Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Speaking out for health. Speaking out for nursing.

Response to the Minister of Health and Long-term Care on:

Initial Draft Regulation under the Long-Term Care Homes Act, 2007

Registered Nurses' Association of Ontario

June 5, 2009

Registered Nurses' Association of Ontario
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Table of Contents

Summary of Recommendations

1. RNAO strongly urges the Ministry of Health and Long-Term Care to legislate and fund a minimum of 3.5 hours of nursing and personal care for residents of long-term care homes, attached to average acuity. Greater acuity would require more hours of care.

2. RNAO strongly urges the Ministry of Health and Long-Term Care to require by regulation and fund a minimum of 0.5 hours of activation and recreational programs that promote socialization, engagement in social activities, mental and physical stimulation for residents of long-term care homes.

3. RNAO urges the Ministry of Health and Long-Term Care to establish by regulation a staff mix in long-term care homes of one nurse practitioner (NP) per large facility, 20 per cent registered nurses (RN), 25 per cent registered practical nurses (RPN) and 55 per cent personal support workers (PSW), supported by adequate funding.

4. RNAO recommends that the definition of "nursing care" in Part I, section 1, be clarified to mean skilled nursing given by an RN or an RPN, and a definition be added for "personal care", meaning personal care given by an unregulated worker under the supervision of an RN or RPN.

5. RNAO urges the government to stay on track with its commitment to achieving 70 per cent full-time employment for nurses and personal support workers in LTC facilities as crucial in ensuring continuity of caregiver and positive outcomes for long-term care home residents.

6. RNAO urges the government to address the inequity in wages between the acute care and community and long-term care sectors to ensure continuity of care-giver and the best quality patient care.

7. RNAO urges the Ministry of Health and Long-Term Care to commission research to update the findings of the 2001 PriceWaterhouseCooper's report into staffing and acuity levels in Ontario's Long-Term Care homes to allow LTC facilities to better plan staffing needs in the short and medium term.

8. RNAO urges government to quickly expand the Long-Term Care Best Practices Initiative as it has proven to be an effective support in implementing best practices for long-term care homes and staff.

9. RNAO recommends that the definitions of "abuse" in the draft regulation s.2(1) be extended to include neglect, as well as unreasonable confinement in the definition of physical abuse, removal of decision-making power in the definition of emotional abuse and subtle and intentional or unintentional abuse in the definition of emotional abuse. In addition we recommend that:

a. The definition of “neglect” in the draft regulation s.4 be expanded to include systemic neglect and the failure to make best efforts to meet and fund standards of care and staffing.

b. The Ministry of Health and Long-Term Care adopt a provincial standard for a zero tolerance policy for abuse and neglect, using RNAO’s Preventing and Managing Violence in the Workplace Best Practice Guideline as a model of a comprehensive and strategic approach.

c. The government allocate adequate funding for staffing, mandatory education and leadership development to prevent, identify and respond to abuse and neglect.

d. The Ministry introduce whistleblower protection for those who report abuse, neglect and any other care deficiencies, in long-term care homes.

e. The regulatory college of any regulated staff be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect in addition to the police notification requirement in s.18 of the draft regulation.

10. RNAO recommends that there be mandatory reporting in writing to the Ministry of incidents where a restraint is used and any changes implemented to minimize the use of restraints. This should include educational programs to understand aggression in the elderly and prevent its escalation.

11. RNAO urges the government to recognize the use of chemical restraints by extending the requirement of a minimizing restraining policy to apply to pharmacological use. This should include defined policies and procedures for obtaining informed consent from the resident or substitute decision maker prior to administration of chemical restraints.

12. RNAO recommends that the government must adequately fund the long-term care sector including ensuring adequate numbers of nurses and other health professionals. Staffing levels should permit Directors of Care to focus on leadership and operations, in addition to allowing the use of full-time rather than replacement nurses in monitoring patients in restraints.

13. The regulation should recognize an applicant’s need to age in place and be placed in a long-term care facility as close to their home, family and community as possible, if requested. Limits on waiting lists should not apply where the facility is in the applicant’s home community.

14. The regulation must clearly define the otherwise subjective term “severe capacity pressures” in s.46(4)(b) of the draft regulation.

