, this ministry has a vision for Ontario, and the mission statement for each facility needs to reflect this vision. We feel that language to guide such a mission statement is missing. We would also like you to endorse a values statement to reflect that mission.

Standards are an ominous task but not prohibitive in setting challenges. First of all, you have focused on the very important need for a care plan. What is missing is a universal statement of purpose. It must include: first, care to adequately meet the individual needs of the resident; second, a focus on safety, whether it is for a resident or caregiver or the environment; third, effectiveness that is inherent in a principled plan of assessment, planning, implementation and evaluation and revision; and fourth, efficiency. "Efficiency" is a term that requires a clear definition of its expectations. Standing alone, it does not include all these other processes, but without them it is not efficient. If it is not effective, it is not efficient.

You have highlighted the importance of quality and risk management in many different passages. However, we found that the paper was not comprehensive because there was no cross-referencing to related goals. For example, the language of section 6 on plan of care and 7 on care and services is not exclusive to other assessment language found under section 36 on regulations and admissions, section 37 on training and section 74. Simultaneously, it raises the flag on exemptions in section 139, general management in section 82, and municipal and joint homes and First Nation homes in section 116, part VIII. The relationship of these sections to each other strongly indicates the need for universal standards that meet quality assurance and risk management standards for all residential homes.

May I point out to you that a universal standard for care plans is already a construct of the nursing profession, which has created a tool for continuing improvement? It is the required standard of every registered nurse as a prerequisite skill to practise. All those under his or her supervision must provide the standard to which he or she is responsible. This is a poignant fact and a grave concern to the many RNs facing a future of nursing without support for these regulated standards.

Let me say it another way. You have already indicated that there needs to be an RN on duty 24/7 in all of these facilities. The standards of operation and clinical delivery by every service must minimally be implemented to the lowest, most common denominator of standards of the RN. In other words, they are quite high—and that is what you want, after all. If you do not do this, you will have greater recruitment and retention issues than those that already exist. It is not only the availability of an RN that is the issue; it is the issue of the standards that must not conflict with the ethics of the RN. It is about the lack of attractiveness to this profession. Nursing journals have focused on this topic for many years, especially since the cutbacks. These core standards need to be documented into the code of ethics for this act. Then it becomes everybody's responsibility.

This now brings me to the issue of leadership. You have fundamentally created a transformational standard of shared leadership, and this is golden. Therefore, it will be necessary for all the affected facilities to provide leadership that is equally transformational, and that means education and participation will become the hallmarks of excellence. All of these can be constantly monitored through continuous improvement strategies that meet community standards. Quality cannot prevail without transformation. The nurse manager must be supported to marry the operational and managerial objectives to the clinical objectives serving the needs of the residents. This is missing from the language.

1340

There will be strong competition for skilled resources such as RNs. It will be the personal care worker, or PSW, who will be doing most of the work. The scope of practice is limited for the PSW, who has no regulatory body. He or she may have a short community college education or be trained on the job, but without standards, it is difficult to measure the standards of this group of dedicated workers. The responsibility for standards and safety again falls to the one RN who must be present. There is no language in the act recognizing the ongoing need of education for these workers, yet this is part of the transformational process. At some time in the near future, there needs to be a discussion on the practice and ethics of the PSW and whether this group needs to be regulated.

It is good to see the word "training" in print. The most common reported experience about education in the workplace is that when staff goes to training, there is a reduction in staff for supervision, and this is where managerial decisions can shortchange the clinical standards. Yet training is supportive of those standards and is a mark of quality. There is no funding provision in the document that relates to training, and this is important. This opportunity cannot occur without the funding. Be aware, though, that even with the funding, the resources will be so scarce that training probably will require extended hours for employees until the graduates of existing programs begin to be available.

There is no reference to conflict management in the language or the standards, yet research shows that nurse managers spend up to 20 minutes of their time each day settling conflict. Once again, the cost of training will have long-term qualitative effects, with improved time management and interpersonal relationships. Please include this goal of a universal conflict policy as a condition of workplace standards.

In the auditor's report of 2002 and 2004, there was a strong reference made to the need for prioritizing quality assurance and risk management. Once again, this speaks to the need for highly qualified nurse managers, a minimum standard of care, and sufficient staff and funding to support this initiative. We strongly recommend that you endorse this specifically in the document. The ministry supports improved funding through the minimum standards set—MDS—implementation in Ontario. There is no benchmark for all facilities to begin and complete this

process. It is important to know that this process for an existing facility is demanding and stressful and therefore needs to be managed in phases. Managers report that their staff experience high levels of stress because of the countless paperwork and theft of hands-on task time.

There is a relationship between time, workload, quality and funding. The Ontario Health Coalition is advocating for 3.5 hours of care per resident to become the standard minimum hours of care for all providers in the circle of care. This is not the optimum, but it is necessary for maintaining the clinical and management standards. Presently, there is no minimum. The need for more time has been endorsed by the Ontario Long Term Care Association since March 2006 in their “20 minutes more” campaign. Likewise, the Ontario Association of Non-Profit Homes and Services for Seniors, through the Casa Verde case, demonstrated the need for more time, and therefore more funding, for meeting the special needs of residents experiencing dementia and mental challenges.

Currently, the most common funding model is the case mix index, but it does not capture all of the actual work done by a caregiver. This is critical for a worker who cannot meet the needs of the resident because, for example, the non-availability of incontinence products reduces the standard of care. In this instance, the professional standards are now also conflicted. In the circle of care, the multidiscipline approach is the best practice for overall plan reviews. Research shows that the involvement of line staff within the management circle for clinical and structural issues raises the quality of care and satisfaction for both resident and staff. So once again, the MDS assessment tool may better reflect the variable needs.

Presently, the copayment for basic and private is universal throughout Ontario. However, the private-to-public ratio is 60-40. Many seniors have expressed concern that they fear a lack of availability of non-preferred beds because of their lower incomes. Hospitals are extending hospital stays for non-acute patients waiting for admission, but there are no non-profit beds. If you need an example of that frustration, please recall the recent example of the Kingston lawsuit caused by 60 patients in non-acute beds waiting for placement. This often contributes to a backlog in emergency departments. Therefore, we ask you to reverse this ratio to 40 preferred-60 non-preferred beds and focus on this by dedicating all new beds to the non-profit sector.

Guelph has been approved for 90 more beds, but residences which are substandard to the new building guidelines will lose out because they are not eligible. There needs to be some funding for building standard upgrade built into the long term for any of these buildings so that this kind of thing will not happen. They are expensive to build and expensive to retrofit. Storage is such a big issue that, alone, it can improve the quality for both workers and residents. It is important to plan to work together to find a solution for these homes.

This brings us to the big issue of public trust. In the community, there is a need to build trust—

The Chair: One minute.

Ms. McGuire: —that this sector will be well maintained, and inviting family representatives or legal designates into the circle of care is one good way of guiding this.

I’m going to skip down to the restraint policy, which I’m sure you’ve heard about, because we feel that it is extremely important that where chemical restraint is used in an acute situation, there should be an immediate consultation of an experienced doctor of gerontological pharmacology, and it may not be the best skill set of the resident physician.

Finally, in my last thought, if I leave you with anything that’s really important in this presentation, I want you to remember the role of the registered nurse and the standard by which she performs, because it will be pivotal to the success of this change. I ask you to honour and protect this position as a core value in the passage of this document.

Thank you very much.

The Chair: We’re out of time and there will not be an opportunity for questions, but thank you.

COUNTY OF OXFORD

The Chair: That brings us to the county of Oxford.

If you would state your names, please.

Mr. Paul Holbrough: My name is Paul Holbrough, warden for the county of Oxford. With me today is Tony Orvidas, director of social housing and—

Mr. Tony Orvidas: Social services.

Mr. Holbrough: Social services. Sorry.

Oxford county council very much appreciates the opportunity to make this submission regarding Bill 140. The county of Oxford, with a population of approximately 100,000 people, is located in southwestern Ontario and is comprised of eight municipalities, including three urban centres. It owns and operates Woodingford Lodge, comprised of three long-term-care homes totalling 228 “approved” beds. One hundred and sixty of these are located in Woodstock, while another 34 beds are in Tillsonburg, and the remaining in Ingersoll. The two 34-bed satellites are “new builds,” while the 160-bed Woodingford Lodge Woodstock is currently being rebuilt, with residents being relocated to the new site later this year.

Woodingford Lodge has already struggled to achieve much of what is contemplated in Bill 140. While the county of Oxford is supportive of the principles of Bill 140 that are related to the care and safety of residents and of the province’s efforts to “build a strong and safe long-term care system,” the county is, however, concerned about the way in which the government proposes to apply the legislation.

This submission will focus on five matters of interest to Oxford county council. The first two deal with perceived omissions in Bill 140, while the remaining three make recommendations regarding amendments to various sections of the proposed act.

A paramount concern of the county of Oxford related to this piece of legislation deals with the failure of the province to make a commitment to ensure that there will be sufficient long-term-care beds available in Ontario in general, and in Oxford county in particular, to meet the future long-term-care needs of the residents of our communities.

Point number 1: enhanced staffing levels and associated funding. A simple answer to meeting the needs of residents in long-term care is bringing Ontario's long-term-care staffing levels up to those of other provinces like Saskatchewan and Manitoba, both of which provide more than three hours of care a day. As the Ontario Long Term Care Association has stated, "This 30-minute gap between care required and care funded is the challenge that residents, families and the" long-term-care "sector believe must be a government funding priority."

Various unions, as well as the Ontario Health Coalition, among others, have expressed similar concerns about this issue.

Increased staffing levels are particularly critical in resident home areas of long-term-care homes. These are areas that are designed and used as specialty or "secure" units for residents with cognitive impairments and where there is a significant risk of serious bodily harm to the residents or other persons.

1350

In an attempt to more appropriately meet the needs of its residents, the county of Oxford currently staffs Woodingford Lodge at an average of approximately 2.8 hours of personal and nursing care per resident per day. Staffing levels in its secure wing are naturally higher. Provincial funding does not cover the costs of the additional staffing. The county has to provide a substantial subsidy to offset the additional expenditure. Here you'll see a recommendation that we're suggesting.

Number 2: a commitment to increased operating funding. Long-term care is chronically underfunded. It is therefore critical that the province honour its commitment to provide \$6,000 per resident for the purpose of care and that it also provide new funding allocations in line with any new requirements. The county of Oxford contributes some \$5 million per year to the cost of resident care and services at Woodingford Lodge to meet the current standards. It is becoming progressively more difficult to maintain this level of subsidy due to the capital financing commitments. Unless the government provides additional funding, Woodingford Lodge will be forced to apply even more of its limited resources to meeting all the new administrative requirements of the act. As the Ontario Association of Non-Profit Homes and Services for Seniors has stated, this "means that less money will be getting to the bedsides of residents."

Establishing new requirements and standards without providing the means to achieve them is only a prescription for failure. As an example, the act identifies new training requirements for staff and, while everyone agrees that more training would be good, the act is silent on any commitment to provide funding to make this happen.

It should be further noted that in section 88 of the proposed legislation, the Minister of Health and Long-Term Care makes no commitment to providing funding for long-term-care homes. The county of Oxford fully understands that more funding is a budget issue. The fact that Bill 140 asks long-term-care homes like Woodingford Lodge to do what is not possible at current levels of funding is, however, a legislation issue.

Number 3: a requirement to establish and maintain a home. Under section 117 of Bill 140, southern municipalities will continue to be required to establish and maintain a long-term-care home or joint home or help maintain a home or joint home with the ministry's approval. Northern municipalities are exempt from this requirement, as is Pelee township. The county questions the reasoning behind this requirement for southern municipalities when the province is not prepared to provide these municipalities with sufficient resources to meet the care needs of the residents in their homes.

