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COMMENTARY

ONTARIO GOVERNMENT'S INTRODUCTION OF
PROVIDING MORE CARE, PROTECTING SENIORS AND BUILDING MORE BEDS ACT, 2021

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This Bill repeals the Long-Term Care Homes Act of 2007 and creates a Fixing Long-Term Care Act, 2021.

Sometimes it is all in a name, and the name of this Bill suggests we are approaching an election year. Symbolic politics[1] are likely to be the order of the day, and this Bill demonstrates that.

The fundamental principle in the Bill states "a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

Institutions are not homes. Decades of experience have shown that the LTC system has failed to meet even basic requirements of the law and that successive governments have failed to ensure even the safety of residents, much less quality of life. It is inconceivable that this Bill will somehow result in a transformation of what is essentially a dysfunctional, outdated, institution-based system.

The Ontario government obviously wishes the public to believe that this time it will all be different.

Key Components of the Bill[2]

Increase Hours of Direct Care (Part II)

The Bill proposes providing an average of four hours of daily direct care per resident, per day but not until March 31, 2025. Section 8(1) states "This section establishes a target for the average number of hours of direct care to residents to be provided by individuals who are hired by or otherwise work for licensees in a long-term care home as personal support workers, registered nurses, or registered practical nurses." "The target is for an average of four hours of direct care to be provided per resident per day." 8(1)(2)

[1] Symbolic politics refers to symbolism rather than substantive and effective policy changes.
[2] The full Bill can be found here - https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2021/2021-10/b037_e.pdf

LTCF's are currently unable to staff their facilities, and recruitment and retention of front-line workers is a serious problem. This problem is made worse by the government's plan to end the temporary wage increase for PSW's in March, 2022. It is made even worse by potential workers leaving for other sectors where job satisfaction and working conditions are better.

The key word here is also "average" meaning that many residents will not receive four hours of care daily, and that four hours of care for those needing it will not be reached until four years from now.

Resident's Bill of Rights Is Strengthened (Part II)

The Bill proposes to align the Residents' Bill of Rights more closely with the Ontario Human Rights Code, and recognize the role of caregivers. The problem is who will enforce that? And what sanctions will there be for facilities that fail to implement the Bill of Rights?

The government also seems unaware of the recent court case in Nova Scotia which establishes that forcing people with disabilities to live in institutions in the absence of in-home and community care options is, itself, discriminatory, and therefore a violation of their human rights. Litigation is ongoing in this matter (Disability Rights Coalition of Nova Scotia, 2021).

What would address this problem is a section in the Bill allowing the $201 per diem funding for institutional beds to be portable, so that those who wish to leave LTCFs could take this funding with them to a community residential placement. Having such a provision in the Bill would likely empty a considerable number of institutional beds.

This Bill also places enforcement of the Bill of Rights on residents rather than government. "A resident may enforce the Residents' Bill of Rights against the licensee as though the resident and the licensee had entered into a contract under which the licensee had agreed to fully respect and promote all of the rights set out in the Residents' Bill of Rights." (Part 2 (3)).

This means a resident or family member would likely have to hire a lawyer to enforce "the contract" between the resident and the facility, and it may mean the government could try to avoid enforcing the Bill of Rights suggesting that residents do so instead.

New Resident, Family and Caregiver Surveys

After essentially locking even essential caregivers out of long term care facilities for months, refusing to listen to LTC residents saying they want to go home, and older adults saying they never want to end up in a LTC institution, the government is now implementing surveys of their opinions.

Surveys are often examples of symbolic politics since there is no requirement that the government actually follow the advice and feedback provided in response to these surveys.

Compliance and Enforcement (Part X)

Fines are to be doubled on conviction of an offence under this Bill. The steep fines included look good on paper, but the likelihood of these sanctions succeeding, based on how well enforcement of any kind in long-term care has succeeded in court in the past is questionable.

Historically LTC corporations with deep pockets and expensive lawyers have done very well at winning court cases against government lawyers in even the most grievous circumstances. Are we to expect that this new sanction is likely to be more effective than attempted sanctions in the past?