15. The government should adopt the recommendations of the Casa Verde coroner's inquest, including ensuring that individuals with high medical needs, mental illness or who are prone to aggression and are a threat to themselves and others are only placed in long-term care facilities once they have been appropriately assessed, a care plan developed, and the LTC facility has regular access to specialty services such as psychogeriatricians, specialty Advance Practice Nurses or outreach consultants to support on-going care of these residents. In addition, RNAO supports inquest recommendation #22 that urges the Ministry of Health and Long-Term Care to fund specialized facilities to care for cognitively impaired residents who exhibit aggressive behaviours.

16. RNAO urges the Minister to ensure that an appropriately education registered nurse dedicated to infection control is a funding priority to ensure all long-term care facilities have the capacity to implement the infection prevention and control program consistent with best practices and professional standards.

Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Hon. David Caplan
Minister of Health and Long-Term Care
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June 5, 2009

Dear Minister,

Thank you for the opportunity to respond to the Initial Draft Regulation under the *Long-Term Care Homes Act, 2007* (LTCHA)[1]

When the *Long-Term Care Homes Act, 2007* was introduced on October 3, 2006, the RNAO applauded measures to help residents of long-term care homes, including provisions for whistleblower protection and the requirement that every LTC facility have at least one RN on duty and on-site 24 hours a day, seven days a week. Significant concerns were voiced at the time by the RNAO and others that the legislation failed to commit to a minimum number of hours of nursing and personal care for residents, an omission that in our view compromises resident safety. Moreover, RNAO was concerned that the Act did not contain a stronger commitment to not-for-profit delivery, particularly for new long-term care beds.

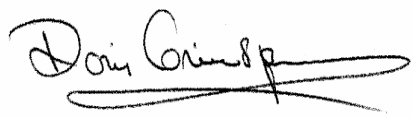
RNAO's concerns have not been alleviated by release of the initial draft regulation.

There is no standard of nursing and personal care or staffing in the regulation, nor is there a provincial standard for zero tolerance of abuse and neglect. Whistleblower protection is inadequate and restraint minimizing provisions are silent on the use of chemical restraints. There is little protection against inappropriate admission of residents with complex care requirements and not enough recognition of the need for people to live as close as possible to their families, communities and support systems.

One lesson of the global economic crisis is deregulation does not work, and there are many examples of lax regulation in the long-term care sector not being in the public interest. In the attached response to the initial draft regulation, RNAO focuses on the most crucial issues outlined above. However, we agree with those who suggest it is inappropriate and premature to finalize the regulations under the *Long-Term Care Homes Act, 2007* prior to release of the Ontario Ombudsman's current investigation into Ontario's long-term care homes and his recommendations. It is vital that we take the time required to get the regulations right.

RNAO looks forward to continuing to work closely with you to develop regulations that will improve the care and quality of life of the over 75,000 Ontarians who call long-term care facilities home.

Kind regards,



Doris Grinspun, RN, MSN, PhD(c), O.ONT.
Executive Director, RNAO

Wendy Fucile, RN, BScN, MPA, CHE
President, RNAO

The Registered Nurses' Association of Ontario (RNAO) is the professional organization for registered nurses who practice in all roles and sectors across Ontario. Our mandate is to advocate for healthy public policy and for the role of registered nurses in shaping and delivering health services. We welcome the opportunity to respond to the Initial Draft Regulation under the *Long-Term Care Homes Act, 2007*.[2]

Background

On June 4, 2007, the *Long-Term Care Homes Act, 2007*, received Royal Assent. Now, two years later, the first of at least two draft regulations has been released for consultation by the Ministry of Health and Long-Term Care. Only when the regulations are approved by Cabinet and in place will the Act finally take effect.

Most of Parts I, II and III of the Act are covered in the draft regulation subject to this consultation. This includes provisions related to care plans, abuse and neglect, restraints, and admissions.

Nurses applauded the introduction of the *Long-Term Care Homes Act, 2007* with its provision that long-term care facilities have at least one registered nurse on duty and on-site 24 hours a day, seven days a week.[3] However, RNAO has stated consistently and firmly that patient care would be compromised if the Act and regulations did not prescribe a minimum number of hours of nursing and personal care for residents. It is for this reason that the RNAO is profoundly disappointed that the draft regulation completely omits any mention of minimum number of hours of nursing and personal care in long-term care homes.