Furthermore, under section 133 of the act, the ministry may order renovations, additions or alterations of a municipal home and require that the order be complied with by a certain date. This would be done without any commitment from the Ministry of Health and Long-Term Care for additional funding to cover extra costs associated with the order. There's a recommendation on that item.

Number 4: duties of directors of a corporation. Section 67 of the act makes every member of the county of Oxford council potentially guilty of an offence for any infractions of administrative requirements in the bill that have no connection to the well-being of residents. This is further expressed in section 22 of the proposed legislation where, for example, misuse of funding or failure to report an incident by either an administrator or other staff member would be grounds for charging members of council.

Bill 140 makes members of the board personally liable for the failure of employees to meet the requirements of the act. The penalties even exceed those identified in the Public Hospitals Act. The county of Oxford questions why the crown, as a partner in care, appears to be exempt from any liability at all, especially when it comes to ensuring appropriate levels of funding.

Number 5: a prescriptive regulatory environment. Bill 140 takes a command-and-control approach to long-term care, which, according to the Association of Municipalities of Ontario, contrasts with the previous statements by the Premier and the Minister of Health and Long-Term Care that acknowledge municipal leadership on the issue.

If Bill 140 is passed with the current language, it will increase documentation requirements and thus staff workload. Woodingford Lodge employees will have to spend a great deal more of their time and resources on compliance and administration. The county of Oxford is therefore very worried that the proposed legislation will lead to a reduction in care and services for our residents rather than an increase.

The proposed legislation comes across as unfair and heavy-handed, particularly in section 156, with compliance and enforcement, where Woodingford Lodge could be subject to a non-compliance order whether or not the home “took all reasonable steps to prevent the non-compliance.”

Without question, a long-term-care home must be held accountable. The county of Oxford supports measures that will enhance standards, and agrees that there is a need to address the small percentage of homes in the long-term-care sector that would be considered “bad apples.” The county is concerned, however, that rules and regulations alone will not ensure resident care, security and safety. It also takes resources.

In conclusion, the county of Oxford would very much appreciate the committee’s consideration of the five matters that have been raised in this submission. If the province continues to require municipal involvement in the long-term-care sector and is prepared to properly fund this involvement, the county will continue to play a leadership role in providing quality care for the current and future residents of its long-term-care home and to work with the government to make lasting improvements to the long-term-care system in Ontario. Unfortunately, Bill 140, as it is now drafted, does not encourage a true partnership between providers and the government and appears adversarial in nature.

The proposed legislation is a major and long-awaited development, and with the appropriate amendments it will offer a unique opportunity to foster a more positive relationship between government, care providers, residents and their families. Thank you.

The Vice-Chair (Mr. Khalil Ramal): Thank you very much for your presentation. We have three minutes left. We’ll have one minute for each side, and we’ll start with Mr. Hardeman.

Mr. Hardeman: Thank you very much, Warden, for your presentation. The number one issue in the whole presentation appears to be that we can make these changes, and a lot of the changes are good for the system, but what we need is funding to go with it. So we’ll leave the funding as the number one priority.

As the second priority in your presentation, what would you say if we could convince the government to make a change, but only one? What would it be in the bill that would make this a better bill as it relates to long-term care and the county’s operation of Woodingford Lodge?

Mr. Holbrough: If I could maybe turn that over to Mr. Orvidas, who, as I mentioned, is the director and has a little more day-to-day interaction with staff, the residents and also family members.

Mr. Orvidas: I think enhanced funding is a critical component. However, I think that’s so closely tied to operational funding that one goes hand in hand with the other.

An area that we have particular concern about, as has been mentioned, is the prescriptive regulations and the need for staff to spend so much more of their time, then, to meet those requirements rather than doing what they do best, which is bedside nursing.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you very much to both of you for your presentation and for the county’s work in long-term care. I want to focus on money as well. I look at what a licensee’s, or, in your case, because you have approved beds, what your responsibilities are with respect to ensuring that the care plan that’s developed is totally complied with: that you are sure to have an organized program of recreational and social activities, an organized program of nutrition care, an organized program of housekeeping, an organized program of volunteers, etc. You’re already putting in \$5 million over and above what the province puts in. If you don’t get some support for the changes here, along with the money that the government promised in additional funding for residents, what are you going to do to make sure you can comply with everything that’s set out here?

Mr. Holbrough: We’ve been fairly proactive in trying to initiate volunteers. We have a very strong volunteer base within all three of the homes. But, as everyone’s aware, volunteers also become tired.

The funding: Actually, the \$5 million is probably a little conservative. We’re probably closer to \$6 million a year, within our budget, which we’re just going through now, and it’s a concern. We did go through an operational review that did create some pain within the organization, mostly staffing cuts; that’s where we’ve basically gone. We’ve cut some staffing levels—that is, decreased their level of care—and created very, very poor morale. We’re trying to work through that with our association, our residents, our family councils and so on and so forth to make it a little more palatable, but it’s still not very appropriate for the residents.

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

1400

Ms. Smith: Thank you for being here. I noted at your three sites that you’re doing very well on compliance, so congratulations on running some great homes.

The list that Ms. Martel just went through with you of the different programs that are required: I am quite sure that your home is already running all of those programs because they’re already required for the most part, and I would be very surprised if you weren’t already running a fairly healthy volunteer program.

I did want to ask you about the minimum standard, which is getting lots of attention, lots of discussion. You said that—well, I won’t get into the whole debate about who is doing what across the country. Needless to say, I contend that there is no jurisdiction that has a minimum standard of 3.5. Very few have minimum standards at all. You state that your calculations show 2.8 of personal and nursing support. I just wondered what you would include in that when you do that calculation.

Then, because he’s going to cut me off, I’m going to put my other question really quickly. You talked about your resident home areas or your secure units. We had another presenter this morning who talked about the lack of need for consent to move someone into that. I just

wanted to know your opinion on that, whether or not you feel there should be rights advice in that consent provision before someone is transferred into secure.

So, minimum standards and secure units.

Mr. Holbrough: On the minimum standards, as I say, we're at 2.8 hours per resident. I know that's been debated publicly within our local municipalities. The CAW says we include administrators and not hourly staff but administrative staff within the organization, within those 2.8. We're of the nature that we believe they aren't. That's up for public debate and you could probably play with numbers all day if you wanted to.

The Chair: We're short on time.

Mr. Holbrough: Fine. We're maintaining it at 2.8. We'd like to see it increased, but how we do that is probably not without funding. I'd ask Tony to answer the last question, if possible.

Mr. Orvidas: Regarding that component, personally, I hesitate to make any definitive comment on that.

The Chair: Thank you.

COUNTY OF ELGIN

The Chair: The next presentation is the county of Elgin.

Welcome. If you would state your name for Hansard.

Ms. Lynn Acre: My name is Lynn Acre. I am the warden of Elgin county. With me today are members of staff, including my CAO and the three directors of our long-term-care facilities.

First of all, we want to thank you for adjusting your timetable and holding these public consultations. Important and timely legislation such as this deserves our full attention. While we salute the desire to improve, we lament many aspects of your approach.

By way of background, Elgin county owns and operates three long-term-care facilities for a total of 247 residents. We have an annual operating budget in excess of \$15 million and we top up the ministry's contribution by more than \$3.5 million every year. For the record, we want you to know that we do support the submissions of AMO and OANHSS. The fear of administrative overburden is real; the apparent lack of specific support for the not-for-profit sector is of concern; the potential for micromanagement and somewhat punitive regulations is worrisome; the imbalance of individual rights at the expense of the collective is troubling; the problems of fixed-term licences and mandatory capital improvements are disconcerting; and the liability of directors is extremely problematic. We note that detailed explanations of these concerns are well documented in the submissions from our colleagues. We're certain that you will hear more about those concerns from others today, and we encourage you to consider and address those issues.

Our focus today is on but one of the many important and troubling aspects of the proposed legislation, that being the new training requirements envisioned in section 74. In short, all volunteers, as well as staff and anyone who provides direct services to residents, are mandated to

have received training before commencing services on a variety of comprehensive subjects such as fire prevention, resident abuse, restraints, infection control and residents' bill of rights, to name a few.

In an ideal world, with adequate funding, the goals of the act would be laudable. However, in the real world, with inadequate provincial funding—and please keep in mind that Elgin's municipal subsidy does exceed \$3 million annually—they are not realistic. Besides, we currently provide an extensive and value-added orientation program to our staff, a program that will have to be curtailed in order to meet these new requirements. Moreover, including volunteers in many of the training requirements, such as restraint policies, adds another burden, more cost and unnecessary strain on resources. No volunteer is expected to apply such policies as it is a matter for the home and its paid personnel. Indeed, the opposite will be achieved, as limited resources get moved around in an attempt to comply with the legislation. Volunteers may even decline to offer their time due to stringent training requirements, and certainly our administrators, with already limited training budgets, will make sacrifices in the established training modules, which we submit are already refined.

Prescribing a strict orientation outline and time frame will be a prescription for failure for many homes and actually work against the intent of the legislation. In addition, writing such prescriptive legislation limits flexibility and innovation, and even more concerning, it limits our future ability to adapt and anticipate changing needs, because our resources will be tapped as we attempt to finance the unnecessary regulations involved in the training section of the act.

Before I conclude, I feel compelled to comment on how contradictory this legislation really is when compared with the McGuinty government's professed desire to treat municipalities as an order of government. The much-touted memorandum of understanding between Ontario and its municipalities seems light-years away from the intent of this proposed legislation. The Minister of Municipal Affairs has stated repeatedly that municipalities should be treated with respect. This proposed legislation flies in the face of the minister's mantra.

As AMO states in its brief, we are the most accountable form of government and we heavily subsidize the provision of long-term care in this province. Our record demonstrates our commitment and maturity. Please don't undermine that record with heavy-handed legislation.

I will close by urging you to consider our comments and those of our partners. Don't try to fix something that's not broken. And, if you see needed improvements, then help to fund them in a predictable manner, at an adequate level and in the true spirit of partnership.

Thank you for this opportunity to address you today, and good luck with your deliberations.

The Chair: Thank you. We appreciate that. I will also add, on a personal note, being the age I am, that I appreciate the size of font that you chose for this. I can actually read it.

We have close to about two minutes and 20 seconds per caucus, and we will start with the NDP.

Ms. Martel: Thank you for your presentation, your participation and your contribution to long-term care.

I'm glad you focused in on this section, because there's more than one problem. First of all, "volunteers" isn't defined in the legislation, so we're not sure who they are. "All persons who provide direct services to residents": "Direct services" is not defined either. So you could say to yourself, "Does that mean clergy, does that mean dentists, dental hygienists, pharmacists, doctors on a periodic basis, once a week, twice a week, who knows?" Then there's the long list of training which all of those people, and we really don't know who they are, are supposed to have before they start. I think the killer in this one is under paragraphs 9 and 10, and 10 in particular: "Any other areas provided for in the regulations." So after the long list from 1 to 9, then you have the catch-all phrase at the end. This is excessive, and I think you've made that point as well. So this whole section either needs to be thrown out or really significantly improved to make it clear whom we're really talking about and what we need them to do.

Do you have any sense, in looking at this, of how much more of a requirement in staff time this might be for anybody trying to figure out whom you have to train under this section?

1410

Ms. Acre: We actually anticipated that question, so I'm going to pass it over to Melissa Lewis.

The Chair: If you could state your name first.

