Submission to the Standing Committee on the Legislative Assembly re Bill 37 (*Providing More Care, Protecting Seniors, and Building More Beds Act, 2021)*

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Summary of recommended amendments:

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP), and nursing students in all roles and sectors across Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contributions to shaping the health system and influenced decisions that affect nurses and the public we serve. RNAO welcomes the opportunity to provide feedback to the Standing Committee on the Legislative Assembly on Bill 37, Providing More Care, Protecting Seniors, and Building More Beds Act, 2021. RNAO proposes the following recommendations:

Hours of Direct Nursing and Personal Care

1. Commit to a guaranteed minimum of four worked hours of direct nursing and personal care per long-term care (LTC) resident per day in legislation, rather than a targeted average**.**

Staffing and Skill Mix

2. Commit to the following staffing and skill mix standards in legislation:

a) Guaranteed minimum of four worked hours of direct nursing and personal care per LTC resident per day, provided by the appropriate staffing mix as outlined in this table:

Role	**Skill mix of care per day**	**Worked hours of care per day**
Registered nurse (RN)	Minimum of 20%	0.8 per resident
Registered practical nurse (RPN)	Minimum of 25%	1.0 per resident
Personal support worker (PSW)	Maximum of 55%	2.2 per resident

b) One nurse practitioner (NP) per 120 LTC residents.

c) One Infection Prevention and Control RN per 120 LTC residents.

d) An average of one hour of care per day per LTC resident from allied health professionals

Quality Care and Continuous Quality Improvement

3. Urge LTC homes to use RNAO's LTC Best Practices Program as a resource for the purpose of implementing continuous quality improvement initiatives.

4. Establish an LTC Quality Centre that showcases the outstanding work of RNAO, Advantage Ontario, OLTCA, and others engaged in evidence-based person centre care.

5. Mandate all long-term care homes to track, measure and publicly report on key performance indicators, and to evaluate and show improvements in LTC settings, including those relating to:

- Quality of care
- Resident/family satisfaction
- Infection prevention and control
- Human resources
- Resident Bill of Rights

Funding

6. Change the funding formula to account for complexity of residents and quality outcomes. The current formula based solely on CMI acts as a financial disincentive to improve resident care and outcomes.

Not-for-Profit Care

7. Provide a right of first refusal to non-profit homes for developments, and provide supports for them to succeed in expansions.

Inspections, Enforcement and Licensing

8. Implement measures to improve inspection processes, and mandate in legislation a requirement that every LTC home be subject to an annual comprehensive Resident Quality Inspection (RQI).

9. Impose a higher standard of accountability and compliance on homes with chronic compliance issues, including escalating stringency of responses to non-compliance and stronger enforcement of licence revocation or transfer.

Culturally Safe Care

10. Update the Resident Bill of Rights to require that all licensees implement measures related to:

- Respecting sexually and gender diverse communities in long-term care
- Providing culturally-safe and linguistically appropriate care options in long-term care

Retirement Homes

11. Transfer the regulatory oversight of retirement homes from the Retirement Homes Regulatory Authority to the Ministry of Long-Term Care (the Ministry).

Introduction

The COVID-19 pandemic has exposed a fragility of Ontario's long-term care (LTC) sector that stems from systemic ageism, manifest as decades of neglect and underfunding. It has also brought to light the tragic consequences of successive governments ignoring decades of evidence-based policy that pointed to the urgent need for better funding, stronger staffing and a fundamental reconsideration of our approach to the care of Ontario's nursing home residents (RNAO, 2020b). Nearly 16,000 Ontario LTC residents and more than 7,000 LTC staff have contracted COVID-19 since the start of pandemic (Public Health Ontario, 2021). We have lost more than 4,000 long-term care residents, as well as 10 LTC staff members, to COVID-19 in Ontario (Public Health Ontario, 2021). The Canadian Armed Forces and the Canadian Red Cross were both brought in to deal with the most catastrophic examples of this system failure. This tragedy was avoidable. We are dedicating our submission to residents who tragically lost their lives, to their injured families and staff, and to the nearly 80,000 residents for whom nursing homes is their home.

The pandemic experience confirms the need for fundamental changes to long-term care in Ontario. That need ought to be fully reflected in Bill 37. It is not. The Bill promises to improve care in Ontario's nursing homes but doesn't go far enough. For example, skill mix changes are not outlined, and the funding formula which serves as a disincentive to improve outcomes of residents remains the same. Thus, Bill 37 proposes that Ontario move forward with much of the same LTC system that collapsed under the

weight of the pandemic. Changes to the Act need to make real its commitment to its fundamental principle – that "a long-term care home is primarily the home of its residents".

