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

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

Part 2 of the Draft Regulation under the Long-Term Care Homes Act, 2007

October 15, 2009

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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 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 per long-term care home or 200 to 300 residents, 20 per cent registered nurses, 25 per cent registered practical nurses and 55 per cent personal support workers, supported by adequate funding.**

3. **Add "continuity of care-giver" in addition to continuity of care in s.18 of the draft regulation.**

4. **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 care-giver and positive outcomes for long-term care home residents.**

5. **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.**

6. **Amend s.32 of the draft regulation to clarify that "emergencies or exceptional circumstances" does not include budget pressures, whether of a foreseeable nature or not.**

7. **RNAO strongly urges the Ministry of Health and Long-Term Care to amend s.43 of the draft regulation to require a daily minimum of 0.5 hours of activation and recreational programs that promote socialization, engagement in social activities, and mental and physical stimulation for residents of long-term care homes.**

8. **RNAO strongly recommends to the government that if the Alternate Level of Care (ALC) strategy is to succeed, adequate funding must be available to support Aging-at-Home and the availability of age-appropriate care from home and community care, long-term care and hospital care.**

9. **The regulation should recognize the need of applicants for short-stay and long-stay beds 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.**

10. **Define "staff who provide direct care" for the purpose of required training and target training to the needs of the particular direct care provider using adult education principles. Training should be ongoing, not limited to once a year, and be based on best evidence and practice such as RNAO's Best Practice Guidelines.**

11. **Set a maximum allowable temperature for long-term care homes in addition to the current minimum temperature.**

12. **Amend s.184(1)(c) to require the resident to have made "reasonable efforts" to exhaust support payments due and owing to the resident under a court order for support.**

13. **In the interest of resident safety the RNAO recommends that the term "retirement home" in section 192(d) of the draft regulations be deleted or clearly defined.**

14. **Provide a right of first refusal for not-for-profit homes in any transfer of a long-term care home licence.**

15. **Ensure that any competitive process should not disadvantage the establishment of non-profit homes or reduce the number or share of not-for-profit beds in Ontario.**

16. **RNAO urges that both terms Registered Nurse (Extended Class) and Nurse Practitioner be used together in the draft regulation to ensure consistency and avoid confusion.**

17. **Amend s.161(1)(b) to include a registered nurse in the extended class (RN(EC)).**

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

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October 15, 2009

Dear Minister,

Thank you for the opportunity to respond to Part 2 of 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 protect the rights of long-term care residents. While ambitious, the Act sought to give effect to the important principle, articulated in section 1, that long-term care accommodations are the residents' homes and must be operated so that residents may live with dignity and in security, safety and comfort, and have their physical, psychological, social, spiritual and cultural needs adequately met.[2]

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 were not alleviated by release of Part 1 of the initial draft regulation,[3] nor are they addressed by Part 2.

Most notably, the initial draft regulation represents an intersection of the key government priorities in health care, including the wait times strategy, the Alternate Level of Care (ALC) strategy and the Aging-at-Home strategy. This potential strength can also be a major weakness, particularly during times of government budget-cutting.

The RNAO strongly urges you not to allow the various strategies to operate as silos. Funding decisions need to recognize the primacy of individuals receiving care and services in the most appropriate setting for them and promote aging in place with quality of life. Adequate funding for the government's Aging-at-Home strategy to ensure the availability of high-quality age-appropriate care must be in place if the ALC strategy – including implementation of the long and interim short-stay programs in the draft regulation – is to succeed.

As RNAO recommended in our response to Part 1 of the proposed initial draft regulation, we urge the government not to rush to finalize the regulations. Rather, we suggest that the government wait for 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 working 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,

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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 Part 2 of the Initial Draft Regulation under the *Long-Term Care Homes Act, 2007*.[4]

Background

On June 5, 2009, the RNAO responded in writing to Part 1 of the Initial Draft Regulation under the *Long-Term Care Homes Act, 2007*. Part 1 included provisions related to care plans, abuse and neglect, restraints and admissions. RNAO's detailed response to Part 1 can be found at:

http://www.rnao.org/Page.asp?PageID=122&ContentID=2943&SiteNodeID=390&BL_ExpandID=.

Part 2 of the Initial Draft Regulation covers residents' rights, care and services; admission of residents; councils; operation of homes; funding; licensing; municipal homes and First Nations homes; compliance and enforcement; and, administration. This corresponds with the content of Parts IV to X of the Act and significant sections of Parts II and III. Once all the regulations have been consulted on and approved by Cabinet, the *Long-Term Care Homes Act, 2007* itself will be proclaimed in force.

