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June 5, 2009

Ms. Colleen Sonnenberg
Ministry of Health and Long-Term Care
LTCHA Regulation Project
56 Wellesley Street West
9th Floor
Toronto, ON
M7A 2J9

Dear Ms. Sonnenberg:

Please find enclosed our submission on the draft regulations under Parts I to III of Bill 140, the *Long-Term Care Homes Act, 2007 (LTCHA).*

The Canadian Union of Public Employees (CUPE) Ontario welcomes this opportunity to provide comments on the appropriateness of the draft regulations. Across Ontario's long-term care sector, CUPE represents 24,000 workers in 217 long-term care homes. CUPE represents workers at 35 charitable homes, 69 Homes for the Aged, 71 nursing homes and 42 retirement homes. Forty-seven per cent of CUPE members work in the non-profit sector and 53 per cent work in the for-profit sector.

Unfortunately, the draft regulations under Parts I to III of the *Act* are a major disappointment. These proposed regulations are completely inadequate to the task at hand and appear to be more in line with the Government's deregulation initiative than the promised "revolution" in long-term care to protect Ontario's vulnerable seniors. The draft regulations manifest a clear failure to pay attention to the concerns raised by virtually all community groups that made representations during the committee hearings when the Bill was debated in the provincial legislature.

Regulations for long-term care facilities were created for a reason – there was, at the time they were created, and continues to be, a need for standards, inspection and enforcement regimes to protect those impacted by conditions in the homes. Ontario has the most privatized long-term care sector in the country, with the majority of homes now owned and operated by for-profit companies, many of them multinational chains. The for-profit industry has created a powerful and aggressive lobby for more funding with fewer strings attached. The result has been a virtual warehousing of seniors who need care and respect.

It is our hope that our submission, among others, will illustrate to the Government that its path of deregulation will not serve Ontario seniors and other residents of long-term care.

Respectfully,

Sid Ryan

Patrick (Sid) Ryan
CUPE Ontario President

S. Schmidt

Sue Schmidt, Chair
HCWCC
CUPE Ontario

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cc: Home Care Workers Coordinating Committee (HCWCC)

CUPE Ontario
Brief / Submission to the
Standing Committee on Social Policy — Bill 140
Long-Term Care Homes Act, 2007 (LTCHA)

Friday, June 5, 2009

Ontario needs minimum standards of care in nursing homes that give seniors the "dignity
and respect" they deserve, Premier Dalton McGuinty says…

Legally binding minimum standards of care could be in place within three months of the next government taking office, thanks to legislation the Liberals passed earlier this year, Smitherman said.

- Nursing home changes coming, McGuinty says
Toronto Star October 5, 2007.

Introduction

The Canadian Union of Public Employees (CUPE) Ontario welcomes this opportunity to provide comments on the appropriateness of the draft regulations under Parts I to III of Bill 140, the *Long-Term Care Homes Act, 2007 (LTCHA).*

The Canadian Union of Public Employees is Canada's largest Union representing more than half a million workers across Canada including approximately 200,000 employees in Ontario.

CUPE Ontario members are employed in Health Care, Education, Municipalities, Libraries, Universities, Social Services, Public Utilities, Transportation and Emergency Services. Our members include service providers, white-collar workers, technicians, and labourers, skilled trades people and professionals. Across Ontario's long-term care sector, CUPE represents 24,000 workers in 217 long-term care homes. CUPE represents workers at 35 charitable homes, 69 Homes for the Aged, 71 nursing homes and 42 retirement homes. Forty-seven per cent of CUPE members work in the non-profit sector and 53% work in the for-profit sector.

In addition, CUPE members are residents and users of Ontario's health system. Many of us have family members, colleagues and friends living in Ontario's nursing homes. The CUPE Ontario brief is submitted on behalf of our 200,000 members and in support of the 24,000 CUPE members working in the long-term care sector.

Our members eagerly anticipated the release of the draft regulations. We strongly supported the call of the previous Minister shortly after the 2003 election for a revolution in long-term care. Our members struggle day and night to try to deliver the care needed by the residents of Ontario's long-term care facilities. The Minister was correct in recognizing that major changes were necessary to ensure residents are treated with respect and receive the care they need.