But more than that, Bill 37 needs to recognize that nursing home residents are increasingly people with complex physical, cognitive, mental and social needs. As expressed by Ontario's LTC COVID-19 Commission (2021):

"The government should amend the fundamental principle in section 1 of the Long-Term Care Homes Act, 2007, to explicitly acknowledge that long-term care residents have complex physical and mental health needs, including cognitive impairments, and to promise that licensees will ensure that residents' complex care needs are met."

Missing from Bill 37 are several changes that would signal a fulsome understanding of the profound and real change needed in Ontario's LTC sector. Critical deficiencies that hinder Bill 37 from making a real and positive impact on LTC residents, their loved ones and staff include:

- Bill 37 falls short of mandating a minimum of four worked hours of personal and nursing care for each LTC resident, and is completely silent on the skill mix of nursing home staff that provide LTC.
- Bill 37 fails to amend a funding formula that includes a disincentive to quality-of-care programming.
- Bill 37 does not include satisfactory language to ensure culturally-safe care for LTC residents.
- Bill 37 must enable a first right of refusal for non-profit home developments.

These and other gaps must be amended to address the fundamental transformation Ontarians need to regain trust that we and our loved ones will receive the dignity and expert care we need when we live in any nursing home in Ontario. These and other changes are also urgently needed to attract talented staff to the sector, and to retain them. COVID-19 has only magnified a problem that has existed for decades. The

government should be bold – it should embody the fundamental principle of the Act and achieve long-overdue changes in LTC.

RNAO's expertise, role, and input

RNAO has been championing the need for attention to safety and quality in LTC for two decades. RNAO's work includes the world-renowned *Best Practice Guidelines Program* (BPG) launched in 1998 (Grinspun & Bajnok, 2018). The BPG program includes leading-edge support and monitoring of the uptake of nursing best practice guidelines (BPGs) through our LTC program. This pillar of the BPG program was introduced by the Ministry in 2005, in partnership with RNAO in an advisory role; and it was transferred to a program led by RNAO in 2008. RNAO expanded this program in 2014 with the introduction of the Long-Term Care Best Practice Spotlight Organization (BPSO) model to ensure sustained organization-wide use of evidence in practice with impressive outcomes for residents, staff and the long-term care homes.

RNAO also fueled the government response in 2017 to establish the Long-Term Care Homes Public Inquiry following the deadly outcomes for residents due to the actions of an LTC staff member. At that time we urged to leave no stone unturned and worked with government to ensure broad terms for the Long-Term Care Homes Public Inquiry to include the long-standing systemic failings in LTC.

For over a decade, RNAO has led the way in speaking out for an increase in regulated staff in LTC, including championing funding for one attending nurse practitioner (NP) for every 120 residents in each of Ontario's 626 LTC homes (RNAO, 2016).

Throughout the COVID-19 crisis, RNAO has been relentless, calling attention to LTC problems related to policy neglect, and releasing several reports alongside calls to urgent action (RNAO 2020b; RNAO, 2020c; RNAO 2020e, RNAO 2020f)

The COVID-19 crisis both imposes an obligation and presents an opportunity to correct the long-standing history of underfunding and understaffing in Ontario's LTC system. We urge the government to rise to this challenge: it is time to grasp the opportunity to make the fundamental changes needed to ensure that the *Long-Term Care Homes Act* (the Act) lives up to the promise of its fundamental principle. RNAO advises that, while Bill 37 presents improvements to long-term care, it falls short of what needs to be done to provide homes for people with increasingly complex care needs. We urge our government to join us in having the ambition necessary to provide the fundamental changes needed for safe, dignified care of nursing home residents in this province.

RNAO's recommended amendments to Bill 37

In this submission, we will address the following elements of Bill 37:

- Schedule 1 (*Fixing Long-Term Care Act, 2021*)
- Schedule 3 (*Retirement Homes Act, 2021*)

RNAO urges the adoption of the following amendments to Bill 37:

Hours of Direct Nursing and Personal Care

1. Enshrine in legislation a guaranteed minimum of 4 worked hours of direct nursing and personal care per resident per day, rather than a targeted average.

Schedule 1 of Bill 37 currently provides: "*The target is for an average of four hours of direct care to be provided per resident per day* (at subsection 8(2))."

All long-term care residents in Ontario require a **minimum** of four worked hours of direct nursing and personal care per day to meet the fundamental principle of the Act – a commitment to meeting the needs of residents (Armstrong et al., 2020; Feuerberg, 2001; Ontario, 2017; RNAO, 2020c; Sharkey, 2008). A "targeted average" does not guarantee this minimum standard of care for all residents. As outlined in the Ontario government's own Long-Term Care COVID-19 Commission Report (2021), *"The presentation*

of staffing data as an average is misleading; the danger lies in the extremes, where insufficient care is being provided."