In the context of a growing and aging population with residents of long-term care homes having more complex care needs, RNAO has consistently argued that long-term care reform must occur within an overall seniors' strategy focused on aging in place. Long-term care home regulations must represent an integral part of health care transformation focusing on health promotion and quality of life.[5] [6]RNAO endorses the five principles of the National Framework on Aging to guide all policy development in this area: dignity, independence, participation, fairness and security[7].

For this reason, nurses applauded the introduction of the *Long-Term Care Homes Act, 2007* with its articulation of the fundamental principle that long-term care accommodations are the residents' homes and must be operated so that residents may live with dignity and in security, safety and comfort, and have their physical, psychological, social, spiritual and cultural needs adequately met.[8]

However, RNAO has stated consistently and firmly that patient care would be compromised if the Act and regulations do 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 both Parts 1 and 2 of the draft regulation completely omit 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,[9] the

regulation must clearly specify the minimum number of hours of nursing and personal care to which every resident is entitled.

A. Residents Rights, Care and Services

a. Nursing and Personal Care Services

Section 18 of the draft regulation elaborates on the requirement in ss.8(1)(a) and (b) that a licensed home must ensure that there is an organized program of nursing services and an organized program of personal support services for the home to meet the assessed needs of residents. A written staffing plan is required to provide for a staffing mix "consistent with residents' assessed care and safety needs", set out staff shift schedules and promote continuity of care. Section 19 adds that each resident is entitled to receive individualized personal care, including hygiene care and grooming "on a daily basis".

However, both the Act and draft regulation are silent on the minimum care standard or the minimum level of personal and nursing care that each resident should receive.

With the needs of long-term care home residents becoming more complex, increasing in acuity by 29.7 per cent from 1992 to 2007,[10] 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.[11] 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,[12] and the 3.5 hours per day that the Ontario Health Coalition,[13] RNAO,[14] and Ontario Nurses Association[15] 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.[16] 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.

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.

With respect to the mix of care providers referred to in s.18 of the draft regulation, 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.[17] 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. Specifically, RNs are assigned the total nursing care for residents with complex needs and unpredictable outcomes and RPNs are responsible for the total nursing care for residents with stable needs and predictable outcomes. 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.[18] [19]

Utilizing nurse practitioners to provide primary care to residents and leadership to nursing staff has been demonstrated to improve access to care for residents[20], enhance quality of care for residents[21], prevent hospital admissions[22], and provide a role model for nurses in assessment skills and problem-solving medical issues.[23] The success of the Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project[24] [25] showed the potential positive outcomes for residents, staff and the health care system of nurse practitioners in the long-term care sector. While extrapolation from the pilot project is difficult, key informants suggested the ratio of NPs to facility should be 1:1 or one NP for every 200 to 300 residents.[26]In addition, advanced practice nurses engaged as clinical nurse specialists have been demonstrated to improve resident outcomes in nursing homes.[27] [28]

Given the available evidence and staffing standards in other jurisdictions,[29] RNAO recommends a staff mix established by regulation of: one nurse practitioner for every 200 to 300 residents or long-term care home, 20 per cent registered nurses, 25 per cent registered practical nurses and 55 per cent personal support workers.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.

Recommendation: 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 per long-term care home or 200 to 300 residents, 20 per cent registered nurses, 25 per cent registered practical nurses and 55 per cent personal support workers, supported by adequate funding.

Section 18 (3)(c) requires the staffing plan to promote continuity of care and accomplish this by "minimizing the number of different staff members who provide nursing and personal support services to each resident." As written, the draft regulation correctly is prescribing continuity of care-giver as well as continuity of care and this is an important clarification that should be added to the subsection. 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 were often not familiar with individual needs and routines.[30] 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.[31] [32] [33] [34]

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: Add "continuity of care-giver" in addition to continuity of care in s.18 of the draft regulation.

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 care-giver 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.

b. 24-Hour Nursing Care

When the government enshrined 24-hour RN-provided nursing care in the *Long-Term Care Homes Act, 2007*, the RNAO publicly applauded this key resident-safety measure.[35]Section 8(3) of the Act states:

> 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.