If the government is to meet its commitment "to the health and well-being of Ontarians living in long-term care homes now and in the future", set out in the Bill's preamble,[4] the regulation must clearly specify the minimum number of hours of nursing and personal care to which every resident is entitled.

A. Nursing and Personal Care and Staffing Standards

Given that the needs of many long-term care residents have become more complex, with an increase in acuity of 29.7 per cent from 1992 to 2007,[5] there are two crucial elements to be considered in determining the appropriate level of care: the first is levels of care and the second is the mix of care providers.

Early in 2007, the government released information that levels of care in long-term care homes in Ontario were averaging 2.86 hours of nursing and personal care per resident day.[6] This fell short of the no less than .59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case mix measure recommended by the Casa Verde Coroner's inquest,[7] and the 3.5 hours per

day that the Ontario Health Coalition,[8] RNAO,[9] and Ontario Nurses Association[10] have been calling for that would bring Ontario into line with care standards in other jurisdictions.

While the Sharkey Report recommended against a regulated care standard, it did support raising PSW and nursing hours "up to" 3.5 hours, although not necessarily on average.[11] In fact, the average of 3.5 hours of nursing and personal care is based on average acuity and will need to increase as the acuity of long-term care home residents continues to rise.

The draft regulation is also silent on standards for programs that promote socialization, engagement in social activities, and provide mental and physical stimulation for residents of long-term care homes. Section 10 of the Act mandates a licensee to provide an organized program of recreational and social activities to meet the interests of residents,[12] but the draft regulation fails to set standards and requirements or outcome measures. A daily minimum of 0.5 hours of activation and recreational programs should be required.

With respect to the mix of care providers, an Ontario study released in 2001 indicated that health care aides provide 75 per cent of care, RPNs 13 per cent and RNs 11 per cent.[13] With the increased employment of RPNs and personal support workers in the intervening period, the mix has probably shifted by several percentage points, though the report has not yet been updated.

An inter-disciplinary staffing model best facilitates high quality, resident-centred care that addresses the range of physical, psychological, emotional, spiritual and social aspects. Nurse practitioners, registered nurses and registered practical nurses should be working to full scope of practice in each facility, assisted by personal support workers to provide safe and comprehensive care. Other health professionals such as physiotherapists, occupational therapists, recreational therapists and social workers fill essential roles in the model to enhance the residents' well-being. A number of studies have established strong links between staffing, particularly RNs, in long-term care facilities and resident outcomes, including lower death rates, higher rates of discharge to home, improved functional outcomes, fewer pressure ulcers, fewer urinary tract infections, lower urinary catheter use, and less antibiotic use.[14] [15]

Utilizing nurse practitioners to provide primary care to residents and leadership to nursing staff has been demonstrated to improve access to care for residents[16], enhance quality of care for residents[17], prevent hospital admissions[18], and provide a role model for nurses in assessment skills and problem-solving medical issues.[19] The success of the Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project[20] [21] showed the potential positive outcomes for residents, staff and the health care system of nurse practitioners in the long-term care sector.

Given the available evidence and staffing standards in other jurisdictions,[22] RNAO recommends a staff mix established by regulation of: one nurse practitioner per large

facility,[23] 20 per cent registered nurses, 25 per cent registered practical nurses and 55 per cent personal support workers. For clarity, definitions in s.1 must distinguish between "nursing care" (RN or RPN) and "personal care" (PSW). This staffing model would result in substantive improvements in residents' clinical and social outcomes such as reduced rates of pressure ulcers and falls, decreased aggressive behaviours with improved dementia care, and increased residents' and families' satisfaction. It will also lead to better system utilization and shorter wait times, with decreased transfers from long-term care to hospital emergency departments.

Staffing and standards of nursing and personal care also relate to the continuity of caregiver. In her report, Shirlee Sharkey told of fragmented staff complements due to shortage and absenteeism affecting quality of care. Replacement staff often were not familiar with individual needs and routines.[24] Meeting the government's commitment to achieve 70 per cent full-time employment is crucial to ensuring continuity of caregiver, prevention and early detection of complications, commitment to resident-centred care, and positive relationships between nurses, PSWs and residents.[25] [26] [27] [28]

An additional factor causing fragmented staff complements and difficulty in attracting and retaining full-time regulated staff to the long-term care sector is the inequity in salary levels between staff in acute care and those working in long-term care and community settings. With the aging population and growing acuity of long-term care home residents, continuity of care-giver is increasingly important to quality of care, and the unfairness in remuneration must be addressed.