In RNAO's Submission to the Long-Term Care Staffing Study Advisory Group, we cautioned that four hours of nursing and personal care is a minimum standard based on research that is decades old, when resident acuity was lower (RNAO, 2020c). According to Armstrong et al. (2020) the four-hour estimate grows more conservative over time as resident acuity rises. Evidence points to rising acuity levels in long-term care. For example, the percentage of long-term care residents with heart disease and dementia has increased by 14.3 per cent and 12.5 per cent, respectively, since 2009 (Office of the Auditor General of Ontario, 2021). And the provincial case mix index (CMI) score for LTC residents has increased by 20 per cent since 2004 (Long-Term Care Staffing Study Advisory Group, 2020).

Rising acuity, associated in part with demographic trends and an insufficient number of LTC beds, results in a LTC resident population with increasingly complex care needs. For example, the *Auditor General Special Report on Pandemic Readiness and Response in Long-Term Care* (2021) identified that over 85 per cent of long-term care residents require extensive or 24/7 daily assistance, and that approximately one third of long-term care residents have severe cognitive impairments. These findings were corroborated by the Ontario Long-Term Care COVID-19 Commission (2021). Further, *The Auditor General Special Report on Pandemic Readiness and Response in Long-Term Care* (2021) indicated that as of March 31, 2020:

- 75.9 per cent of long-term care residents had heart disease;
- 63.2 per cent had dementia (including Alzheimer's disease);
- 28 per cent had diabetes;
- 18.3 per cent had lung diseases such as asthma and chronic obstructive pulmonary disease; and
- 9.7 per cent had cancer.

RNAO insists that the Nursing Home Basis Care Guarantee (NHBCG) of four worked hours of direct clinical and personal support care – and the skill mix outlined in the NHBCG and in Commissioner Marrocco's (2021) recommendations (44, 46, 24a,) – be enshrined in Bill 37 as a minimum standard to ensure residents' safety and quality:

Staff	RNAO recommended skill mix	Current estimated skill mix as per Auditor General report (2021)
RNs	20%	11%
RPNs	25%	20%
PSWs	55%	69%

To realize the fundamental principle of the Act, staffing and care levels provided to LTC residents must correspond to the care needs of the resident population. This has not been true in decades. The promise in Bill 37 of a targeted average of four hours and the lack of specific skill mix parameters fails to recognize the amount of care needed to ensure that Ontario's nursing homes are places where residents "may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met." In this, Bill 37 falls woefully short of the principle it commits to.

Staffing and Skill Mix

2. Mandate and enshrine the following staffing and skill mix standards in legislation (Marrocco et al., 2021; RNAO, 2020c):

a) Guaranteed minimum of 4 worked hours of direct nursing and personal care per LTC resident per day as outlined in this table:

Role	Skill mix of care per day	Worked hours of care per day
Registered nurse (RN)	Minimum of 20%	0.8 per resident
Registered practical nurse (RPN)	Minimum of 25%	1.0 per resident
Personal support worker (PSW)	Maximum of 55%	2.2 per resident

b) One nurse practitioner (NP) per 120 LTC residents.

c) One Infection Prevention and Control RN per 120 LTC residents.

d) An average of one hour of care per day per resident from allied health professionals

The acuity profile of the LTC resident population, as described above, demands both more care than Bill 37 currently promises, and the right skill mix essential to adequately meet LTC residents' needs (RNAO, 2020c).

The bulk of nursing and personal care in Ontario's nursing homes is provided by three types of staff: PSWs), RPNs, and RNs. PSWs generally study a 28-week program at one of Ontario's Colleges of Applied Arts and Technology. PSWs support the activities of daily living and, in collaboration with regulated nursing staff, observe and report on residents' behaviours and conditions. To ensure residents' safety. Peace of mind for families, and PSW retention -- it is essential for PSWs to have ready access to regulated nursing staff -- so that their observations can be reported, assessed and needed interventions acted in a timely manner.

Regulated nursing staff are most easily distinguished by their education. RPNs have a two-year college diploma while RNs have a four-year baccalaureate preparation.

The College of Nurses of Ontario (CNO) determines scope of practice for RNs and RPNs, using a three-factor framework (client, nurse and environment). The level of autonomous practice of RNs differs from that of RPNs. The complexity of a client's condition and the predictability of their outcomes influences the nursing knowledge required to provide the level of care the resident needs. A more complex resident in a nursing home, necessitates at the very least consultation with and/or direct care provision by an RN. In a LTC setting, while RNs and RPNs play full roles in all dimensions of practice, RNs must lead care provision and provide complex care to LTC residents and their families – this is seldom the case today.