Ms. Melissa Lewis: My name is Melissa Lewis. I'm the director of seniors' services for Elgin Manor with the county of Elgin. At the present time, our homes actually provide a multi-home, multidisciplinary orientation day in addition to the shift-by-shift training and orientation we do with staff. That day will no longer be possible because the concept really is that every month or bi-monthly we gather new staff from all of our homes and provide them with orientation centred around health and safety; infection control, which is actually presented by public health; dealing with difficult behaviours; Ministry of Health standards and policies; resident abuse and residents' rights. That day affords us the opportunity to bring new staff together to really convey to them the culture of our organization, to tell them what it is we do and how they contribute to the greater good and what their role is in long-term care. We will no longer be able to do that orientation day, and when we look at redistributing that time of training, we actually have some numbers that show it's about \$185 per participant to do that orientation day as a group. It is twice that amount, \$370, to do that same concept but as on-the-job training, because it does require more of a one-to-one model.

Our idea here really was to look at something which on the surface appears to be a good idea. It's a good idea that our staff are adequately oriented, and it's a good idea that some things happen very quickly when they start work, and there is definitely information they need to

know right away. But our concept here today was to give you in essence what happens when something that on the surface seems like a good idea becomes applied very strictly in our environment, how limiting that is. We're concerned that it's in the legislation directly, not in regulations that would provide future flexibility so that concepts and innovations such as those we have undertaken in the county of Elgin could be accommodated in long-term care.

The Chair: Thank you. Parliamentary assistant?

Ms. Smith: Thank you for being here today. I don't necessarily agree that your innovation and training cannot coincide with this piece of legislation. I think there may be some timing issues around when people come in for their training, but you're probably covering off most of what's in this list in your training already.

I did want to address just one concern I had, and the fact that you have training modules and a plan of training is great; certainly not all homes do, and that's why we have to include such things in our legislation. You talk about a requirement that all volunteers be trained in restraints policies. In fact, just to clarify, they have to be familiar with or be trained on the policy of least restraints. You're not required to teach all your volunteers about all the requirements in the act about restraints, only that your home has a least-restraints policy and what that policy is, which is the requirement in the act that you develop that policy. I just wanted to clarify that for you.

I also note that at Bobier Villa you have a kind of unique campus or setting with not-for-profit housing as well as child care. I just wondered if you could speak to the benefit to the community of that home, because it is such a unique structure and we haven't heard from anyone who has a similar model. If you could just speak to that, it would be great.

Ms. Acre: I'll let our director for Bobier Villa speak.

Ms. Pat Vandevonne: My name is Pat Vandevonne. I'm the director at Bobier Villa in Dutton. Monique, I'm very happy that you asked me that question. Bobier Villa is a very unique home. We have 57 beds and we actually have a triangle, per se, of the supportive housing next door to us, Caledonia Gardens, plus our long-term-care facility of 57. Then we have a day centre across from us. So we really have a lot of intergenerational activities going on. We have a lot of families that perhaps live in the apartments next to us and actually do not have to go outside; they can come through the enclosed walkway into Bobier Villa to visit family members. So there are wonderful linkages between those three.

Ms. Smith: That's so important. Thank you so much.

The Chair: Mr. Hardeman?

Mr. Hardeman: Thank you very much, Madam Warden, for the presentation. I gather, I guess from page 2, shall we say that all is not well in the relationship between the municipalities and this piece of legislation as it relates to the municipality of Elgin county. I read on the page describing the legislation the words "fear," "concern," "worrisome," "troubling," "disconcerting" and "problematic," and they would kind of say that

maybe you would like it changed somewhat before the government passes it.

We've had, I think, three presentations this afternoon from municipal homes for the aged, which of course would be yours as well. It used to be separate legislation, apart from the long-term care. The fact that the municipal homes for the aged are presently spending a great number of tax dollars to make up the difference between the cost of operation and the amount that the province provides—and then as we go to page 6, you talk about the council being unconcerned about the fact that they don't seem to be getting any recognition or respect for their input into the system, recognizing that the county of Elgin's taxpayers are putting in \$3.5 million at the present time to give care beyond the level of care that is mandated by the province. And yet here we have, in other areas, with no consultation directly to municipalities about how it should it be done, the province telling them how they have to do it. I wonder if you could explain to me very quickly council's position on that: their not talking to them on the memorandum of understanding with municipalities as they were supposed to do.

Ms. Acre: Yes. As the county of Elgin, with the municipalities, we are the most accountable form of government. As the memorandum of understanding said, we should be afforded some respect and we should be allowed to be innovative and look for ways to change and meet the needs of our residents. When you have seemingly heavy-handed legislation like this, instead of enhancing the care of our residents, which is our main concern, it seems to be tying our hands and tying up our resources and not allowing us to do the good job that we've been doing in the past.

The Chair: Thank you. We're out of time.

LONDON HEALTH COALITION

The Chair: The next presentation is the London Health Coalition.

Welcome.

Mr. Jim Kennedy: Thank you. Good afternoon. My name is Jim Kennedy. I am the co-chair of the London Health Coalition. I'd just like to thank the Chair for the opportunity to speak today to the standing committee.

As everybody is aware, the London Health Coalition is under the umbrella of the Ontario Health Coalition. We are a network of over 400 grassroots community organizations representing virtually all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively involved and engaged in the making of public policy on matters related to health care and healthy communities. We are an extremely collaborative organization working with many different organizations. We share resources and information. We are committed to maintaining and enhancing our publicly funded and publicly administered health care system. We work to honour the principles of the Canada Health Act. We work in partnership with the Canadian Health Coalition and we obviously do coordination of community-based health coalitions.

Some of the impacts of the new act are as follows. There are approximately 75,282 long-term-care beds in Ontario. In these homes live thousands of vulnerable and dependent adults. Thousands of volunteers help out, and additional thousands of Ontarians work in assisting with daily life for the people who have been our mothers, fathers, aunts, uncles, brothers and sisters. We need to start putting our energy back into some family commitments that most of us made when we were born.

The new act respecting conditions and standards for these homes will impact millions of Ontarians in intimate and life-altering ways: the amount a time a staff person has to bathe a resident and feed residents; the quality of food that they receive; whether a resident has activities, stimulation and supportive surroundings; safety from violence for all involved in the home; illness and injury; the ability to access timely medical help; the gentleness of care that they receive; and whether the residents thrive or deteriorate. It's all going to be impacted by this bill. These issues are of critical importance to all residents, their families and their caregivers, paid and unpaid. I do feel and believe strongly that these issues are of critical importance to Ontario's policy-makers.

The key issues that we have are as follows. Through our extensive consultation with member groups, residents, family members, volunteers, care workers and facility operators, one common theme has emerged: The care levels in the facilities are inadequate to protect from harm and to ensure the provisions of a decent and dignified quality of life. Everywhere in Ontario we have heard from frustrated caregivers, residents and family members who cannot give the care they want to give or access the care they need. Families are forced to hire in extra help if they can afford it. If they can't, residents go without. Everywhere people are identifying that heavier-care residents now live in these homes. Staff feel unequipped to appropriately care for the residents with cognitive difficulties and behavioural problems. Yet, the downloading of heavier-care patients from mental health facilities and acute care hospitals continues.

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These findings aren't localized. While good facility management and lots of volunteers can help us compensate to some extent for the inadequacies, they can't provide the levels of care across the province that are a minimum requirement to protect from harm. The evidence is that the lack of care is so widespread as to be a systemic problem that requires a change in public policy to be adequately addressed.

The evidence is that the heavier-care needs will continue, and it's going to deepen in coming years. It is now generally accepted that 60% to 80% of all facility residents have some form of cognitive impairment. In 2005, some 140,000 Ontarians had Alzheimer's disease or related dementia. This number is expected to double to 307,000 in the next 25 years. That is coming from the Alzheimer Society of Ontario's position paper on the Casa Verde recommendations of 2005.

This new legislation must ensure that the care needs of our residents are soundly measured and reported, that a

minimum care standard weighted to these assessed needs be established, that the government must fund to a level that is adequate to provide care to the assessed levels and standards, and that the facilities be held to account for providing the care for which they are funded. In its current form, the proposed legislation does not accomplish these things. We've made some recommendations to ensure that these minimal requirements be met.

We suggest some improvements in the proposed legislation as it stands. Many of the provisions of the proposed legislation reflect existing provisions and regulations under the former acts, relying heavily on the Nursing Homes Act. We support several of the new initiatives, including:

- the increased ability of residents to promote their rights contained in the bill of rights;

- written sign-off of facility operators to confirm their review of admission documents;

- the proposed intent to limit casual and agency staff to be included in the regulations is a good first step, but the limitations must be strengthened;

- the inclusion of an RN on-site 24 hours a day, seven days a week—absolutely wonderful;

- increased powers of inspectors and continuation of regular unannounced inspections. Great. It would be nice, though, to see some sort of language in that bill to have inspectors talk to family councils and patients. Far too often, those inspectors are coming into long-term-care facilities, and the only person who gets their ear is the administration. Unfortunately, time and time again there's a different story coming from the front-line health care worker that comes from the administration.

There's some prevention of harm that we have to look out for. The Minister of Health has promised a revolution to ensure that we will never allow the repeat of such preventable tragedies as the sad and painful death of Natalie Babineau from a bed sore, the deaths of Ezzeldin Elroubi and Pedro Lopez, who were beaten by a cognitively impaired resident at Casa Verde, and the many other attacks and inadequate care that have irreversibly damaged peoples' lives. But if the new act is to succeed in this, it must provide the legislation and regulatory standards that will protect residents, staff, families and visitors from harm. The coroner's jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.

These aren't localized issues. I can see today that we have some family members here in this city, such as an 84-year-old woman who went into a long-term home. She had raised her family at home, had a wonderful life, never once having to worry about harm. She was attacked by a cognitively impaired patient, the reason being that there weren't enough staff to stop that. That's appalling. At 84 years old, this woman never once has had to worry about abuse in her home and now, today, she does. We've got to stop that.

The bill must be amended so that the zero-tolerance and reporting policies conform to a minimum standard

across the province, with allowance for additions to fit the context of the particular home.

Neglect should be defined so that facility operators and the government, who bear the majority of the responsibility for funding and assessment and for spending decisions which are critical to preventing neglect, are held accountable for these decisions.

Staff who whistle-blow can still lose their jobs and will have to grieve or go to the labour board to get them back. There are cases in Ontario of firings due to whistle-blowing. This is a significant financial barrier to whistle-blowing. At a minimum, this section should be amended to ensure that financial barriers to whistle-blowing are removed. We have to make it easy for staff to come forward and report neglect. We have to make it easy for them to be able to do the right thing. People don't come forward because it's going to cost them their job. People don't come forward because it's going to cost them out-of-pocket money to try to win that job back. That's a disgrace.

There should be a proactive duty of operators to provide a living and working environment that's respectful and free of fear. The bill should be amended so that gag orders and other such clauses in employment contracts would be unlawful, and this has got to be enforceable.

Proactive public and mandatory staff education similar to the models used to prevent workplace harassment, discrimination and family abuse should be instituted. Time and time again we're having off-loading of mental patients into our long-term-care facilities. Unfortunately, our staff are not being trained properly to take care of them. We need to have some language in the legislation that affords for training.

In addition to protections for the residents, the act must also ensure that facilities are safe for staff, who have alarmingly high rates of illness, accident and injury.

The act needs to include clear assurances of staff coverage for care during absences for training. All too often, when we do get some training dollars put toward the staff, what happens is they take the staff who are on duty that day to do the training; the residents go without.

We have received many complaints about inadequate training for staff working with people moved from mental health facilities into long-term-care homes. Special training to address the care needs and safety concerns regarding residents with psycho-geriatric issues must be included in the act.