Recommendation: RNAO strongly urges the Ministry of Health and Long-Term Care to legislate and fund a minimum of 3.5 hours of nursing and personal care for residents of long-term care homes, attached to average acuity. Greater acuity would require more hours of care.

Recommendation: RNAO strongly urges the Ministry of Health and Long-Term Care to require by regulation a daily minimum of 0.5 hours of activation and recreational programs that promote socialization, engagement in social activities, mental and physical stimulation for residents of long-term care homes.

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Recommendation: RNAO recommends that the definition of "nursing care" in Part I, section 1, be clarified to mean skilled nursing given by a registered nurse or a registered practical nurse, and a definition be added for "personal care", meaning personal care given by an unregulated worker under the supervision of a registered nurse or registered practical nurse.

Recommendation: RNAO urges the government to stay on track with its commitment to achieving 70 per cent full-time employment for nurses and personal support workers as crucial in ensuring continuity of caregiver and positive outcomes for long-term care home residents.

Recommendation: RNAO urges the government to address the inequity in wages between the acute care and community and long-term care sectors to ensure continuity of care-giver and the best quality patient care.

Recommendation: RNAO urges the Ministry of Health and Long-Term Care to commission research to update the findings of the 2001 PriceWaterhouseCooper's report into staffing and acuity levels in Ontario's Long-Term Care homes to allow LTC facilities to better plan staffing needs in the short and medium term.

B. Required Programs and Long-Term Care Best Practices Initiative

Sections 9 to 13 prescribe interdisciplinary programs that are required to be developed, implemented, evaluated and updated. These include programs for falls prevention and management, skin and wound care, continence care and bowel management, and pain management. The Long-Term Care Best Practices Initiative can be used as a key resource to support the implementation efforts of LTC homes in developing the required programs mentioned in the draft regulation.

The aim of this government funded initiative is to enhance the quality of care for residents in Long-Term Care Homes (LTCHs) and facilitate a culture of evidence-based practice through the implementation of clinical and healthy work environment Best Practice Guidelines (BPGs) by front-line staff in LTCHs. The Long-Term Care Best Practices Initiative has proven to be a valuable support in assisting the LTC homes in improving the delivery of effective care to residents; capacity building in the LTC sector; promotion of interdisciplinary knowledge transfer; utilization of evidence-based decision making in professional practice; and improvement in work environments.

To date, there are only eight LTC Best Practice Coordinators to support over 600 LTC homes in the province. RNAO urges the government to expand the LTC Best Practices Initiative and increase the number of LTC Best Practice Coordinators to meet the growing demands in the LTC sector.

Recommendation: RNAO urges government to quickly expand the Long-Term Care Best Practices Initiative as it has proven to be an effective support in implementing best practices for long-term care homes and staff.

C. Abuse and Neglect

"Abuse" is defined in s.2 as including emotional, financial, physical, sexual and verbal abuse. While the definition of abuse is broad, it fails to include neglect, which, as a

failure to act, is clearly a form of abuse. It also does not follow the lead of the Ontario Network for the Prevention of Elder Abuse (ONPEA) in including "unreasonable confinement" in the definition of physical abuse and "removal of decision making power" as included under emotional or psychological abuse[29]. Emotional abuse is defined to mean "any action or behaviour that may diminish a resident's sense of well-being, dignity or self worth", but could be clarified to include forms of abuse that are subtle and perhaps unintentional such as ignoring call buttons or putting telephones or alerting devices out of reach.[30]

Section 4 defines "neglect" as the failure to provide a resident with the care and assistance required for health, safety or well-being, and can include inaction or a pattern of inaction that jeopardizes residents' health or safety. This definition appears to focus on the role of staff who may act or fail to act in such a manner as to affect a resident's health, safety or well-being. However, it is often decisions by government and funders that limit the capacity to provide adequately for residents' health. Systemic neglect, and specifically the failure to make best efforts to meet and fund standards of care and staffing, would strengthen the definition of "neglect" in the regulation.