NPs, also known as registered nurses in the extended class (RN-EC), have met additional education, experience and examination requirements set out by the College of Nurses of Ontario (CNO). NPs are

authorized to diagnose, order and interpret diagnostic tests, and prescribe medication and other treatments. NPs in Ontario also currently have an untapped potential as attending NPs in LTC (RNAO, 2018c). NPs in the attending role assume responsibility for the management and coordination of resident care as Most responsible Providers (MRP), and also advance health promotion, management of chronic conditions, and the early detection and treatment of medical complications (MOHLTC, 2017; RNAO, 2018c). The presence of NPs in LTC homes allows for point of care staff education, resident assessment and rapid clinical decision-making that maximize care quality and avert complications that end in unnecessary transfers of residents to emergency departments (ED). Such transfers are costly in human and financial terms (RNAO, 2016; RNAO, 2020c). NPs also provide a supportive, mentoring environment for other staff, enhancing all staff's ability to work at full scope, and advance staff retention (RNAO, 2021d). Overall, homes with NPs have: decreased unnecessary transfers to Emergency Departments; implemented best practices; and created a holistic, end-of-life care culture (RNAO, 2021s). The increasing acuity of residents in long-term care, presentation of complex problems and need for regular review of interventions, medications and referrals clearly supports the need for a readily available NP in LTC homes.

As highlighted earlier on this submission (see chart on page 9), the existing skill mix of nursing and personal care fails to meet the promise of the Act in light of resident acuity levels. Specifically, current levels of regulated nursing staff are dangerously low. This is especially the case for RN staffing. The Auditor General Report (2021) suggests that PSWs currently make up 69 per cent of the total long-term care staffing in Ontario, while RPNs account for 20 per cent, RNs account for 11 per cent, and NPs account for less than one per cent. Current regulations only require one RN on-site per shift. Once the single RN on the shift completes the LTC home administrative, management, and specific required clinical decision-making, there is often little or no time to directly attend to complex patients and follow up with and receive feedback from PSWs and RPNs.

Compounding these deficiencies is the fact that funding presently exists for only 75 attending NPs for Ontario's 626 nursing homes. RNAO is delighted with the recent announcement of another 225 attending NPs over the next three years, and continues to ask that the government increases the funding to ensure 100 NPs are hired each year and commits to meet the requirement of one (1) NP per 120 residents required to adequately meet resident needs (Marrocco et al., 2021; RNAO, 2016; RNAO, 2020c).

In addition, one registered staff (RN or RPN) from this already stretched resource is often placed in the infection control and quality improvement role. Because of competing demands on registered staff—keeping abreast of the myriad of requests from residents, families and other professional team members, and tending to clinical care needs and treatments—infection control and quality improvement roles can fall by the wayside until there is an outbreak and it is then too late. Although there is a commitment in Bill 37 to ensure that every home have "*an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program*", we urge that section 23(5) be amended to indicate that the infection prevention and control lead must be a licensed RN. Bill 37 should also be amended to reflect RNAO's recommendation that there should be a minimum of one Infection Prevention and Control RN per 120 LTC residents, a recommendation also adopted by the Ontario Long-Term Care COVID-19 Commission (2021).

Lastly, we argue that section 9(2) of Bill 37 should be amended to reflect a targeted average of **one hour** of direct care per resident per day from allied health professionals, rather than 36 minutes (Marrocco et al., 2021).

The above changes reflect RNAO's Staffing Vision for long-term care (RNAO, 2020c). RNAO recommends, based on a guaranteed minimum of four worked hours of direct nursing and personal care per resident, per day:

- **PSWs** should provide at least 2.2 worked hours of direct supportive care to each resident on a daily basis. They provide the majority of direct care to residents needing support with activities of

daily living. In doing so they have regular contact with registered staff that follow up on PSW observations, provide oversight of their personal care, and give direct nursing care as required.

- **RPNs** should provide at least one worked hour of direct care per resident per day focusing on working closely with PSWs and RNs administering treatments, medications and following up on expected outcomes and any related challenges. The RPN cares for and regularly monitors stable residents with physical and mental health needs including those with dementia, those requiring monitoring for cardiac conditions, diabetes, bowel and bladder issues, wound care, or hypertension. There is time to conduct regular planned rounds throughout the shift to address issues as they arise, and interact with residents and families.
- **RNs** should provide at least 0.8 worked hours of direct care per resident per day, to follow up on observations made by PSW staff, work collaboratively with RPNs, and members of the interprofessional team, and complete full assessments of residents as needed—to detect infection or any change in overall health status that requires NP follow up. RN staff members are available to monitor or, in specific cases, provide direct care to those residents with more complex clinical, behavioural support and mental health needs, and make decisions related to referrals, follow up and in some cases to transfer to hospital as necessary. The RN staff complement also supports a quality resident admission process including introduction to the facility, a comprehensive assessment and establishment and maintenance of a person-centred care plan, relationship building with the new resident and their family, and full documentation.
- An **NP,** for every 120 residents, in an Attending role or as Director of Clinical Care, to facilitate a smooth work flow, enabling treatments, referrals, and/or medications to be ordered, changed or discontinued based on resident need. NPs also provide expert clinical and gerontology knowledge and skill, and enable in-depth evaluative programmes, enhancing the level of care.
- A full time **IPAC RN** for every 120 residents, to make sure that protocols for preventing and managing infections are up to date and implemented. Regular audits, adherence to best practice