We're asking for a minimum care standard. We're insisting that the key component is the reinstatement of a minimum care standard. We recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per resident. This is to reach the goal of prevention of risk; it's not an optimum. Increases in staffing should be shared proportionately among all members of the health care team. 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.

The bill should be amended to require cabinet to set a minimum staffing standard in the regulations. The regulations should require the 3.5-hour minimum care standard described above. The staffing standard should be required to meet the assessed needs of the residents. Government must provide funds in the nursing and personal care envelopes to meet the required staffing standard.

What is a minimum care standard? This is a defined number of hours of care that is attached to a particular level of assessed need. We are proposing that Ontario adopt a 3.5 minimum care standard for hands-on care. This means that a facility with an average case mix, or an average level of need, would receive resources for nursing and personal care specifically to provide 3.5 hours. Those facilities with lower acuity levels would receive less; those with higher acuity levels would receive more. We need some sort of standardized tool to determine the acuity levels across the province so that we can keep that minimum staffing level the same from home to home to home.

In 1996, as you all know, the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. We're insisting that the government reinstate a care standard to improve the quality of life in long-term-care homes. Since the level of acuity has increased with the downloading of heavier-care patients from hospitals and mental health facilities, and with the aging of residents, the standard must be modernized to meet today's care needs. Based on our research of standards in other jurisdictions across Canada and the US, we believe that 3.5 hours of care—

The Chair: One minute left.

Mr. Kennedy: —would be the minimum. This should be adopted as an interim measure while the government undertakes the research necessary to define the care levels associated with the assessed needs.

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How do we propose that this standard work? The government uses an assessment tool now to figure out how much care residents need. The current tool is recognized as flawed. The government is piloting a new assessment tool in 70 long-term-care homes. The tool allows facilities and the government to determine the case mix. The average case mix across the province is then calculated. Those with lighter needs than the average are deemed to have lower acuity; those with heavier needs, higher acuity. The funding that the homes receive for personal support care, feeding and bathing—and most people think that twice a week is not enough—and activities of daily life is based on the level of acuity in the home.

However, there is no expected amount of care that is attached to the average level of acuity. Many reports and exposés, and testimony from families and staff—

The Chair: I'm sorry.

Mr. Kennedy: Thank you, Chair.

Mr. Khalil Ramal (London–Fanshawe): We have it.

Mr. Kennedy: You have it, and I hope you do take the time to read it.

The Chair: We certainly will. Thank you.

CAROLYN BEST

The Chair: The next presenter is Carolyn Best.

Welcome. If you would state your name for Hansard, and you have 15 minutes.

Ms. Carolyn Best: My name is Carolyn Best. I really want to thank you for listening to my concerns today. Forgive me; I'm a bit nervous.

Background: My grandmother lived in long-term care for 13 years. Presently, my mother is in the same facility, and she has been in that facility for the last six and a half years. On average, I visit that home three times a week, three and a half to four hours at a time. The last two years, my mother has had four injuries. I now spend, on average, four times a week at the nursing home. My concerns really are on a personal level, but they affect a lot of people. My mother, because of this injury now, cannot walk on her own. There is not enough staff on the floor for the patients who have dementia or Alzheimer's. They require extra care. When I did find her injury, as I did the previous injuries, I found them myself. The staff did not call me about the injuries. I found the injuries. When I asked to take her to hospital and asked for a requisition for an X-ray, I had to beg for a requisition. I was then told to either transport her myself or pay for an ambulance. I did transport her myself and one injury required four visits. It also required a follow-up CT scan, as it was a major injury.

My next point is, I find there are too many double shifts on the floor. The staff are working double shifts because there is not enough staff if someone is sick, if someone has called in. When they work that double shift, I feel they're too tired. Maybe there could be a pool of people available near retirement or something who could be called in for a short shift or to fill in instead of using that person for a double shift. They are too tired, and they are not attentive when they're tired.

If a resident is in a home and has had an injury, as my mother did—she walked up to four or five hours a day before the injury. After the injury, she cannot walk on her own; she has to have help. Now the staff say, "We're too short. We can't walk your mother." So she sits in a chair all day. She's withering away; she's 84 years old. She was very active up to that point of injury. Even if they'd just walk her 15 minutes a day I'd be happy, but a resident should be entitled to a walk somehow. The staff said there is not enough staff to do it.

Family, I feel, should be allowed to feed their loved one in the regular dining room, whereas at the home we have to take her to a separate room and feed her by herself if we want to feed her. They say it's too disruptive, but it's also disruptive to put her in a small room and feed her by herself, because she knows that's

not her daily eating habits. So I don't agree with that. A person should be in their regular environment, because with dementia it really throws you off.

They did hire a recreation person on that floor for safety reasons when I requested it. That person was hired for four hours, supposedly from five till nine. Now that person is down to one hour a day. She goes to one floor for one hour and then she leaves that floor and goes to another floor for one hour. Most times she's doing work that the staff should be doing, not recreation with the patients. She's taking the patients into meals, which is not what she was there for. She was there for some sort of recreation.

My last point is that staff shouldn't be allowed, when there is an outbreak on the floor, to go and work on another floor and then come back to the floor they were working on. We just had Norwalk, or a similar outbreak. Staff would be working, another floor would be short, they'd be sent to that floor, and then they'd turn around and come back to the floor that didn't have an outbreak. And they wonder why the outbreak has spread in the unit. It's just not common sense. If they would use a pool and call somebody in who didn't work that day, there wouldn't be this transmission among floors. They say that the rule is they don't do it, but I'm there four days a week, and they do do it. I've seen it. When I go looking for a nurse, it takes me 10 minutes to find one, maybe 15, and then I'm told they're on another floor.

Those are my points. Thank you very much.

The Chair: Thank you. There is a little over two and a half minutes for each caucus, and we will start with the parliamentary assistant.

Ms. Smith: Thank you so much for coming and sharing your story with us today and giving us your perspective. Do you have a family council at your home?

Ms. Best: Yes. I have been to the family council. I've brought up my concerns at family council, and I noticed when the minutes came out at the meeting that there wasn't one item that I brought up in the recommendation, in the letter that came out. They told me that I speak too much on a personal level.

Ms. Smith: The council told you that?

Ms. Best: Yes.

Ms. Smith: I appreciated your comments about wanting an activity person on the floor. I would just note that in our legislation we're requiring not only that they have recreational and social activities for the residents, but, without restricting that general provision, we've also required that they include services for residents with cognitive impairment and residents who are unable to leave their room, because we know that it's very important for everyone to have some kind of stimulation and activity in their day.

Ms. Best: That person was hired, and when I told them about safety—there is a pod where the residents are; there is a pod this way and a pod that way and a floor in between. If there are two workers on that pod bathing a patient and there are two down there and the RN is on the telephone, you have 36 to 38 patients wandering

around hurting each other. One grabs your hand and yanks your fingers out of socket; the other one's kicking you under the knee, which happened to my mother. She had two fractures from someone just sitting and kicking. No one can see anything, because they're busy. There is nobody on the floor. They took my recommendation and they used it as a rec person, but like I said, now they've taken it away. They've got one person where they had two. The one person is one hour and one hour where they were four and four, and now they're taking people in to meals. They're not a rec person; now they're working. They're not getting paid or anything, and the rec part is gone.

We do have quite a bit of recreation in the facility. I'm not complaining about that. If we can take my mom to recreation, I take her. But with the injuries, she seems to be spending all her time in her room anymore. She can't get walked because there is not enough staff, so I go. When I ask to feed her in the dining room, they say, "No, that creates too many people in the dining room. Go to her room and feed her." When I take her to the room, she falls asleep. It's her sleeping area. It's disruptive to do that. She's used to eating with the people at her table.

So it doesn't matter what I try. I keep trying things, and I keep trying to keep out of the way. I know I'm in the way, but you know what? If you're not in the way, you don't get heard.

Ms. Smith: I appreciate that. I really appreciate you coming today to share with us. Thank you.

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The Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for sharing your mother's situation with us. As I've listened to the presentations, it sometimes makes you fearful of getting older. We've heard from—

Ms. Best: Actually, that's why I came, because I'm probably next, right?

Mrs. Witmer: That's right. We've heard from concerned children, and we've certainly heard from staff who feel terribly overworked and very stressed in the environment, who have told us they don't feel they can provide the level of personal care that residents such as your mother deserve.

Were you aware of the fact that the government, when they were elected, did promise \$6,000 of additional care for residents such as your mother, but up until now they've only provided \$2,000? So if that additional \$4,000 were going to flow, people like your mother would at least have that opportunity, but so far that promise has not been delivered on. I didn't know if you were aware of that or not.

Ms. Best: No. You know, we just need a bit more staff on the floors that need it. There are floors that don't need it, and I understand, but they need looking after properly too. But there are floors, like a dementia and Alzheimer's floor, where if you spend time on that floor and you see what happens, it's a nightmare. And it's really hard, unless you're in the environment—people who do the funding need to spend a day or two days, a week, un-

announced; just go and be in the environment. I feel sorry for the people. They've lived a good, honest life, and they need proper care. I'm not saying the staff is not competent and they're not doing their best.

Mrs. Witmer: There's just not enough of them.

Ms. Best: There's not enough.

Mrs. Witmer: And that \$4,000 extra for your mother and others would allow for more staff and it would allow for them to get a greater amount of personal, hands-on care. Maybe then your mother could be walked and there would be recreational and social activities.

Ms. Best: When I go on that floor, I try to help other patients if I see a problem too. But then you're kind of told, "Mind your own thing," and I try to do that too. But you'd like to help everybody.

Mrs. Witmer: Well, it's a good thing that you're there. So many people don't have a daughter or a son or somebody there to help them, simply because they move—

Ms. Best: Hardly anybody goes on the floor.

Mrs. Witmer: That's right.

The Chair: Thank you. Ms. Martel?

Ms. Martel: Thank you for making the presentation that you did today, which comes right from the heart.

Ms. Best: I'm upset about the situation.

Ms. Martel: It was important for us to hear. My grandmother spent the last five years of her life in a home for the aged. She had dementia. She had also had a stroke, so she was in a wheelchair. She was lucky, if I can use that term, that she was in a home for the aged, because of course the municipality was topping up, so there was actually more staff than there might have been otherwise. Still, there wasn't enough.

I think that what you've displayed for us today is very clearly the need for more staff. I'm distressed to hear of staff moving from one floor to the other. I would have thought that after the SARS crisis, if we learned anything, we would have learned not to have that happen. So it really is incumbent, as the government puts through this legislation, that the government also keep the promises that it made, both with respect to the funding that Mrs. Witmer talked about and also with respect to having a minimum staffing standard. Those two things have to come, and they have to come soon.

Thank you very much for your presentation today.

Ms. Best: Thank you for listening.

The Chair: Thank you very much.

COUNTY OF MIDDLESEX

The Chair: The next presentation is the corporation of the county of Middlesex. For those who have just joined us, there are refreshments available at the front.

Would you please state your name for Hansard?

Mr. Bill Rayburn: Bill Rayburn, chief administrative officer, county of Middlesex.

Thank you, Chair, and members of the standing committee on social policy. We represent the corporation of the county of Middlesex, which owns and operates

Strathmere Lodge in the municipality of Strathroy-Caradoc. My name is Bill Rayburn. I am the chief administrative officer for the county of Middlesex. With me today, on my left, is Larry Hills, the administrator of Strathmere Lodge, and on my right is Warden Wes Hodgson. We appreciate the opportunity to be here this afternoon and offer our comments on this important legislation.

For over 100 years, Strathmere Lodge has proudly offered its services to the residents of Middlesex county and area. Strathmere Lodge is a not-for-profit long-term-care home, municipally owned and subsidized by the county of Middlesex. County ratepayers currently contribute close to \$1 million towards the operation of our 160-bed facility, which, as my warden reminded me today, is only the operating side. We also have a capital side to the bill as well.