Section 32 of the draft regulation sets out the exceptions to the rule that there must be at least one full-time staff RN on duty and present 24 hours a day seven days a week. For homes with 64 beds or fewer, the regulation would permit a contract RN, or an

agency RN if a staff RN is available by telephone, or, in the case of "emergencies or exceptional and unforeseen circumstances", a staff RPN if a staff RN is available by telephone. For homes with between 64 and 129 beds, a contract RN if a full-time RN is on a planned or extended leave of absence, or a contract or agency RN in the case of "emergencies or exceptional and unforeseen circumstances" if a staff RN is available by phone or and a staff RPN is on duty. There is no definition of the exceptional and unforeseen circumstances that would justify the numerous long-term care homes in communities across the province relying on agency RNs and RPNs with no staff RN on duty. While there undoubtedly are circumstances such as "acts of God" or illness that would justify a departure from the necessity of having 24-hour coverage by at least one staff RN, there is nothing in the draft regulation that would prevent diluting RN staffing levels for budgetary or other reasons.

Recommendation: Amend s.32 of the draft regulation to clarify that "emergencies or exceptional circumstances" does not include budget pressures, whether of a foreseeable nature or not.

c. Recreational and Social Activities

Section 10 of the *Long-Term Care Home Act* requires every licensee to provide an organized program of recreational and social activities to meet the interests of residents[36]. According to the draft regulation, s.43(2), this program must include the provision of supplies and appropriate equipment, a range of indoor and outdoor activities during days, evenings and weekends, and opportunities for resident and family input into the development and scheduling of activities. Sections 44 and 45 set out the requisite qualifications for staff members providing recreational and social activities services, including the designated lead of the program.

However, the draft regulation is silent on standards and outcome measures for organized recreational and social activities, a significant omission considering the potential of the program to promote socialization, engagement in social activities, and provide mental and physical stimulation for residents. It is essential that a daily minimum of 0.5 hours of activation and recreational programs be prescribed.

Recommendation: RNAO strongly urges the Ministry of Health and Long-Term Care to amend s.43 of the draft regulation to require a daily minimum of 0.5 hours of activation and recreational programs that promote socialization, engagement in social activities, and mental and physical stimulation for residents of long-term care homes.

B. Admission of Residents

Sections 91 to 100 of the draft regulation set out the proposed rules governing admission to the Interim Bed Short-Stay Program.

To be eligible for the interim bed short-stay program, an applicant must first meet the eligibility criteria in s.30 of Part 1 of the draft regulation. Under s. 30, 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.

Each licensee that has interim beds shall keep separate waiting lists for short and long-stay beds (s.92 of the draft regulation). Criteria for placement on the waiting list for short-stay beds include that the applicant occupies a bed in a hospital and is deemed to require "alternate level of care" and does not require acute care services from a hospital. In addition, the applicant must already be on at least one waiting list for admission to a long-stay bed in a long-term care home (s.94). Under s.95(2), an applicant is ranked for admission according to the time at which they applied for admission to an interim short-stay bed.

Alternate level of care (ALC) patients are defined by the Ministry of Health and Long-Term Care as "individuals in hospital beds who would be better cared for in an alternate setting, such as long-term care, rehab or home. Having more home care and community services enables ALC patients to leave hospital sooner, making more beds available to ER patients who are waiting to be admitted to hospital."[37] ALC, therefore, is defined more in terms of freeing ER beds than in ensuring the most appropriate health care for residents and patients.

With current pressure to reduce wait times by moving alternate level of care (ALC) patients out of hospitals and the system-wide drive to cut costs, there is a serious risk that residents who have acute care needs will be placed inappropriately in long-term care homes, particularly in interim, short-stay beds. It is crucial that access to long-term care, acute care and home and community care be designed with the needs of residents in mind, not budget imperatives and government policies operating as silos. Adequate funding for the government's Aging-at-Home strategy to ensure the availability of high-quality age-appropriate care must be in place if the ALC strategy – including implementation of the interim short-stay program in the draft regulation – is to succeed.

Recommendation: RNAO strongly recommends to the government that if the Alternate Level of Care (ALC) strategy is to succeed, adequate funding must be available to support Aging-at-Home and the availability of age-appropriate care from home and community care, long-term care and hospital care.

An additional concern relates directly to the Aging-at- Home strategy and the principle of enabling people to age in place with dignity, in their community, to the extent possible. There is no provision in either Part 1 or Part 2 of the draft regulation whereby an applicant's eligibility or ability to be placed on a waiting list for a short-stay or long-stay bed 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.37and 41 of Part 1, draft regulation) and the requirement of accepting a placement within five days of it being offered (s.42, Part 1 and s.99 of Part 2 of draft regulation), many people will be forced to move into long-term care homes far from their families and community support systems.

Recommendation: The regulation should recognize the need of applicants for short-stay and long-stay beds 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.