and proactive prevention of outbreaks is crucial to ensure a safe home for residents, staff and visitors.

- **Allied health professionals** should provide at least 1 worked hour of care per resident per day, including physiotherapy, speech therapy, dietary, dental/oral care providers and others. They should be available to meet the numerous specialized needs of residents, on referral from RNs and RPNs.

Quality Care and Continuous Quality Improvement

3. Urge long-term care homes to use RNAO's LTC Best Practices Program as a resource for the purpose of implementing continuous quality improvement initiatives.

RNAO's LTC Best Practices Program is a valuable and extensively used resource that enables LTC homes across Ontario and LTC BPSOs to provide quality care for their residents. The LTC Best Practices Coordinator role was introduced to the sector as a pilot project funded by government in 2005. Many successes in LTC homes have been achieved through this project, including improved quality of care for residents, and the implementation of best practice guidelines (BPGs).

In April 2008, the Ontario Ministry of Health and Long-Term Care's Performance Improvement and Compliance Branch requested RNAO to lead the program given our proven success in delivering in time and in outcomes. This program supports LTC homes in adopting evidence-based practices that support systematic and consistent approaches to providing quality care for residents.

Benefits of the LTC Best Practices Program include:

- enhanced capacity for knowledge transfer
- improved quality of care and resident outcomes
- support for leaders, nurses and staff in LTC homes in implementing BPGs
- improved quality of work life

While the program is not mandatory, it provides an important opportunity for LTC homes to access expertise in implementing evidence-based practices to enhance resident care. Thus, LTC homes should be urged to use RNAO's LTC Best Practices Program as a resource to ensure rapid learning and continuous quality improvement.

4. Establish an LTC Quality Centre that showcases the outstanding work of RNAO, Advantage Ontario, OLTCA, and others engaged in evidence-based person centre care.

RNAO celebrates the establishment of a Long-Term Care Quality Centre as provided for in Bill 37; and offers to lead this initiative in partnership with AdvantAge Ontario, the Ontario Long Term Care Association, the National Institute on Ageing, Ontario Centres for Research and Innovation in Long-Term Care and other government-funded organizations engaged in evidence-based person centre care. RNAO is uniquely positioned given our track record of long-lasting expertise and results since 1998, leading the BPG Program and its BPSO knowledge movement. RNAO's program includes a specific focus on LTC, working with both the not-for-profit and the for-profit sectors.

5. Mandate all long-term care homes to track, measure, and publicly report on key performance indicators, to evaluate and demonstrate improvements in LTC settings, including those relating to:

- **Quality of care**
- **Resident/family satisfaction**
- **Infection prevention and control**
- **Human resources**
- **Resident Bill of Rights**

In order to show its commitment to the fundamental principle of the Act, the government should track, measure and publicly report performance indicators in several areas to evaluate and demonstrate quality of care in LTC settings, including:

- **Quality of care indicators:** Fund and implement the RNAO-PointClickCare proposal Building Capacity and Achieving Excellence in Long-Term Care to embed RNAO's BPG in electronic medical records, thus standardizing care, measuring outcomes consistently, and optimizing residents care experiences and outcomes -- in all long-term care homes (RNAO, 2020a). The clinical pathways included in this digital health solution are evidence-based and provide key performance indicators for each of the required clinical programs that the government can track in real time. The proposal has already been piloted and is fully supported by OLTCA and Advantage Ontario (Levin, 2020).

- **Resident/family satisfaction indicators:** Standardize the Resident/Family Satisfaction Survey used in LTC homes. A standardized assessment of key indicators will provide insights into quality of care from resident and family perspectives.

- **Infection prevention and control indicators:** Develop key performance indicators on infection prevention and control that can be publicly reported, in collaboration with Public Health Ontario, such as number and causative agent of outbreaks, reports from IPAC inspections, and infection rates.