I want to start my presentation today by talking about this contribution; specifically, the contribution that all municipalities in Ontario make to the provision of long-term-care services.

As you may know, approximately 30% of municipal budgets go towards supporting provincial health and social service programs. This equates to a contribution of approximately \$315 per capita that municipalities in Ontario contribute to health and social services. For comparison, in 2004, the municipalities in the rest of Canada spent \$33 per capita on health and social service programs. I don't need to tell you what a difference this means to the municipal tax rate when compared to other non-Ontario municipalities, as Ontario has the highest property taxes in Canada, and much higher than in the USA.

I tell you these facts to clearly point out that the province of Ontario is not keeping pace with their financial support of long-term care, and municipalities are carrying that expensive burden. The end result is a lack of competitiveness for Ontario's municipalities both nationally and globally. I also point out these facts in regard to Ontario's contribution to social spending to suggest to you that it is time to fulfill the government of Ontario's campaign promise to provide additional funding for long-term care in Ontario. This funding is long overdue.

Ontario's municipal governments go far beyond what they are required to do in law by investing a net \$270 million a year of municipal resources in the provincial long-term-care system through the funding and operation of homes for the aged. Why do municipalities contribute so much to long-term care? Because they recognize the need for services in their communities and because provincial funding for the provincial long-term-care system is woefully inadequate.

The other reason that municipalities fund long-term care is that we do not have a choice. Provincial legislation requires counties in Ontario to own and operate a long-term-care facility. Recently, the county of Middlesex reviewed its subsidy to the provision of long-term care and the requirement to be in the long-term-care business, and we drew some interesting conclusions.

Throughout the long-term-care bed allocation process, we heard from several private sector providers in our community. They stated that they were more than willing to build additional private facilities if additional provincially allocated beds were made available. Unfortunately, as a result of the provincial requirement for counties to be in the long-term-care business, we were left with no choice but to spend public sector dollars to compete with proposed private facilities. Considering the demand for scarce municipal tax dollars, it certainly does not make any sense to my council to utilize our tax dollars for the provision of a service that the private sector is more than willing to provide in our community.

As a result, my council is on record on several occasions for their request to provide counties in Ontario with the option of not providing a long-term-care facility if the provincial allocation of long-term-care beds can be provided by the private sector. While we recognize that this option will not be utilized throughout Ontario, there are municipalities in Ontario that would utilize this option to permit private sector opportunity and to reduce the municipal contribution to long-term care. We respectfully request that you give strong consideration to the provision of this qualified option to municipalities.

In addition to our concerns with funding for long-term care, we want to draw your attention to a specific concern with the administrative sections of Bill 140. The administrator for Strathmere Lodge, Mr. Larry Hills, will present this section of our presentation.

Mr. Larry Hills: Thank you. I want to address the issue surrounding secure units.

Not every long-term-care home is able to provide a secure area for those residents with dementia who need added safety and security. Since 1962, Strathmere has maintained a secure unit for the care of residents with Alzheimer disease and other dementias. Based on this experience, we are concerned that measures in this bill do not appropriately address the unique nature of secure units in homes or serve the best interests of the residents who benefit from them.

Section 28 of the bill considers residents in a secure unit as being subject to restraint. This fails to recognize the role of secure units as one of providing safety rather than imposing restraint. An environment that fosters residents' safety by reducing risk of harm to themselves and others while providing programs suited to their unique needs is not one that meets the definition of a restraint.

Furthermore, adhering to the extensive monitoring and reporting requirements that apply to restraining measures will impose a significant workload which present staffing resources do not allow. We estimate that for the 32 residents now cared for in our secure home area at Strathmere Lodge, this will require an additional two hours of nursing staff time daily, without adding to resident care or their quality of life.

The bill also places constraints on the admission process and internal transfer of residents to a secure unit. These have the potential to deny an applicant or an

existing resident appropriate care and programs. The bill proposes that a substitute decision-maker be required to give consent to placement in a secure setting. If such consent were to be denied, residents with aggressive behaviours or at risk of wandering could well be admitted into the general population of homes, where they would present a significant risk to themselves and others. For those residents already in the home and who now present a risk, the need to act is often immediate. Staffing limitations and the lack of support from outside agencies only add to the urgency often faced by homes. Confronted with urgent situations and without any means of discharge at its disposal, the home could face increased liability exposure from an inappropriate placement while lacking the ability to act responsibly to safeguard all its residents.

1450

The plan of care which is prepared for each resident is based on assessed needs and includes input from family. The admission and transfer of an applicant or resident into a secure unit should respect this process. Therefore, we believe that a physician's order, made in collaboration with the care team, should be sufficient to allow admission or transfer to a secure unit. The overly prescriptive measures now contained in the bill will serve to hinder access to care for those with dementia, as well as place an unnecessary administrative burden on the very staff who are charged with providing hands-on care. Our recommendation is that the definition of a secured unit be amended so as to remove it from the restraint provisions.

A word now on the liability provisions: Bill 140 creates unprecedented liability for municipal councillors, municipal governments and property taxpayers through its heavy-handed approach to the issue of duty of care. Section 67 sets out a requirement that a committee of management for a municipal home will "take all reasonable care to ensure" that the operation of the home complies with "all requirements under this act." Every person who fails to do so would be "guilty of an offence." This means, without any exaggeration, that a municipal councillor is guilty of an offence if they cannot demonstrate "reasonable care" to ensure that the administration of the home meets even the most minuscule administrative requirement.

This section is not about safeguarding the rights or interests of residents in the home, but sets out to establish liability for municipal councillors with a penalty of fines up to \$25,000 or imprisonment of up to 12 months for a first offence. Furthermore, this section would make anyone think twice about operating a home or running for a seat on council.

Interestingly, the penalties far exceed the offence provisions for members of hospital boards under the Public Hospitals Act. We urge the province to take a more reasonable approach and align the offence provision under Bill 140 with the Public Hospitals Act.

In conclusion, on behalf of the county of Middlesex, I thank you for the opportunity to present these concerns to committee. We look forward to seeing our concerns

addressed in further iterations of Bill 140. In particular, we ask that you pay close attention to the detailed recommendations being provided to the committee by OANHSS and AMO during this consultation process. Thank you.

The Chair: Thank you. We have just over one minute per caucus for questions. I will start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. We've heard from a lot of the municipal homes, and we appreciate the taxpayer funding that goes to support them.

You had an extensive presentation on secure units. I think you indicated here that in order to abide by the new monitoring and reporting requirements, for 32 residents it will require two additional hours of nursing staff daily. Is that right?

Mr. Hills: That is correct.

Mrs. Witmer: And that's for all 32?

Mr. Hills: Yes, 32.

Mrs. Witmer: Also, you had real concerns about the admission process and transfer based on the fact that sometimes, in order to protect the individual or those around them, there is a need for immediate action. What change would you propose the government make to allow for that type of transfer, where you wouldn't be in a position where you could face some increased liability? What should happen there?

Mr. Hills: In terms of admission to the home, the substitute decision-maker is proposed to be part of the process. If that is taken care of before the paperwork and the resident are at the door of our home, that's fine. But my concern is that during the admission process, if the substitute decision-maker chooses not to, and in some fashion or other the resident or the applicant finds their way through the system, we could find ourselves with a resident who requires certain care, such as a secure unit, because of the lack of the approval from the substitute decision-maker, in our general population.

So how do you fix that? I'm not saying that we want to remove the substitute decision-maker totally from the process, but I think measures need to be enshrined in the bill to delineate certain types of applications, so at the earliest stage, through the CCACs, it is identified that this person does require the benefit of a secure unit, so that in no way will they find their way into the general population.

Ms. Martel: Thank you for your presentation here today and for the contribution that you're making financially and in other ways to long-term care.

I want to focus on the secure units as well. When you say you've done the addition and it will require an additional two hours of nursing staff time daily to meet the requirements, can I ask how many staff you have working in that unit right now on one shift?

Mr. Hills: On our day shift, we would probably have five.

Ms. Martel: And at night?

Mr. Hills: We would have two.

Ms. Martel: So to comply both during the day and, more specifically, at night—because behaviours would be quite different—this means a significant shift away from hands-on care to the folks in that unit, doesn't it?

Mr. Hills: Yes.

Ms. Martel: And I suspect you're not in a position to hire more staff in that unit to meet those requirements.

Mr. Hills: Certainly not.

Ms. Martel: So if this section and many others are going to work at all, what is really required is that the government fund the provisions or any of the new requirements that they are making through the bill. Is that correct?

Mr. Hills: I would agree.

Ms. Martel: I think you're right.

Ms. Smith: Just so I'm clear on the secure unit question, can I take it that you don't believe we should require the consent of the resident or his substitute decision-maker for him to be placed in a secure unit?

Mr. Hills: I'm not saying that we shouldn't have the substitute decision-maker. I'm just saying that in terms of admissions, there should be a clear delineation through the admission process whether a resident is to be headed toward a secure unit or not, so there will be a separate channel of processing these applications, so homes will not find themselves with a resident who should have been in a secure unit but, because of the lack of consent provided, is now in the general population.

Ms. Smith: I think if you look at section 41, on the placement and the assessments that are required prior to placement, we are now going to require that the full assessment of the applicant's current behaviour and behaviour during the previous year be reviewed so that we can assure that we are doing a proper placement. As well, we require that assessments be done within three months of admission to a home. I would assume, because it's the case in so many other areas, that you probably do have a waiting list. So you probably have a bit of time, prior to admission, for someone to be assessed and therefore being able to get the proper rights advice prior to being admitted into a secure unit.

Mr. Hills: So long as they're channelled through the normal application process, that might be acceptable. But if there is going to be something that would be akin to a crisis admission, that's when I can see some issues arising.

Ms. Smith: The legislation allows for the application of the Health Care Consent Act, so for a crisis admission, the rights advice could come subsequent to that.

The Chair: We're out of time. Thank you very much.

ST. JOSEPH'S HEALTHCARE SYSTEM

The Chair: The next presentation is by St. Joseph's Healthcare System, Hamilton.

Please state your name for Hansard. Please feel free to start.

Mr. Bob Taylor: Good afternoon. My name is Bob Taylor. I am here on behalf of the St. Joseph's Healthcare

System. I am a member of the community advisory committee of St. Joseph's Brantford. Joining me is Jan Lord, chair of St. Joseph's Guelph, and Marianne Walker, president of our Guelph facility. Jan and I represent many volunteer governors who serve our residents in the tradition of the Sisters of St. Joseph of Hamilton.

Our submission represents the response of our board of directors to the proposed Bill 140. While we support the bill's desired outcomes, which focus on safe, quality and respectful resident care, in its current form it will disenfranchise the contribution of voluntary governance, take away valuable resources from the residents' bed-sides and negatively impact resident and staff safety in the workplace.

St. Joseph's Healthcare System has a long-standing partnership with the Ministry of Health to provide care across a health continuum. We are responsible for the management and governance of three non-profit, long-term-care facilities: St. Joseph's Lifecare Centre, Brantford; St. Joseph's Villa, Dundas; and St. Joseph's Health Centre, Guelph.

I will now ask Jan Lord to highlight our response to the legislation, and we welcome your comments.

1500

Ms. Jan Lord: Good afternoon. My name is Jan Lord. Thank you for this opportunity and allowing us to present today.