Our members supported the enactment of Bill 140. We supported the contention that residents of all long-term care homes in Ontario deserve a common set of rights and standards of care. Our members saw the legislation as an opportunity to immediately raise standards in the "for- profit" nursing home sector at least to the levels of other long-term care homes and then begin to raise standards for all homes to the point where they will genuinely meet resident care needs.

Overall Concerns

Unfortunately, the draft regulations under Parts I to III of the *Act* fail to meet these expectations. The draft is a major disappointment. These proposed regulations are completely inadequate to the task at hand and appear to be more in line with the government's de-regulation initiative than the promised "revolution" in long-term care to protect Ontario's vulnerable seniors. The draft regulations manifest a clear failure to pay attention to the concerns raised by virtually all community groups that made representations during the committee hearings when the Bill was debated in the provincial legislature.

Regulations for long-term care facilities were created for a reason – there was, at the time they were created, and continues to be, a need for standards, inspection and enforcement regimes to protect those impacted by conditions in the homes. Ontario has the most privatized long-term care sector in the country, with the majority of homes now owned and operated by for-profit companies, many of them multinational chains. The for-profit industry has created a powerful and aggressive lobby for more funding with

fewer strings attached. The result has been a virtual warehousing of seniors who need care and respect.

Over the last decade, there has been a series of de-regulations that has not been in the interests of residents nor the public. Indeed, there has been regular reporting of unnecessary deaths, homicides, infectious disease outbreaks, poor conditions, lack of transparency, inadequate inspection and enforcement, rationing of supplies and inadequate staffing in the homes. It is not in the public interest, nor in the interests of residents, caregivers and staff in long-term care homes, to remove needed regulations governing the practices and standards required in Ontario's long-term care homes. Roughly 75,000 Ontarians, mainly vulnerable seniors and persons with disabilities, live in Ontario's long-term care homes. They need and deserve the protection afforded by a robust regulatory and enforcement regime, and public access to information.

The major area of discussion prior to the publication of the regulations was on the issue of formulas to provide guaranteed minimum hours of care. While the Bill was amended to provide for such a regulation and such a regulation was promised before the government's re-election, the government had indicated it was going to rely upon the recommendation of its consultant, who subsequently declined to recommend such guarantees.

The draft regulations identify a number of outcome indicators:

a. falls prevention and management,
b. skin and wound care,
c. continence care and bowel management,
d. responsive behaviours and altercations, and
e. pain management.

Implicitly, each of these indicators would only be satisfactorily met if residents received more hours of care from nursing and personal care staff. However, there are no up-front enforcement mechanisms. At best, action would be taken well after the deterioration in

resident condition as the Ministry would await the “after the fact” outcomes reports and analysis before stepping in. We need clear requirements for increased staffing up front – only these will facilitate meeting the new outcome indicators.

CUPE wishes to restate its position that residents will only begin to have their care needs met if the Ministry requires operators to immediately provide as a minimum care based on a formula tied to the average care needs of the residents in each home with 3.5 hours of actual care from nursing and personal care staff for a home whose resident acuities were equal to the average Case Mix Measure (CMM) in the province in the spring of 2007 when the *Long-Term Care Homes Act, 2007 (LTCHA)* was passed. This is the same general approach used by the province to determine how much money should be provided to homes to fund their operations. Enacting such a regulation will ensure that residents are receiving the care that is the very reason for which the homes are receiving the funding from the government. Please recall that in early 2001, both provincial long- term care home associations called on the government to provide them with sufficient funding to cover the costs of providing 3.06 hours of care to residents. That figure was based upon the level of care being provided to long-term care residents in Saskatchewan. Since then, average resident acuity has increased by more than the 14 per cent necessary to raise care levels to 3.5 hours.

Finally, we repeat the call in the recommendation of the Casa Verde Coroner’s Jury that, following the immediate implementation of the 3.5 hour minimum average, the government should sponsor an evidence- based study supervised by representatives of all stakeholders in this sector, to scientifically identify what additional increases in care are required to finally fully meet resident care needs.