- **Human resource indicators:** Develop monitor and publicly report on human resource indicators to monitor staffing ratios and turnover in key positions: Nursing, PSWs, Executive Directors and Administrators, Directors of Care, and Infection Control Leads. These indicators are also needed to monitor staffing ratios, hours of care per resident per day, skill mix, and provider experiences.

- **Bill of Rights indicators:** Develop indicators to monitor licensees' adherence to ensuring rights of residents are respected and promoted, consistent with the Residents' Bill of Rights. This must include indicators related to the provision of culturally-safe care in LTC homes.

Further, Bill 37 should also impose upon government the obligation to:

- establish provincial targets for all reportable performance indicators

- establish a publicly available report card with real-time information about a home's performance indicators and inspections

Bill 37 should also require nursing homes to:

- share their report card with each placement applicant and essential caregivers.
- participate in the provincially-funded RNAO LTC Best Practices Program to develop and implement evidence-based quality improvement plans, if they fail to meet provincial targets (2018b).

Funding

6. Change the funding formula to account for complexity of residents and quality outcomes. The current formula based solely on CMI acts as a financial disincentive to improve resident care and outcomes.

The absence of any changes to the Act related to the funding model is a missed opportunity to improve care for residents. RNAO has cautioned for years that the current funding formula acts as a financial disincentive to improve resident (RNAO, 2018a; RNAO, 2018b; RNAO, 2018c; RNAO 2020d; RNAO 2021a). Moreover, the current funding model relies on retrospective case mix index (CMI) data, which does not account for the rapidly changing acuity of long-term care residents.

The Ontario Long-Term Care Staffing Study (2020) indicated that the current funding model for LTC settings "may inadvertently provide disincentives to homes from doing the best work they can". Moreover, reports from The Long-Term Care Homes Public Inquiry (2019) and the Ontario Long-Term Care COVID-19 Commission (2021) both recommended that the Ministry of Long-Term Care should "encourage, recognize, and financially reward long-term care homes that have demonstrated improvements in the wellness and quality of life of their residents."

To make improvements, the LTC funding formula must be amended. It should be based on:

- Both the complexity of resident care needs and quality outcomes. As such, LTC homes that decrease CMI due to evidence-based care should be able to retain all funding to reinvest in staffing and programs for residents, rather than facing a financial penalty (RNAO, 2018a; RNAO, 2018b; RNAO, 2018c; RNAO 2020d; RNAO 2021a).
- Current resident acuity and care needs, rather than using retrospective data that does not account for the rapidly changing acuity profile of long-term care residents (RNAO 2018b).

Not-for-Profit Care

7. Provide a first right of refusal to non-profit homes for developments, and provide supports for them to succeed in expansions.

We are concerned about the following language in the preamble:

"Are committed to the promotion of the delivery of long-term care home services by not-for-profit and ***mission-driven organizations*** [emphasis added]*"*

The addition of "mission-driven organizations" to this clause continues an unfortunate and inadvisable shift to for-profit LTC in Ontario. Ontario currently has the highest proportion of for-profit LTC homes in Canada, with 57 per cent of homes being for-profit (Canadian Institute for Health Information, 2021). Moreover, it is noteworthy that out of 220 new long-term care facilities being built in Ontario, 140 of these (64 per cent) are for-profit (AdvantAge Ontario, 2021). The government's commitment to creating 15,000 new LTC beds and upgrading 15,000 LTC beds is a promising start, but RNAO is concerned about the trend towards new for-profit LTC beds. Compared to non-profit LTC homes, for-profit homes have been associated with higher rates of resident hospitalization and mortality, inferior staffing levels, lower quality of care, and increased COVID-19 related outbreaks and deaths (Amirkhanyan et al., 2008; Chown Oved et al., 2020; Comondore et al., 2009; Grabowski et al., 2013; Grabowski et al., 2016; Harrington et al., 2012; Marrocco et al., 2021; McGregor et al., 2005; Office of the Auditor General of

Ontario, 2021; Pue et al., 2020; Stall et al., 2020; Stall et al., 2021; Tanuseputro et al., 2015; Tubb et al., 2020).

The government should commit in Bill 37 to reducing and eventually phasing out for-profit long-term care homes across Ontario. As a start, Bill 37 should stipulate that all new LTC beds be developed by not-for-profit providers, including municipalities, or that these be at least be given fist right of refusal.

In support of a shift to not-for-profit provision of long-term care, Bill 37 should relieve not-for-profit LTC providers of their unique challenges to new bed development. RNAO recommends that the government, in concert with Infrastructure Ontario, implement the following measures to facilitate not-for-profit development of LTC bed capacity:

- Work with the federal government to ensure that viable not-for-profit projects are able to receive necessary infrastructure funding and mortgage or lending arrangements on sustainable terms, whether or not the proponents have capital reserves.