The St. Joseph's Healthcare System recognizes that the government, through Bill 140, has attempted to develop legislation that will strengthen accountability and resident-focused care. However, one of our concerns is that the legislation leaves a really negative impression and concern about the care that is provided. Our communities are left with the feeling that the care in long-term-care homes is substandard and that accountability is not important to us. I want to assure you that, in the over 145-year history of providing health care services to seniors, the St. Joseph's Healthcare System has always taken accountability seriously, and the focus on providing quality services has been very important to us. I'm just going to highlight three major themes of concern.

The first theme is, as you've heard previously, the direct impact on resident care. While increased provider accountability is appropriate, the Ministry of Health and Long-Term Care has got to acknowledge that there is a cost attached to this and that the legislation, as written, will take critical resources away from direct resident care. Nurses may be forced to spend their time away from residents, and our sector is already stretched with the challenges of meeting their needs. Certainly, in our Guelph facility, we already supplement our direct care by a large number of dollars in order to provide a high standard of care.

Our recommendation is that the Ministry of Health and Long-Term Care honour its commitment to provide increased long-term-care funding in the amount of \$6,000 per resident per year. The other important thing is that the ministry analyze the cost for implementing the new requirements contained in the bill prior to the

implementation of the non-direct care activities, as required.

Again, as you've heard before: the concern of disenfranchising volunteer community leaders. Although liability insurance can provide some protection to volunteers, it's the content and tone of the legislation that has a potential to threaten some of the viability of volunteer community leaders, who give their time, energy and expertise in order to improve the quality of life for seniors. Best-practice governance models stress the importance of boards governing and not managing. This legislation forces boards to be involved in the detailed operations that are the responsibility of management. This, coupled with the significant personal liability of \$25,000 and/or imprisonment for not more than 12 months, will create barriers for the recruitment and retention of high-quality volunteer board members. For example, if a person would like to volunteer to sit on a board, they may be more inclined to sit on the board of a hospital, where there is less personal liability.

Therefore, our recommendation is that the volunteer community board members in the non-profit long-term-care sector be afforded the same respect and protection as hospital counterparts under the Public Hospitals Act.

Again, as you've heard in several submissions today: the concerns for resident and staff safety. We certainly concur with the Ministry of Health and Long-Term Care that residents' rights are paramount. However, there has to be also consideration for the collective rights of all residents and staff to live and work in a safe and secure environment. For example, a resident may have refused to allow staff to use a mechanical aid in lifting as it infringes on their rights. However, that puts the staff person at risk for injury.

Again, the safety concern related to the approval process for the use of the secured unit: Homes are faced with an increase in residents with disruptive, high-risk behaviours. We agree there should be an appropriate decision-making process; however, it's important that health professionals are left with options that are available quickly to ensure safety for all.

Again, our recommendation is that a balance be found between the individual rights of residents to refuse measures to address potential disruptive or high-risk behaviours and the collective rights of residents and staff to live and work in a safe environment.

I'm going to ask Marianne to give us examples of some of those issues that we've brought forward.

Ms. Marianne Walker: If we go to the first issue about taking staff away from the bedside, even for our organization because we have over 700 beds, we looked at how much it would cost to train. We're not sure exactly from the legislation because it's not detailed what needs to be trained, we just sort of have the headings, but let's take one day of training. We have to take those staff away, so per 100 employees, you're talking about \$16,000 to \$20,000, depending on the rate of pay. That's going to have significant impact if that has to be absorbed. Mind you, the training needs—we believe that

those are the requirements. At the same time, looking at how we get some standards about the training that's required throughout the province so that each home isn't different and how we get together so that each home isn't taking those resources to develop those programs. So that's important.

The other thing, about the safety risk about the secured area, it's great news to hear in the legislation that we're going to get good data, good information about people coming in. That's very important to us and we're happy to see that. Where our issue lies is related to the residents who are already in the home and their behaviour deteriorates. How do we move them to the secure area quickly? This is about when the substitute decision-maker—we've had this and I'm sure others have—has said, "No, I don't want my loved one moved. I don't care if they get hit by a car." That's not acceptable for our sense of making sure that person is safe. So the issue is to ensure, if we're going through the rights adviser, etc., that there's a speedy process. What is the timeline of getting those approvals completed? That's the key: to ensure that the health professionals who have already assessed the person needing that type of care can do their job and make sure that all the residents are safe, including the one who needs to go to the secured area.

The Chair: Thank you. We have a minute and 20 or 25 seconds per party. We'll start with Ms. Martel.

Ms. Martel: Thank you very much for your participation here today. Can I just focus on your last point—a timeline? Do you have any sense of what that might be, given that you've had this experience?

Ms. Walker: Sometimes it's in hours that we need the answer.

Ms. Martel: I appreciate that. You also said that in October the board received an internal report on disruptive behaviour. Can I just ask what prompted that and what your results were in terms of what your needs are now?

Ms. Walker: At the initial stages we looked at the Casa Verde report and the coroner's report. Because we have quite a few organizations, including our affiliation with acute care and mental health, we brought a team together to look at all the things we should be doing to lessen the risk of this type of behaviour. I think there are about eight recommendations from that steering group, and now we're looking at how we implement it—from assessment to what do you do when it happens, training of staff, etc. There's quite a list of items.

Ms. Martel: This is on your own initiative. Have you costed that out?

Ms. Walker: No. We're still working through that process. Actually, because of the freezing rain we didn't get to meet this week. We would have known; so we're working through that.

Ms. Martel: I appreciate that.

Ms. Smith: It's nice to see you again, Marianne. Thanks for coming. I had two things I wanted to talk about: one, the secure unit and the consent question. The act does say that they shall promptly notify, that the

rights adviser shall promptly give the resident written notice. So the legislative framework is that rights advice be given promptly. However, I did want to assure you, as I did with the previous presenters, that the Health Care Consent Act still applies. So if you're in a crisis situation, then a resident could be placed into the secure unit or measures could be taken to ensure the safety of the resident and the other residents, and the rights advice and rights provisions would then apply shortly thereafter. You do have that ability still with the Health Care Consent Act to take immediate action if it's necessary. So when you say "a matter of hours", you can do that.

1510

I was interested in something in your presentation where you talk about—and I know, Marianne, you just noted that the admission provisions allow for assessments and further information being provided, but you had a concern about the constraints on the flow of pre-admission information through privacy legislation. Can you just elaborate a little bit on what your concern is there?

Ms. Walker: Yes. I guess what we're getting at is, looking at the coroner's report in the Casa Verde case, I think there was some information withheld by the physician that did not come forward. So how do we ensure that information is brought forward? Actually, that's one of the areas where our group that's looking at it has concern. We're looking at even doing many mental health assessments ourselves before the person actually comes to the home for that reason, if someone is keeping that information because of the privacy.

Ms. Smith: Right. Certainly in light of Casa Verde—that's why we drafted subsection 41(4) in the way that we did, recognizing that we needed to do an assessment of the individual's functional capacity, requirements for personal care, their current behaviour and their behaviour during the year previous. So we're looking at not just how they've been the last week or so but what their behaviours have been so that you can better prepare and determine the needs.

Ms. Walker: Would this legislation then allow us to get all the information from, for example, the physicians or psychologists or psychiatrists who are seeing the residents?

Ms. Smith: I'll get back to you on that.

The Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for your presentation. I can certainly attest to the fact that the St. Joseph's Health System in its different locations gives outstanding, quality care. I really do appreciate your presentation. I think your presentation speaks to the fact that you're always looking forward, trying to be proactive in responding to the needs of residents and new legislation that might be introduced.

You've indicated your concern about the use of volunteer community leaders and the fact that they might be disenfranchised. So you are then recommending that they would be under the same type of provisions as the Public Hospitals Act and that would adequately address your concerns. I appreciate that.

The other issue is that you indicated here that that collective rights of residents and staff need to be considered and the fact that families also have some sort of responsibility. Could you expand on that?

Ms. Lord: Marianne?

Ms. Walker: Sure. We've actually experienced that throughout our organization, where a resident said, "My bill of rights tells me I can determine the plan of care, and I do not want that mechanical lift used." It was quite a bit of time working through that, to say, "No, we've got to also look at the risk to the staff." The ministry certainly recognizes that when they give us money for the mechanical lifts, which was greatly appreciated. It has made a positive difference. So those are the things that we're concerned about. There are the safety issues, or—and we've had this also—where a resident believes, "It is my right to bring whatever I want in the room or do whatever I want, with loud music," while the other residents are upset about it. So it's getting that balance. Certainly the legislation talks about that they—I'm sorry, I can't remember the exact clause, but talks about that they can be more forceful in enacting it. We take the bill of rights very seriously, but our issue is how we ensure the collective good of all the residents and staff and families.

Mrs. Witmer: Maybe the legislation needs to be reconsidered in order to make sure that balance is there.

Ms. Walker: That's right.

The Chair: We're out of time. Thank you.

CAW ONTARIO HEALTH CARE COUNCIL

The Chair: The next presentation is from the CAW Ontario Health Care Council.

Not wishing to be repetitive, but if you would state your names for Hansard.

Ms. Darlene Prouse: Darlene Prouse, president of the Ontario Health Care Council. To my right is Robert Buchanan, the national rep and liaison with the Ontario Health Care Council.

I thank you for the opportunity to speak to the standing committee. The importance of the legislation and necessary amendments cannot be overstated.

Our union is deeply committed to ensuring that dignity of work and quality of life exist in Ontario's long-term-care facilities. In Ontario, the CAW represents approximately 9,000 nursing home workers across 85 homes. These homes are both for-profit and not-for-profit. Many of these homes are in the southwestern Ontario region.

The CAW Ontario Health Care Council, three years ago, began a dignity campaign for long-term-care workers and residents. Its policy statement was that seniors in Ontario long-term-care facilities are entitled to quality care delivered with respect and dignity. It also recognized that we needed to create a culture of equality and dignity for all. It also showed that there was a direct causal link between quality care and staffing levels in nursing homes, recognized an increase in heavy-care residents—residents with dementia—and recognized that the staffing

levels have fallen dramatically while absences because of illness and WSIB injuries are at an all-time high.

Although we applaud the effort of many of the proposed aspects of Bill 140, we feel that the most fundamental aspect is not included; that being the reinstatement of a minimum-hours-per-day nursing standard. At times during that campaign, there were 60,000-plus postcards and petitions presented supporting the implementation of 3.5 nursing care hours per day in long-term-care facilities.

Our position reflected an interim standard that accepted further evaluation as the appropriate staffing standard to ensure optimal care for residents in Ontario. Funding would be based on the staffing levels and costs required to deliver quality care. It also reflected on the need to ensure that any funding enhancements for nursing and personal care are directed to hiring front-line staff and not used to reduce deficits.

In December 2006, the CAW Ontario Health Care Council began a second campaign, with high priority again being given to the issue of minimum standard of hours per day. Long-term-care workers continue to tell us of working short and poor working conditions and increased workloads.

Included in this document you will find a list of actual hands-on nursing care hours. The council does yearly updates on the CAW long-term-care facilities for comparisons on the actual nursing care hours per day. You will find the April 2006 report with comparisons made in those that reported to the actual hours in 2004. When you look at it, you will notice that most that reported in 2004 have had an actual decrease in the hours per day or a minimal increase, compared to the 2006 hours per day. Of particular interest, of course, is the fact that during that period of time was the implementation of the 24/7 RN and the two baths per week.

Of note as well is the fact that these hours are based on regularly scheduled shifts. They don't take into account the long-term-care facilities with policies regarding replacements of staff only after the second or third absence. This places workers and residents at risk and provides difficulty in providing quality of care.

A minimum staffing standard is a means of providing accountability from both the provider and the government in their insurance to provide adequate and appropriate staffing.

A staffing standard must have the ability to provide those residents with less individual nursing care needs with a minimum number of hours per day and to provide those with increased acuity and nursing care needs the variability to provide the maximum quality of care required. The inclusion of the minimum nursing standard would ensure that the Long-Term Care Homes Act would provide the residents of long-term-care facilities with the best possible level of care.