New provisions are also included concerning suspension of licenses and the establishment of, and powers of LTCF supervisors in the event a facility is taken over by the Ministry until another option can be found.

This opens the door to the option of another LTC corporation or management company operating a facility at the government's behest. We have already seen an example of this with UniversalCare being asked to manage another LTC facility (Wallace, 2020). It is unlikely, given this scenario, of residents being much better off.

The government also plans to double the number of inspectors so that there is one for every two LTCFs. This would allow a more proactive approach, the government says. Except it all but eliminated proactive inspections in 2019 and now appears to be reinstating them. A recent press report also appeared to indicate that the Ministry did not draw reasonable conclusions from inspectors' findings. The Globe and Mail reported:

"A dozen inspectors from the Ministry of Long-Term Care spent 70 days in the two homes between May and July, poring over the health records of residents who died during outbreaks of COVID-19 in 2020. "Concerns were identified during the inspections in relation to dehydration and malnutrition," says a copy of the review, which the government plans to release on Monday. "However, based on its thorough review, the [ministry] did not identify any resident whose death was a result of dehydration or malnutrition." (Howlett, October 25, 2021)

So in spite of the Ministry's own inspectors having concerns about dehydration and malnutrition, the Ministry came to the conclusion, apparently in the absence of coroner's investigations or reports, that residents did not actually die of dehydration and malnutrition.

Similarly the military has now backed away from the findings of its own experts on the ground working in those facilities who raised concerns that residents had died of malnutrition and dehydration. Saying it did not conduct forensic investigations, it is now dismissing its own personnel's reports.

The public is unlikely to accept these kinds of conclusions. And it raises the question, if the Ministry is unwilling to draw reasonable conclusions based upon what its own inspectors are reporting, how does adding more inspectors actually address this problem?

Minister Can Review Director's Decision Re: Licensing

This Bill facilitates a Minister potentially overruling the decision of the Director under the Act regarding licensing of a LTC facility.

Ministers, being elected officials, can, and often do accept political donations from known principals in the long term care, development, pharmaceutical, and other industries. This raises the spectre of a serious conflict of interest with respect to licensing decisions by the Director being overruled by the Minister.

Establishment of the Office of Long-Term Care Homes Resident and Family Adviser

Section 40 of the Act allows the Minister to establish an Office of LTC Homes Resident and Family Adviser to "assist and provide information to residents and their families and others" and "advise the Minister on matters and issues concerning the interests of residents; and perform any other functions provided for in the regulations or assigned by the Minister."

This appears to be the government's attempt to avoid the establishment of an <u>independent</u> Advocacy Office with the power to order changes for residents in LTC facilities, similar to the Ontario Human Rights Commission. This much weaker version allows the Ministry to remain in control much as its funding of Family Councils Ontario and the Ontario Association of Residents Councils has prevented advocacy independent of that Ministry from occurring.

Other Highlights Include:

- Every LTC facility must have a **mission statement** that includes a goal of ensuring that resident care is "resident-directed and safe" and revised in collaboration with the Residents' and/or Family Council at least once every five years (Section 4(1)(a) It is unclear how residents or family members might achieve adherence to any stated mission statement.
- Section 6(1) deals with **plans of care**, the development of which residents or their designated substitute decision maker are supposed to take part in, an assessment is to have occurred with the resident's consent, the resident is provided with a copy, and staff is aware of the plan and have access to it. One of the most cited areas currently in inspection reports is facilities' failures to address plans of care. This is unlikely to change under the new legislation.
- The provision of **specific programs and services** (Part II). Again, enforcement will be a problem and the quality of these programs and services, in the absence of standards, may also be problematic.