A licensee's policy to promote zero tolerance of abuse and neglect would include procedures to support residents who have been abused or neglected and to deal with staff who have neglected or abused residents, or who are alleged to have done so (s.16). Section 18 requires immediate notification of the police of any alleged, suspected or witnessed incident of abuse or neglect (presumably there should be an additional duty to notify the regulatory college for any regulated staff). Section 19 obliges every incident of abuse or neglect to be analyzed promptly and the effectiveness of a zero tolerance policy to be evaluated at least annually, with a written record to be prepared.

Overall, the draft regulation leaves many questions unanswered. For example:

- The regulation expressly applies to abuse or neglect caused by staff, but omits from the zero tolerance policy abuse or neglect by the long-term care owner or anyone else;
- The regulation only contemplates abuse or neglect directed at residents, but is silent on the all-too-common violence that targets volunteers, visitors and staff.
- It is unclear from the draft regulation who investigates allegations of abuse or neglect, what constitutes an "analysis", and the timelines for investigation (except for "promptly").
- There is no direction that the licensee's policy must provide effective whistleblower protection for staff who report suspected abuse or neglect.

In addition, there does not appear to be any attempt to maintain, through the regulation, a consistent, high-level provincial standard for a zero-tolerance policy. A useful model of a comprehensive and strategic approach to tackling violence can be found in RNAO's Preventing and Managing Violence in the Workplace Best Practice Guideline,[31] part of the RNAO Best Practices Guideline Program, funded by the Ministry of Health and Long-Term Care. Guideline recommendations include:

- Adequate funding for staffing, mandatory education and leadership development to prevent, identify and respond to violence in the workplace;
- A violence prevention policy within organizations that addresses all forms of violence and that makes safety of patients, staff, volunteers and students a strategic priority;
- Including whistleblower protection for those who report violence in the workplace;
- Development and monitoring of organizational accountability, including but not limited to indicators to measure effectiveness of prevention programs, prevalence and incidence of violence in the work setting, and fair and consistent response to the reporting of violence, regardless of the power base of those involved in the violence.[32]

Recommendation: RNAO recommends that the definitions of "abuse" in the draft regulation s.2(1) be extended to include neglect, as well as unreasonable confinement in the definition of physical abuse, removal of decision-making power in the definition of emotional abuse and subtle and intentional or unintentional abuse in the definition of emotional abuse. In addition we recommend that:

a. The definition of "neglect" in the draft regulation s.4 be expanded to include systemic neglect and the failure to make best efforts to meet and fund standards of care and staffing.

b. The Ministry of Health and Long-Term Care adopt a provincial standard for a zero tolerance policy for abuse and neglect, using RNAO's Preventing and Managing Violence in the Workplace Best Practice Guideline as a model of a comprehensive and strategic approach.

c. The government allocate adequate funding for staffing, mandatory education and leadership development to prevent, identify and respond to abuse and neglect.

d. The Ministry to introduce whistleblower protection for those who report abuse, neglect and any other care deficiencies in long-term care homes.

e. The regulatory college of any regulated staff be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect in addition to the police notification requirement in s.18 of the draft regulation.

D. Minimizing of Restraining

Sections 20-21 of the Draft Regulation relate to minimizing restraining of residents. A licensee must develop a written policy circumscribing the use of physical devices and barriers, locks and other devices or controls. It would include the duties and

responsibilities of staff, obtaining and documenting consent to the use of restraints or personal assistance services devices, alternatives to restraints, and evaluation of restraints. Section 21 requires residents who are restrained by a physical device to be monitored at least every hour by registered staff or an authorized person. Every two hours residents would be released from the physical device and repositioned, with more frequency depending on the resident's condition and circumstances. The resident's condition and effectiveness of restraining would be reassessed at least every eight hours.

Section 25 obliges the licensee to keep a written record of when restraints were used and any changes implemented to minimize the use of restraints. At the same time, RNAO suggests mandatory reporting in writing to the funding Ministry to better provide centralized analysis and reporting.