In addition to weaknesses in substance, there were also flaws in the process used to solicit public input. While the Ministry had extensive consultations with the industry prior to tabling the draft regulations in May, there was very little interaction with most other sectors of the community. In this light, a 30-day time period is far too limited to compare the rules and protections that exist now to those that will exist following the enactment

of the proposed regulations. It must be kept in mind that the draft regulations will replace not only the whole array of structural and service standards in the regulations, but also the very extensive Policy Manual that had been binding on the operators as a result of the Service Accountability Agreements (SAA). Moreover, following the tabling of the draft regulations, no effort has been made to make Ministry officials accessible to give explanations about the content and intent of the new regulatory regime. In view of these flaws, we recommend that there be a major review of the regulations and their adequacy in a timely fashion. Such a review would be most appropriate once the report addressed in the next paragraph is released.

The timing of the release of the draft regulations is also inappropriate. While it took far too long for the Bill to be tabled and passed (3.5 years), and it is far too long since the promise that effective enforceable standards would be enacted in regulations (over two additional years), now is the wrong time for these regulations to be issued. The Ombudsman of Ontario is just about to complete his review of the adequacy of the Ministry's regulation of the sector and the protection or lack thereof provided to residents. Any recommendations made by the Ombudsman are going to be an essential component of an action plan to finally seriously meet the challenges of long-term care in this province. Pre-empting the report of the Ombudsman sends a damaging message to Ontario's seniors. That message is that the government doesn't respect the views of the Ombudsman and doesn't really care about the concerns of vulnerable people in long-term care homes in this province.

The message from this set of draft regulations even fails to meet the test of the Mike Harris Tories. That government expressed the view that it was more concerned with the interests of taxpayers than it was with the interests of citizen well-being and a civil society. This set of draft regulations doesn't even address the concerns of taxpayers to ensure that value is received for public dollars. Ontario's Auditor General has repeatedly expressed concerns to the government over the lack of accountability of long-term care homes for the money being flowed to this sector. The Auditor General has regularly called for clearer linkages between services provided to seniors and revenues provided

for these purposes. The Auditor General has regularly complained that funding is being sent to long-term care homes without proper documentation and without any indication of how much care is being provided.

Unfortunately, the government is collaborating with the industry in hiding the degree to which additional funding is or is not resulting in increased hours of care. While every long-term care home in the United States that receives public funding sets out on a national website the number of hours of care received by its residents, this information is only available in Ontario if one pursues an application under the *Freedom of Information Act*. That process is very time-consuming. When data is released, it is presented in such a way as to inflate the perception of care because it includes hours of persons other than front line care providers and includes paid hours, hours which are not actually resulting in care for residents because they include vacation time, bereavement or other paid absences.

Nevertheless, the data that has been released shows that the concerns of the Auditor General are totally valid. The government's own reports show that between March 2006 and June 2007 (the latest date for which data is available) average hours of care increased from 2.850 paid hours per resident per day to 2.851 – only 3.6 seconds per day (an increase of 1/3 of 1/10 of 1 per cent) despite an average increase in funding of 8.07 per cent.

Front line workers endorse the sentiments, expressed by the government in the text of the Bill, to achieve safe environments for our seniors where they can live in security without being subject to neglect or abuse. Unfortunately, the actions of the government are inconsistent with such sentiments. By removing virtually all of the previous regulations and manual standards, the government is increasing the flexibility of home operators to do whatever they like with impunity. There is no indication in the draft regulations that the major problem experienced by residents currently is *neglect* – bordering on abuse – because of decisions made by the major decision-makers, including managers of long-term care homes, their superiors in corporate headquarters,

and by Ministry officials as well the Local Health Integration Networks (LHINs). These decisions limit staffing levels to improve profitability and shareholder return. The regulations must make it clear that such personnel are governed by the prohibitions on abuse and neglect.