- Ensure that construction funding subsidies and the development grants offered to not-for-profits are sufficient to meet expenses at current market rates. Funding must also be sufficient to provide for necessary consulting expertise. Funding has been a challenge for many not-for-profit providers.

- Work with relevant levels of government to streamline and expedite the approval process to create new and redeveloped LTC beds, especially in not-for-profit and municipal homes (Marrocco et al., 2021).

Inspections, Enforcement and Licensing

8. Implement measures to improve inspection processes, and mandate in legislation a requirement that every LTC home be subject to an annual comprehensive Resident Quality Inspection (RQI).

Despite the well-established importance of annual RQIs, Bill 37 does not specify what type of inspection must be done. Nor does it require that all aspects of operations in each home be annually inspected (AG

report, 2021). It should. The Auditor General Report (2021) and the Ontario's Long-Term Care COVID-19 Commission report (2021) both found that the government decision in 2018 to discontinue proactive inspections of LTC homes was a significant mistake that led to oversights related to non-compliance of homes. A robust LTC inspection regime must include mandatory annual comprehensive RQIs for every home, in addition to targeted inspections related to complaints and critical incidences (Marrocco et al., 2021; Office of the Auditor General of Ontario, 2021).

The Ministry must therefore:

- Ensure annual comprehensive Resident Quality Inspections (RQI) are mandated in legislation. These inspections need to be unannounced and performed once a year in every Ontario LTC home, without compromising inspections triggered by Critical Incident reports and complaints relating to high-risk incidents.
- Improve inspection processes by:
    - Ensuring that inspection reports recognize areas of compliance as well as areas of non-compliance. Reports of compliance will positively impact the morale of staff and recognize the efforts of compliant homes (RNAO, 2018b).
    - Ensuring that inspection reports recognize and publicly report areas of strength and best practices in a home's performance so to motivate homes and staff, and encourage the sharing of best practices amongst homes.
    - Ensuring that follow-up inspections are completed when non-compliance is identified, to verify that remediation occurs.
    - Ensuring current compliance and enforcement data, such as inspection reports, enforcement/remediation status. This will also require addressing other matters related to legislative and regulatory compliance, including staffing mix and ratios, and making the data available, easily understandable, and transparent to the public.

- Providing consistent mandatory training and clear direction on when and how inspectors should direct LTC homes to consult best practice resources (2018b).

9. Impose a higher standard of accountability and compliance on homes with chronic compliance issues, including escalating stringency of responses to non-compliance and stronger enforcement of licence revocation/transfer.

The 2021 Auditor General Report on Pandemic Readiness and Response in Long-Term Care found "the Ministry's handling of repeated non-compliance by home operators to be weak". The Auditor General further noted that the LTC homes found to be non-compliant with legislative requirements during their 2015 audit of the Ministry's inspection program continued to be non-compliant in their 2020 follow-up audit. Moreover, the Ministry has only revoked the licences of two long-term care homes since 2010, despite several LTC homes having repeated non-compliance issues (Office of the Auditor General of Ontario, 2021).

The Auditor General's recommendations for the Ministry in 2015, six years ago, were:

- that the Ministry strengthen its enforcement processes to promptly address repeated non-compliance, including determining when to escalate to stronger levels of enforcement actions and
- that the Ministry evaluate the use of other enforcement measures, such as issuing fines or penalties to homes

RNAO supports these recommendations. RNAO also supports the Ontario Long-Term Care COVID-19 Commission's (2021) recommendation that the enforcement regime include:

> *"proportionate and escalating consequences for non-compliance. Repeated findings of non-compliance must be met with consequences of increasing severity up to and including measures such as mandatory management orders and the transfer of the long-term care home owner's operating licence"*

RNAO urges that Bill 37 impose a higher standard of accountability and compliance on homes with chronic compliance issues up to and including license revocation or transfer as warranted.

Culturally Safe Care

10. Update the Bill of Rights to require that all licensees implement measures related to:

- **Respecting sexually and gender diverse communities in long-term care**
- **Providing culturally safe and linguistically appropriate care options in long-term care**

RNAO agrees with the Ontario LTC COVID-19 Commission's (2021) statement that:

> ***"****long-term care home licensees should be required to:*
>
> *a. Recognize and respect 2S-LGBTQ+ spousal relationships and chosen/non-biological family relationships generally and in any rules or policies regarding visitation and the provision of essential care to 2S-LGBTQ+ residents; and*
>
> *b. Ensure that residents are provided with culturally and linguistically specific care, including but not limited to traditional foods; activities and opportunities for socializing in the resident's first language; culturally specific activities; observation of holidays; and religious and spiritual practices and services."*

A key example of the failure of Bill 37 to meet the fundamental principle of the Act: its failure to include detailed language in the Residents' Bill of Rights related to:

- respecting sexually and gender diverse communities
- providing culturally and linguistically appropriate care options

All LTC residents require access to culturally-safe care, to ensure that their physical, psychological, social, spiritual and cultural needs are adequately met. A residence that is not culturally safe cannot be considered a home.