- Residents' rights to have **lifestyle and choices** respected. At present residents' basic needs to be fed, clothed, and toileted are not being met in many facilities much less lifestyle choices addressed.
- Introduction of a **palliative care philosophy**. "Every licensee of a long-term care home shall ensure that, subject to section 7, residents are provided with care or services that integrate a palliative care philosophy." (Part II 12 (1)) Palliative care requires compassion and individualized care – something that has been absent from many facilities according to inspection reports. It is difficult to see how this might now be achieved under current conditions.
- Introduction of **restorative care** "Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that, (a) promotes and maximizes independence; and (b) where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee. (13 (1), 14) This is an area that has never been successful over many decades. Most residents are not returned to the community, but die in these facilities. Bed sores from lack of positioning continue to be a serious problem.
- A section on **dietary services**: "Every licensee of a long-term care home shall ensure that there is (a) an organized program of nutritional care and dietary services for the home to meet the daily nutrition needs of the residents; and (b) an organized program of hydration for the home to meet the hydration needs of residents." (15 (1)) A visit to many long term care facilities at mealtimes will raise questions about whether or not the meals served are the same as what is printed on the menus. It is difficult to determine how inspectors will be able to hold facilities accountable concerning dietary requirements.
- **Medical, religious, and housekeeping services** are also included in sections 16-19. One of the most frequently cited areas concern filthy conditions and furniture in disrepair. During the pandemic medical directors abandoned patients with no consequences. The presence of legislation alone is unlikely to change these conditions.
- Each LTCF must have a **volunteer program**. (20(1). So for-profit facilities are now to have unpaid people providing assistance and programs for residents? And we expect unions will support this?
- **Infection control and prevention** is included in Section 23(1) Inspectors cited many facilities for lack of infection control and prevention long after the pandemic had started, yet there were few to no sanctions for these failures. Are we to expect that this will suddenly change under new legislation?
- **Abuse and neglect** provisions remain in (Sections 25 and 25). This is another frequently cited area with little to no accountability involved. With LTCFs able to avoid sanctions in court if necessary, it is unlikely that this area will be effectively addressed either.

- **Complaint reporting requirements** are covered in Sections 26-28, and these include forwarding any complaints to the Director under the Act, a requirement on the licensee to investigate, report, and act, mandatory reporting of abuse and neglect. "A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019."(28 (1)). Provision is also in the Act concerning reports to the colleges of regulated health professionals and the Ontario College of Social Workers and Social Service Workers. Anyone attempting to prevent a report from being made can be charged with an offence under the Act. Inspectors are to attend immediately where serious harm to residents may be indicated. (29(1)) Few staff report observed abuse or neglect because of the culture of these facilities, and failure of facilities to report complaints or even critical incidents resulting in harm have been cited in numerous inspection reports under the current Act. What is expected to change here?
- **Whistle blowing protection** is included in Section 30. And yet, there continue to be few whistleblowers. Staff seldom speak to the press even about the worst conditions because of fear of losing their jobs.
- **Protection from restraint** is included in Section 34. This sounds good except that in many facilities staff are unclear about what constitutes a restraint.
- Implementation of **continuous quality improvement** and the establishment of a LTC Quality Centre (Part III) Without effective enforcement, this is likely to be more window dressing.
- LTCFs must have a **Residents' Council** and <u>may</u> have a **Family Council** and establishes the powers of these councils in assisting residents and advising licensees. (Part V) Again, enforcement will be an issue here. To date both councils have been unable, in many facilities, to gain the changes they are requesting.

Additional details concerning each of these provisions in the Act are included in the Regulations.

Conclusion

All of this sounds good on paper. Unfortunately no government has ever been able to hold long-term care institutions in Ontario to legislation like this.

In the absence of small, residential alternatives to these institutions, located in the community, and preferably operated by municipalities and non-profits through staffed housing arrangements, the government is in no position to close even particularly bad facilities. It has no other options for re-locating residents to safer, community-based residential services that may actually feel more like home to them, or to return them home with a sufficient complement of in-home services and support, or the ability to pay family caregivers to take time off work to support loved ones.

In the absence of all of these alternatives that are available in so many other jurisdictions, the Ontario government has locked itself into an expensive, unsustainable institution-based system, in which any legislation, however positive sounding, can actually be enforced. That is the real problem. Symbolic politics – it all sounds good on paper, but the proof will be in the pudding.

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