RNAO supports the requirement of a written policy to minimize the restraining of residents. However the requirement of the written policy to apply to physical restraints does not refer to the use of chemical restraints or drugs even though psychoactive medications may be used to inhibit movement or a particular behaviour rather than treat illness. Under s. 28(4) of the Act, any drug in the plan of care is not a restraint.[33] Nevertheless, RNAO is concerned about the number of individuals being prescribed anti-psychotics living in long-term care and the potential lack of informed consent prior to administration of anti-psychotics. Unlike physical restraints, chemical restraints are not necessarily obvious and family or substitute decision makers may be unaware they are being administered to the resident. RNAO urges the Minister to recognize the use of chemical restraints by extending the requirement of a minimizing restraining policy to apply to drugs. This should include defined policies and procedures for obtaining informed consent from the resident or substitute decision maker prior to administration of chemical restraints.

A resident restrained under the common law duty set out in s. 36 of the Act must be monitored on an ongoing basis, with the resident's condition reassessed at least every 15 minutes and at any other time based on the resident's condition or circumstances.

Every use of a physical device to restrain a resident must be documented, including circumstances precipitating the application, alternatives considered, who made the order, the device ordered, consent, assessments, monitoring, resident's response to the device, release of the device and repositioning, removal or discontinuance, and post-restraining safety measures. Section 24 of the Draft Regulation contains a list of prohibited restraining devices, such as vest or jacket restraints and any device that cannot be immediately released by staff. Section 25 requires monthly evaluation of the use of restraining and an annual evaluation to determine the effectiveness of the restraint minimizing policy. Any changes and improvements to minimize restraining would be implemented "promptly".

While RNAO strongly supports the policy of minimizing restraints in the Act and draft regulation, there is no question the implementation of the policy will result in a

significant increase in workload for nurses in terms of direct care, documentation and evaluation of interventions. In order to meet the above regulatory requirements and to provide the necessary support and care that Ontarians living in long-term care deserve, it is imperative that there be increased support to the long-term care sector. It is also vital that continuity of high quality care and treatment be assured by using permanent full-time staff rather than relying on replacement staff for essential tasks such as monitoring patients in restraints.

Recommendation: RNAO recommends mandatory reporting in writing to the Ministry of incidents where a restraint is used and any changes implemented to minimize the use of restraints. This should include educational programs to understand aggression in the elderly and prevent its escalation.

Recommendation: RNAO urges the Minister to recognize the use of chemical restraints by extending the requirement of a minimizing restraining policy to apply to pharmacological use. This should include defined policies and procedures for obtaining informed consent from the resident or substitute decision maker prior to administration of chemical restraints.

Recommendation: The government must adequately fund the long-term care sector including ensuring adequate numbers of nurses and other health professionals. Staffing levels should permit Directors of Care to focus on leadership and operations, in addition to allowing the use of full-time rather than replacement nurses in monitoring patients in restraints.

E. Admission of residents

Section 30 of the draft regulation sets out the criteria by which an applicant is eligible for admission as a long-stay resident. An applicant must require the availability of nursing care on-site 24 hours a day, or require, at frequent intervals during the day, assistance with the activities of daily living, or need on-site supervision or monitoring at frequent intervals to ensure their safety or well-being. There can be no alternative publicly-funded community-based service or other arrangements available to the applicant in the applicant's area sufficient to meet the applicant's needs.

Under s.31, an applicant can be eligible for a short-stay of up to 60 days for respite care or 90 days for convalescent care. An applicant is limited, under sections 37 and 41, to being on the waiting list of five long-term care homes at a time, unless the applicant is placed in the "crisis category". Section 46 of the draft regulation lists the circumstances under which an applicant can be placed in the crisis category. These include where the applicant's condition or circumstances are in crisis or where the applicant occupies a bed in a hospital under the *Public Hospitals Act* and require an alternate level of care (ALC) and the hospital is "experiencing severe capacity pressures that have been verified by the Local Health Integration Network".

There is no provision in the draft regulation whereby an applicant's eligibility or ability to be placed on a waiting list recognizes the applicant's need to be as close to their home, family and community as possible and the desirability of people having the opportunity to age in place. With bed shortages in long-term care homes, the maximum limit of being on the waiting lists of five facilities at once (ss.37,41) and the requirement of accepting a placement within five days of it being offered (s.42), many people will be forced to move into long-term care homes far from their families and community support systems.