To achieve the above, LTC homes should:

- ensure that residents regardless of their gender identity, gender expression and sexual orientation are able to live in a long-term care home free of any kind of stigmatization, discrimination and social exclusion (RNAO, 2021b&c);
- implement two RNAO best practice guidelines (BPGs): "Person-and Family-Centred Care" (2015) and "Promoting 2SLGBTQI+ Health Equity" (2021c);
- ensure that all staff, residents and chosen family are provided education about the Resident Bill of Rights including specific content related to person and chosen family-centred care and respecting sexually and gender diverse communities in long-term care;
- be encouraged to create cultural units, floors or entire long-term care homes dedicated to specific cultural groups (which should provide residents with cultural meal options, care provision in their own language, cultural and linguistic programs, and translation services/translated materials) (Cragg et al., 2017a) and;
- promote the development and implementation of LTC models to support Indigenous communities, which must be Indigenous led (including cultural units/floors/homes, and supporting cultural practices to achieve spiritual, mental, physical, and emotional well-being) (Cragg et al, 2017b).

Retirement Homes

11. Transfer the regulatory oversight of retirement homes from the Retirement Homes Regulatory Authority to the Ministry of Long-Term Care.

Retirement homes should be operated under the same fundamental principle as LTC homes; they should be seen as a home for people with complex health-care needs that need to be met. Although resident profiles in retirement homes might show lower acuity levels overall, acuity levels of retirement homes residents are nevertheless high enough to demand similar legislative requirements and resident protections.

The Auditor General's *Report on Retirement Homes* (2020) highlighted the increasingly complex health profiles of retirement home residents. In 2019/2020, 26 per cent of retirement home residents were on the waiting list for a LTC bed, 4,201 patients designated as alternate level of care were discharged from hospitals to retirement homes, and 52 per cent of all retirement home residents received ongoing home-care services (Office of the Auditor General of Ontario, 2020). With the population in retirement homes increasingly in need of acute care, a stronger accountability and regulatory framework is paramount.

Moreover, the Auditor General's 2020 Value-for-Money Audit of the Retirement Homes Regulatory Authority identified long-standing concerns in the retirement home sector, specifically: significant oversight gaps and issues; increasing resident acuity and needs; resident care and staffing issues; data collection; sharing of information; inspections; licensing; complaints; fees; enforcement; and COVID-19 related issues.

The proposed amendments to the *Retirement Homes Act, 2010* miss the mark. The issues identified by the Auditor General are grave, reflect longstanding deficiencies in the existing regulatory regime, and call for the adoption of a fundamentally different way of regulating Ontario's retirement homes. Specifically, the proposed changes:

- fail to provide any meaningful response to the increasing acuity profiles and care needs of residents, or to protect these vulnerable residents
- fail to provide any meaningful response to staffing issues in the retirement homes sector
- fail to provide any meaningful improvements to ongoing accountability, enforcement and complaints processes in the sector

In light of the rising acuity profiles and consequent vulnerability of retirement home residents, the self-regulating Retirement Homes Authority is not the appropriate body to oversee retirement homes, and oversight should be shifted to the Ministry.

Conclusion

We cannot ever lose sight of the catastrophic failure of our long-term care sector under the COVID-19 pandemic. Moreover, it would be a calamity for government to pass legislation that does not fully account for and correct past and present failings. Those failings came at the cost of lives: 4,000 nursing home residents and ten nursing home staff. Our experience under this pandemic -- which is not yet over -- cries out for more fundamental change than that proposed in Bill 37.

The fundamental principle of the *Long-Term Care Homes Act* is a decent one but it needs to change to reflect the changing, increasing care needs of the resident population of nursing homes across this province. If government takes to heart that principle and makes it real, RNAO's proposed amendments will find their way into Bill 37.

Our recommended changes to the bill, if implemented, will bring about fundamental change to Ontario's nursing homes, and the future for residents, families and staff will be brighter. We call for more staff and the right kind of staff. We call for preferencing not-for-profit care going forward. We call for the implementation of best practices and quality care. We call for dignity and safety for all residents of Ontario's nursing home, peace of mind for families, and a place where staff want to build their careers. And, we call for extending the fundamental principle of the Act, and our care and concern, to the residents of Ontario's retirement homes. They and their loved ones also have a right to safe care, dignity, and having their needs adequately met. Their residence, too, ought to be their home.

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