Mr. Robert Buchanan: My name is Robert Buchanan. I'm national rep with the CAW and I service mostly long-term-care facilities in southwestern Ontario.

Experience has taught us that the need for minimum staffing in nursing and personal care is required in long-

term-care facilities. For far too long have residents in these facilities been put in vulnerable situations because there is no minimum staffing requirement.

Governments and policy-makers have recognized the fact that we need to have minimum standards. We have a minimum standard for wages, we have minimum standards for health and safety and we have minimum standards for food preparation, but we don't have minimum standards for nursing and personal care. And let's not forget: We once did have a minimum standard in this province but it was removed in 1996 by the Conservative government. Elderly people living in long-term-care facilities need to have proper care, and that can only be done through having a minimum standard. Otherwise, they're put into vulnerable situations.

1520

I'm going to give you two examples of vulnerable situations where our members were put into serious situations, and so were the residents.

The first happened in May 2005 at Extendicare London. Extendicare London announced to the union in early spring that they were going to cut 28 hours of strictly nursing and personal care—not other services—out of the home. That amounted to 200 hours of nursing and personal care, the equivalent of five full-time care providers, that were cut from the home. These cuts were directed at the front-line care providers—PSWs, personal support workers, and RPNs, registered practical nurses—the people who actually do the hands-on care.

These cuts were made despite the same number of residents living in the home. I can assure you that for-profit nursing homes don't overstaff. Their interest is in making money for their shareholders and providing a service, and they do that at the bare minimum. These cuts had a tremendous effect on the quality of care and the quality of work at Extendicare.

What happens also in these situations is that our members are put into vulnerable work situations because they feel they have to get the work done that they normally would have done with additional staff. So it puts them in a vulnerable situation.

The second circumstance happened at Woodingford Lodge. The county of Oxford runs three nursing homes in Ingersoll, Tillsonburg and Woodstock. In October 2005, 112 hours were cut from nursing care in the two satellite homes. Six months later, 900 hours were cut out of services provided to the residents at Woodingford in the Woodstock area. This resulted in direct front-line care to residents dropping below two hours per day per resident. And this is not just a resident issue. The front-line workers were also involved in situations that resulted in WSIB injuries increasing from 12 just before the layoffs in July to 22, doubling the WSIB injury incidence.

Furthermore, one of the most odious policies that I believe nursing home operators are doing is purposely allowing the floors of nursing homes to be short-staffed. What happens is that typically someone may call in sick, the employer won't replace that person, and in many cases the employer won't replace them until after a

second person has called in sick. This results in the home being chronically understaffed and the floor usually running short.

We've chosen these examples because we believe that if there were a minimum staffing requirement, we wouldn't have had these problems in the first place. Without minimum staffing in nursing and personal care, owners in public, private, profit or not-for-profit will continue to staff at unacceptable levels. A minimum standard would ensure that each resident is guaranteed the dignity and care they deserve.

Thank you very much for the opportunity to speak.

The Chair: Thank you very much. We have about a minute and 25 seconds per party, and we will start with the parliamentary assistant.

Ms. Smith: Thank you. We've heard a great deal about the minimum standard question. I'd just like to ask you whom you would include in the calculation of your minimum standard.

Mr. Buchanan: Are you asking that to me or to Darlene?

Ms. Smith: Either one; both.

Ms. Prouse: You'll see by the survey that it's the actual hands-on care, which would be your RPNs, RNs, PSWs, health care.

Ms. Smith: Do you include in that number the director of care?

Ms. Prouse: No.

Ms. Smith: But you do include the RN.

Ms. Prouse: Yes.

Ms. Smith: Would you include in that number a dietary aide who was feeding? Right; that was no?

Ms. Prouse: Yes.

Ms. Smith: Thank you for being here.

Mrs. Witmer: Thank you very much for your presentation. I think the point has been well made that there does need to be some sort of reinstatement of minimum hours per day of nursing care. We do appreciate the concern that your members have to make sure that residents do receive hands-on touch care. Thank you.

The Chair: Ms. Martel.

Ms. Martel: It would have been great if they had never been cancelled in the first place—I guess I just have to add that—in 1996.

In any event, let me look at your survey. If I read this correctly, you're saying that there has been a decrease in care in most cases or a very minimal increase two years after. So the 2006 figures are actually worse in most cases than the 2004 figures. Is that correct? Am I reading this right?

Ms. Prouse: Yes.

Ms. Martel: Added to that, if I'm also reading this right, is that your numbers were based on regularly scheduled shifts, but we have heard from so many people that most people are not working—there's not a full complement most of the time. In fact, people are working short-staffed. So if we actually were looking at the real hours that had been worked, the situation probably would be worse. Correct? I've been advocating for a long time for 3.5 hours of hands-on care per resident per day as a

minimum. I am encouraging the government to at least live up to the promise that they made, which was to reinstate 2.25 hours. I think it has to be higher than that, given acuity. I think you have very clearly shown with the figures that you've given us why it is imperative that there be a standard in place that has to be met. Further to that, you can have the standard, but you need the money to hire the staff to go with it, which is why the government has to live up to the second promise of \$6,000 per resident per year.

I appreciate very much your giving us these figures, which show what's going on in the homes that you represent, and clearly what's going on in too many cases is a worse situation now than it was two years ago, and that's really regrettable. Thanks very much.

The Chair: Thank you for your presentation.

STEEVES AND ROZEMA NURSING HOMES

The Chair: The next presentation: I apologize if I mispronounce it, but I believe it's the Steeves and Rozema Nursing Homes.

Ms. Joyce Haneca: Yes; Steeves and Rozema. My name is Joyce Haneca.

The Chair: Thank you. Fifteen minutes.

Ms. Haneca: Good afternoon. I am currently an administrator with Steeves and Rozema Nursing Homes in Sarnia, Ontario. I've had the privilege of working in long-term care for the past 18 years. I started out as an office manager for 14 years at Chateau Gardens here in London. It was a 63-bed nursing home, which was a not-for-profit, that appealed to receive D-classification status and subsequently rebuilt. I worked for two years as a ward clerk at Sprucedale Care Centre in Strathroy and I was with them during their recent rebuild with the capital renewal funds as well.

First of all, I understand that a lot of work was involved in writing this new long-term-care act. I am sure it was laborious to amalgamate the three existing acts that were written so long ago. This update has been necessary, and I applaud your efforts thus far. If history is an indicator, once this bill is passed and this act is legislated, it will be the final word on long-term care for many years to come, although I'm not sure that this is really the legacy that you want to leave.

You have had the opportunity of hearing five full days of presentations regarding the new long-term-care act. Since I was originally slotted on the agenda as the last presentation for today, I thought I needed to come up with something very creative and something that would catch your eye: I thought I would be known as the closer. Since then, the agenda has been amended and I'm not the closer, but I'm going to pretend I am. I want to say to you that, because of the nature of this act, I hope this government does not want to be known as the closer of long-term care as we know it today.

All I ever wanted was to become an administrator. I had worked in roles that allowed me to grow but did not give me the chance to effect change. I wanted that opportunity, so I obtained the necessary education, and

after graduation I was offered my current position. Now that I am an administrator, after reading the new long-term-care act, I'm not sure that this is what I want to do. The act promotes an environment of blame, which seems not only onerous but defeating.

1530

I had written our Premier Dalton McGuinty about these concerns. His response was very complimentary. I'll quote you from his letter to me:

"You never fail to care for them"—meaning the residents—"with professionalism, skill and compassion." If this is how our government leaders feel, why is the new act so punitive towards operators and licensees?

As a new leader in this field, I can assure you that there is not a lineup of candidates at my door waiting to work in long-term care. Aside from the inherent stigma that it is a depressing workplace, there is the ongoing message that we are out to make a profit without any care or concern for the residents' wellbeing. If the government is truly convinced that the majority of care providers are good at their job, why is Bill 140 so harsh? In this industry, we are already faced with a severe shortage of professional staff. This act, if it is not revised, will only drive the potential workforce further away from this line of work. No one in their right mind will voluntarily go to work where they have the potential to be ticketed during the course of their duties.

I agree that there should be a method to address abuse, neglect and poor management in any long-term-care home, but this process should not be so cumbersome that it prevents diligent operators and administrators from providing caring, home-like environments. This act has the potential to dehumanize our home and push it into an institutional atmosphere that we have been desperately trying to avoid. Instead of being able to focus on the residents and their wellbeing, we will be busy ensuring that we have dotted every "i" and crossed every "t."

Many people have come before you and addressed a variety of specific issues throughout the act. You have heard the concerns regarding licensing, restorative care, increased paperwork, lack of funding, and on the list goes. I know that you have heard them all and I will not sit here and regurgitate them for the last time. But I would like to invite you to come with me, take a step back, and let's look at Bill 140 in a more global fashion.

There are three stakeholders identified in this act: the minister and/or ministry, where "'minister' means the Minister of Health and Long-Term Care," the director is the ministry's appointee, and a resident is identified as any person "living in a long-term-care home." Then there is the licensee, who is identified as the "holder of a licence issued under this act." In essence, the purpose of the act is to clearly define the rights, responsibilities and accountabilities of each of the stakeholders. So we have established the three primary participants involved in this act.

I ask you to bear with me. Ethics requires the following four cornerstones to be met: beneficence, non-maleficence, justice and fairness. Due to our limited time, I will not dwell on the first two terms, but I would like to

address “justice” and “fairness.” The term “justice” is defined as “The principle of moral rightness; equity ... especially fair treatment and due reward in accordance with honour, standards or law.” The term “fairness” is defined as “Free from bias, dishonesty or injustice.”

Justice and fairness for all the primary stakeholders are essential for this act to meet ethical standards. In raw terms, this would mean that the rights, responsibilities and accountabilities of each party are clearly stated. I truly believe that this is the core issue that has caused so many people to step forward and voice their concerns. The heart issue is that there is no delineation of the rights, responsibilities and accountabilities of all the players.

Part I, section 1, states:

“1 The fundamental principle to be applied in the interpretation of this act and anything required or permitted under this act is that a long-term care home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort.”

Part I, section 1 clearly identifies the rights of the residents, which it should, which are further supported in the residents’ bill of rights. So if it is truly the residents’ home, why does the ministry have the right to determine what is posted on the walls? And where are the residents’ responsibilities to participate with the plan of care or meet their financial obligations or even enter into a contract with the licensee? With rights, there must be responsibilities.

The responsibilities of the licensee are clearly defined throughout the act, and I want to use section 17 as an example: “Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.” Long-term-care licensees have been leaders in zero tolerance for resident abuse. We recognize this as our responsibility, but this statement does not identify the licensee’s right to receive or the ministry’s responsibility to provide adequate funding for staff to prevent neglect. How can the licensee be held responsible when a government arbitrator reinstates a staff member who has been discharged from their duties for resident abuse? The licensee has been stripped of their right to address abuse issues.

If a licensee is responsible to protect the resident from financial abuse, the act does not state that there are any responsibilities of the resident or the power of attorney to co-operate with either the ministry and/or the licensee to address financial abuse issues, so how can the licensee be held responsible for something they have no right to enforce?

Again, if it is the resident’s right to be properly sheltered and fed, should it, then, not follow that it is the ministry’s responsibility to provide adequate funding to feed the resident? It is the licensee’s responsibility in the act that their home meets the operating standards set out by the ministry. If that is the licensee’s responsibility, then where is the ministry’s responsibility to provide the necessary funds, and where is the licensee’s right to have their licence protected to ensure their operating viability?