C. Operation of Homes

a. Training

Section 76(7) of the *Long-Term Care Homes Act, 2007*, lists those areas in which training is mandatory for staff who provide direct care to patients: abuse recognition and prevention; mental health issues including caring for persons with dementia; behaviour management; how to minimize the restraining of residents; palliative care; and other areas provided in the regulations.

Sections 114 to 119 of Part 2 of the draft regulation add the following subjects where training is required for all staff: annual training on cleaning and sanitizing equipment and one-time orientation on handling complaints, safe use of equipment, and cleaning equipment relevant to those staff's responsibilities. Staff who provide direct care to residents receive additional training at least once a year in such prescribed areas as falls prevention, skin and wound care, continence care and bowel management, pain management, responsive behaviours, correct use of therapeutic equipment and adaptive aids, and the use of physical devices to restrain residents and PASDs (s.118(1)). Section 118(3) states the overriding principle that staff who provide direct care should also be trained to "provide support and assistance to residents to promote independence".

Orientation for volunteers must include resident safety, emergency plans, wheelchair safety, escorting residents, mealtime assistance, communication techniques and techniques and approaches to respond to the needs of residents with responsive behaviours (s.119(2)).

While the lengthy list of areas for training in the Act and draft regulations is to be applauded as in the best interests of all residents, there is no definition of "direct care provider". Training should be targeted according to the needs of the direct care provider (e.g., PSW, RPN, RN and Allied Heath) using adult education principles. Training on clinical topics such as client-centred care, falls prevention, skin and wound care,

continence care and bowel management, pain management and responsive behaviours should not be limited to at least once a year. Rather, training on clinical topics should be ongoing and based on current evidence-based practice. RNAO, with funding from the Ministry of Health and Long-Term Care, has developed many best practice guidelines that are relevant to long-term care and are updated routinely. These best practice guidelines should be used and integrated in the ongoing education and orientation of long-term care staff.

The Long-Term Care Best Practices Initiative can also be used as a key resource to support Long-Term Care homes in developing the training and orientation programs outlined in the draft regulation.

Recommendation: Define "staff who provide direct care" for the purpose of required training and target training to the needs of the particular direct care provider using adult education principles. Training should be ongoing, not limited to once a year, and be based on best evidence and practice such as RNAO's Best Practice Guidelines.

b. Air Temperature

Section 127 of the draft regulation requires the minimum temperature of a long-term care home to be maintained at 22 degrees Celsius. However, it does not seem to prescribe a maximum temperature. Given that heat waves and the increasing numbers of smog days can be dangerous for many, particularly older people, it is curious that the regulations omit the need to set a maximum temperature for long-term care homes.

Recommendation: Set a maximum allowable temperature for long-term care homes in addition to the current minimum temperature.

D. Funding

Sections 176 to 190 of the draft regulation address allowable accommodation charges in licensed long-term care homes and the circumstances in which reductions can be claimed. A resident is ineligible to have the basic accommodation charge reduced unless the resident and any dependents have exhausted all benefits, entitlements or other financial assistance that may be available from government (s.184(1)(a)) or has made "reasonable efforts" to exhaust benefits to which the resident may be entitled from a foreign country (s.184(1)(b)). Section 184(1)(c) requires the resident to have exhausted all support payments "due and owing to the resident under a court order for support existing at the time of the application".

A resident may be able to obtain a court order for support payments owing, but that is no guarantee that those support payments will be paid. With at least one third of support orders in arrears[38], disqualifying a resident from obtaining a reduction in accommodation charges because of a support payment that is owed but not reasonably

recoverable punishes the recipient resident twice. As a resident who is owed benefits from a foreign country is required to make "reasonable efforts" in s.184(1)(b), a resident who is owed support payments should be expected to make similar "reasonable efforts" through Ontario's Family Responsibility Office (FRO).

Recommendation: Amend s.184(1)(c) to require the resident to have made "reasonable efforts" to exhaust support payments due and owing to the resident under a court order for support.

E. Licensing

Exemptions from the need to have a licence are listed in s.192 of Part VII of the draft regulations. These include a home for special care under the Homes for Special Care Act, a facility under the Developmental Services Act, a residential hospice where nursing care is funded through the Ministry, and "a retirement home". Unlike the initial three exempted premises, there is no definition of retirement home. While there are indications the government is developing legislation with respect to retirement homes, it is essential for the safety of residents that there be greater definition and protection in the meantime for retirement homes.

Recommendation: In the interest of resident safety the RNAO recommends that the term "retirement home" in section 192(d) of the draft regulations be deleted or clearly defined.