There is also a danger that with the pressure to free up ALC beds in hospitals, patients will be classified as "crisis" under s.46 and be placed inappropriately in long-term care homes. In this regard, the term "severe capacity pressures" in s.46(4)(b) is subjective and must be clearly defined in the regulation.

Some applicants, such as complex continuing care patients, will have high medical needs. The Casa Verde coroner's inquest recommended the need for caution, including full care plans prior to admission, for those whose aggression could be a danger to themselves or others.[34]

Recommendation: The regulation should recognize an applicant's need to age in place and be placed in a long-term care facility as close to their home, family and community as possible, if requested. Limits on waiting lists should not apply where the facility is in the applicant's home community.

Recommendation: The regulation must clearly define the otherwise subjective term "severe capacity pressures" in s.46(4)(b) of the draft regulation.

Recommendation: The government should adopt the recommendations of the Casa Verde coroner's inquest, including ensuring that individuals with high medical needs, mental illness or who are prone to aggression and are a threat to themselves and others are only placed in long-term care facilities once they have been appropriately assessed, a care plan developed, and the LTC facility has regular access to specialty services such as psychogeriatricians, specialty Advance Practice Nurses or outreach consultants to support on-going care of these residents. In addition, RNAO supports inquest recommendation #22 that urges the Ministry of Health and Long-Term Care to fund specialized facilities to care for cognitively impaired residents who exhibit aggressive behaviours.

F. Infection Prevention and Control

Part V of the proposed initial draft regulation, section 64, requires every licensee to institute an interdisciplinary approach to the coordination and implementation of an infection prevention and control program. A staff member must be designated to coordinate the program who has "education and experience in infection prevention and control practices", including cleaning and disinfection, data collection and trend analysis,

reporting protocols and outbreak management. Licensees would be responsible for daily monitoring, recording and analysis of the presence of infection among residents and for implementation of any surveillance protocols provided by the Ministry.

As the provision is written, the onerous duties of coordinating and implementing an infection prevention and control program would be added to the existing responsibilities of a current staff member. Many licensed facilities, particularly those in smaller communities, will lack the capacity to meet the statutory standards of education and experience and to implement the protocol detailed in section 64 without assigning the responsibility to a new staff position.

It is vital that infection control practitioner services not be less in long-term care than in acute care facilities. While staffing could be shared among smaller facilities or delivered through the LHIN, infection control must not merely be an add-on or, in reality, it will not be done. A registered nurse is required, dedicated to infection control, with the appropriate education and commitment to professional standards and best practices in infection control.[35]

Recommendation: RNAO urges the Minister to ensure that an appropriately education registered nurse dedicated to infection control is a funding priority to ensure all long-term care facilities have the capacity to implement the infection prevention and control program consistent with best practices and professional standards.

G. Conclusion

We thank the Ministry of Health and Long-Term Care for the opportunity to comment on the proposed initial draft regulation under the *Long-Term Care Homes Act, 2007*. We urge the government not to rush to finalize the regulations and wait for the release of the Ontario Ombudsman's current investigation into Ontario's long-term care homes and his recommendations. It is vital that we take the time required to get the regulations right.

RNAO looks forward to continuing to work closely with you to develop regulations that will improve the care and quality of life of the over 75,000 Ontarians who call long-term care facilities home.

Notes

[1] *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.
[2] *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.
[3] *Long-Term Care Homes Act*, 2007, S.O. 2007, c.8, s.8(3): "Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.
[4] *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, preamble.
[5] Ontario Health Coalition (2008). *Submission to the Facilitator, Shirlee Sharkey: Review of Staffing and Care Standards for Long-Term Care Homes*. Author. 7.
[6] Monique Smith, *Hansard*, Wednesday 17, January, 2007
[7] Recommendations of deaths of El Roubi, Ezzeldine and Lopez, Pedro at Casa Verde Nursing Home, accessed May 31, 2009. http://www.oha.com/client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/El-Roubi+and+Lopez/$file/El-Roubi+and+Lopez.pdf
[8] Ontario Health Coalition. (2007).*Briefing Note: Why is a Minimum Care Standard so Important?* Toronto: Author. Accessed December 19, 2007 http://www.web.net/~ohc/LongTermCare/LTCBriefingNoteOnMinimumStandards.htm
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