Although there is a suggestion that a capital renewal and retrofit program for B and C homes is not a Bill 140 issue, it has become a legislation issue because the licence has been tied to the structural requirements of the home as outlined in the regulations. There is no justice in a system that requires a licensee to meet standards that it cannot meet without the ministry’s responsibility to provide capital funds.

The ethical cornerstone of fairness is sadly lacking in this act. The act is not free from bias. It has a punitive framework towards the licensee, imposing sanctions, work orders, tickets as deemed necessary by the minister. Again, these are the licensee’s responsibilities, but where is their right, like any common criminal, to be considered innocent until proven guilty? Why is the onus and burden of proof put on the licensee? This framework violates one of the essential components of ethical treatment, and that is fairness.

I could go on and on and give many more examples from this act that would support this view, but suffice to say that this piece of legislation as it stands is an ethical quagmire, and it is opening the door to further abuse of an already beleaguered system.

So where do you go from here? After we have completed these presentations and we all go home and to our offices and you have all returned to your desks, what is the final outcome? What needs to happen? Well, I’ll make it easy. It’s as easy as ABC:

(a) admit that there need to be adjustments to this act as it is currently written;

(b) build into the act an ethical framework which includes the rights, responsibilities and accountability of all stakeholders; and

(c) commit to the capital funds required to provide for the rights of these residents.

Thank you for your attendance, your attention and your interest as we all work together to provide for the future of our valued seniors.

The Chair: Thank you. One minute per caucus, starting with Mrs. Witmer.

Mrs. Witmer: Thank you very much, Joyce, for your presentation. It was certainly very enthusiastic. I was quite moved to hear you say that all you ever wanted to be was in charge of a long-term-care home. That’s an interesting dream to have.

You’ve done an outstanding job. I think you’ve taken a look at the bill from a different perspective than what we’ve heard today, but I think we would all agree with you that certainly the whole issue of fairness is lacking in this legislation. If you had one thing to say to the government, one thing they needed to change to at least help to get it right, what would it be?

Ms. Haneca: I would love to be able to summarize it in one thing, but I think that’s next to impossible. This act cannot be passed as it stands, and there has to be a commitment to funding.

1540

Mrs. Witmer: Thank you very much.

The Chair: Thank you. Ms. Martel.

Ms. Martel: Thank you for your presentation this afternoon. As an administrator, in looking through the provisions of the bill—because there are increased responsibilities—have you been able to put any kind of costing towards that? I'm thinking in terms of human resources to actually ensure that you comply with all of the reporting requirements that are here.

Ms. Haneca: All I can speak of—because we don't know what the potential will be, but I can speak from experience. Any time the Ministry of Health is coming in to do either a complaint investigation or to follow up on a compliance issue, I can pretty well guarantee that my time and all of my manager's, and even front-line staff—because we just had this happen recently; up to five days of each of those people. So you're looking at maybe 20 days of staff time tied up in putting together a compliance plan, making sure that you can effect it, making sure it works—and we want to meet these standards; we want to go beyond these standards. But the onus and the burden is so high, and that's just an amount of time where I'm shutting my door to concentrate on that work. I'm not interacting with the residents or their families, and if they don't change the act as it stands, there's just going to be more of that. It's a real shame, because the whole point of my wanting to be in the business I am is to provide for the residents, not complete more paperwork.

The Chair: Thank you. Parliamentary assistant? No. Thank you.

CINDY RUDDY

The Chair: That brings us to our final presentation, which is Cindy Ruddy.

Welcome.

Ms. Cindy Ruddy: My name is Cindy Ruddy. I am employed at Elgin Abbey Nursing Home in Chesley, and I am also a member of the Service Employees International Union. I'd like to take this opportunity to thank you for allowing me to come and speak today.

I did not prepare a brief ahead of time, as I just decided that I would rather present my concerns with a few notes, kind of wing it and go by the seat of my pants, which I'm known to do, and speak more from the heart. What I'll be discussing today is the current condition of the staffing complements that have been overlooked in Bill 140.

Two patients limp into two different Canadian medical clinics with the same complaint. Both have trouble walking and both need a hip replacement. The first patient is examined within the hour, is X-rayed the same day and is booked for surgery the following week. The second sees the family doctor after waiting a week for an appointment and then waits eight weeks to see a specialist, then gets an X-ray which isn't reviewed for another month, and finally has surgery scheduled for a year from then. Why the different treatment for the two patients? The first is a golden retriever, the second a senior citizen.

I'm not trying to make light of a very serious situation; however, I wanted to point out that we hear many, many

jokes about our health care system and how the flaws associated with it make it easy to poke fun at. We rarely, rarely hear jokes about long-term care, and the reason for that is that unless a loved one requires long-term care, there really is no reason to think about it. As a result, people are completely uninformed of how we, the health care providers, the seniors living within the facilities and their families are left to deal with such an underfunded health care component within the Ministry of Health and Long-Term Care system.

The facility that I work in operates on 2.45 hours of nursing care per resident per day. This is simply not acceptable. I'm not going to reiterate what has already been addressed. You are all well aware of the way the CMM works and how the funding is determined. I'm going to use my time today to describe how this system is failing and why our seniors are considered to be the Ontario government's forgotten.

They're at the post. This is where I wing it. Every day, staff members come to work, and that is exactly how their day starts: They feel like they're horses, and the gate is going to flood open and rush in. It is that way almost every single day. It's overwhelming, it's stressful and completely unnecessary. They spread themselves so very thinly that they leave exhausted every day and wonder if it is going to be any better tomorrow, only to find out tomorrow that it isn't. Like I said, we're rushed.

As I look around, I'm assuming that pretty much everybody here has children. What I like to compare it to is when you get up in the morning and your alarm has not gone off; you're rushed, and you get your kids and whip the clothes on them, only to find out that their socks are inside out and they don't want to work with you. They don't want cereal for breakfast; they want a slice of bread. It goes on and on and on. That is a very sad thing; you know yourself how you feel when you leave. You think, "Oh, that was so terrible. Why did I rush them through that? That was not right." But you had to; in order to get done what you needed to get done, you had to rush. That is exactly what we deal with every day, on a daily basis.

We have families who wish to speak to us, the front-line workers, not the people sitting in their offices. They want the front-line workers. That takes time. You cannot overlook the family members, who need to know that their loved one is being well looked after. They want to speak to us, who deal with them every day. So you stop and you take the time. You are now 10 minutes behind. You were already 15 minutes behind. Now you're 10 minutes more behind.

About eight years ago, a colleague of mine said to me, "You know, Cindy, we do 10 hours of work in eight, and we're expected to do it in seven and a half." She's now retired, and I'm expecting to probably see her in a nursing home some day. I feel sorry for her, because I know how frustrated she will be when she gets in to find out that things have not changed in all those years—things we don't have time for, like cutting nails, something simple that you would probably take for granted. You jump in a bathtub; you clip your nails; you're done.

These people have to wait, and if they don't get done, what happens when they get aggressive? We get scratched. But you have to take priorities and you have to do what is necessary and what is important. There's no time for one on one, to sit, to hold a hand, to talk. That's pathetic. A hug, backrub—we all like backrubs. That was what we did years ago when I first started. I've been there a lot of years; 27, I think, to be exact. We did that; we used to do backrubs. You very rarely see that any more.

Toileting: This is my pet peeve. We have diaper police. I'm sure you've heard this. You wear your Depends until it is 75% wet. I brought one with me today with water in it. That is a wet diaper. It holds this much water. That's what's in there. If it is not 75% wet, we are expected to take it off, wash them, and put it back on. Would you ever consider doing that to a child? But we're doing it to our seniors. That is disgusting; absolutely disgusting. As a result, staff feel like they've let the residents down, which we have, and we deal with that every day. We have what I call the Florence Nightingale syndrome, and that is, we're all nurturers; that's what's keeping our residents well looked after. It's because that's what we do. We don't care that we've been there eight hours or eight and a half hours. We're there to make sure they're looked after.

I have this feeling—everybody I talk to says the same thing: They're all very, very stressed and very tired.

We have Alzheimer's residents who constantly repeat themselves during the day, which is interesting, because you hear the same story every day. That's part of the job. But they still want you to stop and listen. Even though I know it verbatim, they still want you to listen. There are elopers and aggressive people. One person could walk out the door 10 times in five minutes, but you have to go out and bring them back in. That's not personal care; that's just caring for them. For stroke patients with paralysis, their comprehension level is down. They don't understand you, so you are repeating yourself over and over again. Sometimes it takes a while for what you're telling them to reach their brain and for them to understand, so you have to sit and wait. You can't just say, "Here," and they take it. You see that their brain is slow, but you must wait. That's all time-consuming; very, very time-consuming.

Mental illness: We have some people who have mental illness. We have one gentleman in there right now who calls me, "Mommy." So I go to work every day and I'm still hearing, "Mommy, I'm wet." These are everyday things that occur within the facility.

1550

What "care" stands for at present: "C" stands for challenges that we meet every day. "A" stands for agnosia, which is lack of recognition of people. "R" stands for resistance from the ministry for additional funding. "E" stands for exertion and exhaustion.

What "care" and "long-term care" should stand for: "C" is for commitment and continuity from everyone, including the Ministry of Health and Long-Term Care. "A" is for accountability from all disciplines which actively

participate in our elderly population, including the ministry, which establishes and sets the standards for all parties to achieve. This should include the allowances of the appropriate and necessary funding requirements for all long-term-care facilities. "R" is for revolutionary. Giving support and allowing the staff and residents the time to interact more will enhance and allow the development of more specific and individualized programming. This would ensure that our residents' needs and desires are enhanced. After all, this should be the ultimate goal of all disciplines. We all know how important it is to us that while at home we can be ourselves. The older we get, the more support we need to reach this desire. Our staff need the time to help our residents. "E" is for enabling choices. They don't have choices. It's very sad.

It is undeniable to say we are faced and confronted with challenges on a regular basis. This is interesting: I have personally—and you wonder why I cry, but I love my job—been slapped, kicked, punched, pinched, bitten, spat at, yelled at, sworn at, urinated on, vomited on, defecated on and, in the next breath, hugged, kissed, been confided to. I've cried with, laughed with and grieved with many, many residents over the years. We are fortunate to have so many front-line staff who appreciate our elderly for who they are and what they represent. As you are well aware, it is becoming more challenging to recruit this type of person for our elderly to rely on. It is imperative that we recognize the importance of the commitment required to maintain those we have and make it more appealing for potential employees. Our government needs to realize that our seniors deserve to be given the privilege of the support, the dignity, respect and care they are so rightfully deserving of. It is time to care for those people who have taken care of others for so long, including each and every one of you.

I acknowledge that not every resident requires the same care. That just goes without saying. However, there must be a benchmark that must be established to ensure a minimum amount of care. In the United States, a study commissioned by the Federal Centers for Medicare and Medicaid Services identified three staffing thresholds below which the quality of care was found to suffer. The threshold is 45 minutes for RNs; one hour, 18 minutes for total licensed services—RNs plus RPNs; and two hours and 48 minutes for PSWs. Any nursing home that meets these standards would provide at least four hours and six minutes of total nursing care per day. I implore you to amend Bill 140 to reflect the 3.5 hours of hands-on care per resident per day. That would be a major, major contribution to help ensure that this standard is met. Thank you.

The Chair: Unfortunately, there is no time for questions, but thank you.

That concludes the public hearings for Bill 140. The committee will meet next Tuesday to commence clause-by-clause deliberations. The committee is now adjourned.

The committee adjourned at 1556.

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Mr. Ernie Hardeman (Oxford PC)

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Mr. Trevor Day

Staff / Personnel

Ms. Elaine Campbell, research officer,
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