Section 105(9) of the *Long-Term Care Homes Act, 2007* contemplates the transfer of a licence from a non-profit entity to a for-profit entity, though it is limited to circumstances provided for in the regulations. Those circumstances are described in s.196 of the draft regulation. A non-profit long-term care home may transfer its licence or beds to a for-profit entity when the non-profit home is in default of a debt that is secured by a security interest held by the for-profit entity. This could lead to situations where non-profit long-term care homes become managed for profit with the well-documented risk to residents' health.

Considerable evidence is available on quality of care differences between for-profit and not-for-profit delivery across sectors. Studies show that the quality of care in for-profit institutions is lower.[39] [40] [41] [42] [43] The most conclusive evidence comes from systematic reviews and meta-analyses of peer-reviewed literature on for-profit versus not-for-profit health care, which found higher patient mortality rates in for-profit as compared to not-for-profit centres.[44] [45]

Canadian evidence from the long-term care sector has found that staffing levels were higher in not-for-profit facilities than in for-profit facilities,[46] and health outcomes were better in not-for-profit facilities.[47] [48] Differences in staffing were likely to result in the observed differences in health outcomes.[49] A review of North American nursing home

studies between 1990 and 2002 similarly concluded that for-profit homes appeared to deliver poorer quality care in a number of process and outcome areas.[50]

The research evidence is clear – Ontarians will benefit most from strengthening the public financing and public delivery of health services. In addition to making every effort to prohibit transfer of a long-term care home from a non-profit entity to a for-profit entity, such as providing a right of first refusal for non-profit homes when a licence is being transferred, the regulations should also strictly limit those circumstances where competitive bidding for a licence could be allowed (s.115 of the Act).

Recommendation: Provide a right of first refusal for not-for-profit homes in any transfer of a long-term care home licence.

Recommendation: Ensure that any competitive process should not disadvantage the establishment of non-profit homes or reduce the number or share of not-for-profit beds in Ontario.

F. Nurse Practitioners

Amendments to the *Nursing Act, 1991* contained in Bill 179, the *Regulated Health Professions Statute Law Amendment Act, 2009* currently being considered by the Legislature, use the terms Registered Nurses (extended class) (RN(EC)) and nurse practitioner (NP) interchangeably, leading to some confusion in terms. While the proposed initial draft regulation prefers the term RN(EC), the public generally understands the term nurse practitioner. In fact, the Health Professions Regulatory Advisory Committee (HPRAC) recommended simplifying terminology and using 'nurse practitioner'.[51]

In the interest of consistency and to avoid confusion, RNAO recommends that both terms be used in the draft regulation, including sections 1, 59, 61, 75, 84, 112, 118, 157 and 165.

Recommendation: RNAO urges that both terms Registered Nurse (Extended Class) and Nurse Practitioner be used together in the draft regulation to ensure consistency and avoid confusion.

Section 161(1) of the draft regulation states that "every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is…reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician and the pharmacy service provider". As s.59(1) states that a licensee can employ a physician or a registered nurse in the extended class (RN(EC)), s.161(1)(b) should be amended to include a RN(EC).

Recommendation: Amend s.161(1)(b) to include a registered nurse in the extended class (RN(EC)).

Conclusion

We thank the Ministry of Health and Long-Term Care for the opportunity to comment on Part 2 of the proposed initial draft regulation under the *Long-Term Care Homes Act, 2007*. As RNAO recommended in our response to Part 1 of the proposed initial draft regulation, we urge the government not to rush to finalize the regulations. Rather, we suggest that the government wait for 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 the Ministry 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.
. s.1.
[3] Registered Nurses' Association of Ontario. (2009). *Response to the Minister of Health and Long-Term Care on: Initial Draft Regulation under the Long-Term Care Homes Act, 2007*. Toronto: author.
[4] *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.
[5] Registered Nurses' Association of Ontario.(2006). *Dignity, Security, Safety and Comfort for All: Long-Term Care Homes Act, 2006. Submission to the Standing Committee on Social Policy*. Toronto: author, 5.
[6] Registered Nurses' Association of Ontario. (2007). *Staffing and Care Standards for Long-Term Care Homes: Submission to the Ministry of Health and Long-Term Care*. Toronto: author, 3.
[7] The Federal/Provincial/Territorial Ministers Responsible for Seniors. Principles of the National Framework on Aging: A Policy Guide. Division of Aging and Seniors. Health Canada. Ottawa. 1998
[8] *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8.
. s.1.
[9] *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, preamble.
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