The one safeguard against abuse and neglect is fear of disclosure by a whistleblower. The Bill's provisions for protecting residents are premised on the expectation that residents, family members or staff, will report instances of abuse or neglect. In fact, the Bill makes it an offense for workers to fail to report abuse. The Bill recognizes that, if an obligation is going to be placed upon workers to report abuse or neglect, then they must be protected against employer retaliation. While the Bill makes it an offense to take retaliatory action, the Bill fails to provide effective protection for whistleblowers. The Bill will only punish retaliation if it can be proven beyond a reasonable doubt that the retaliator intended to take revenge on the whistleblower because of the whistleblowing activity. Intent is hard to prove. The section making it an offense to fail to report abuse or neglect does not require proof of intention.

Front line care providers expected that the draft regulations would fix this gap in the Bill and prohibit employers from taking any disciplinary action against whistleblowers unless the employer first proves its case to a labour tribunal that the discipline is for just cause and not in any way motivated by the whistleblowing activity. This type of protection is exactly what police officers have. Why shouldn't this protection be extended to those whose task it is to protect vulnerable seniors? This type of employee protection is similar to what the Harper Tories enacted as their first piece of legislation when they came to power. Why is it that similar protection cannot be enacted by the McGuinty Liberals? Instead, the draft regulations fail to address this gap at all. We note, at this point, the need for whistleblower protection for residents, and their family members as well, and leave it to those groups to identify the necessary revisions.

Detailed Concerns

Given the limited time and the massive scope of the regulatory changes, CUPE has not been able to conduct a comprehensive review on its own. We have benefited from the work done by the Ontario Health Coalition (OHC) and to the extent that any issue has not been addressed in these submissions, we wholeheartedly endorse the submissions of that important community umbrella group.

Part I, dealing with definitions, has many gaps and fails to meet the requirements of the *Act* for more detailed provisions. In particular, we are concerned about the limited definitions of abuse and neglect and, specifically, the absence of any focus on the ways that such misconduct could be committed by senior staff of long-term care homes as well as by officials of the Ministry and the LHINs. These concerns are elaborated in the Appendix to these submissions in response to the government's draft comments on Section 16 dealing with Zero Tolerance policies. Moreover, while there may be merit in having each home have its own Zero Tolerance policy to reflect their own specific circumstances, there needs to be a basic provincial set of standards that should be required in each home's policy that guarantees residents a common set of protections irrespective of which home they find themselves in.

Part II starts with Plans of Care. Once again, it appears that the government is using the right to enact regulations for the purpose of cutting back the requirements of the *Act*, instead of building upon those requirements to provide stronger protection to residents. As one example, Section 8 of the draft regulation allows for six months to re-assess residents and revise, if necessary, their plans of care; this is far too long. The new *Act* and regulations have given greater clarification as to what should be in an assessment and in a plan of care. The six-month time period in the *Act* for review was only intended to apply to situations where the previous assessment and care plan fully met the requirements of the legislation.

We have a serious concern that the harm that led to the deaths that were the subject of the Casa Verde Coroner's Inquest has not been adequately addressed. All staff that will

interact with newly-admitted residents must immediately have full details of that person's condition and care needs. Without such information, staff cannot properly care for the new resident, nor can they safely protect other residents from violence or themselves for that matter.

We have a concern that the listing of required programs in Section 9 makes no mention of the important areas covered by Sections 14 and 15; namely, Responsive Behaviours and Altercations. Section 9 should be amended to include the requirement to have programs that address these two areas. Moreover, CUPE is of the view that the list of required programs and outcome indicators in Part II is incomplete (e.g. hydration and weight changes) and these gaps must be rectified.

In the appendix to these submissions, we set out specific changes that should be made in the requirements of the risk indicators that are set out in Sections 10-15. In particular, we want safeguards imposed over the use of pharmaceuticals with a clear requirement that they be used only as a last resort if other forms of therapy are ineffective. We seek to include a presumption that residents should be toileted as opposed to diapered and that residents with soiled diapers should be entitled to a change upon request. Section 9 should be amended as well to reflect our submissions in the Appendix.

We are repulsed by the phraseology of Section 12(2)(f) of the draft regulation in implying that continence products may be used solely or primarily for the convenience of staff. This implication is a perversion of what has been left unchecked in many long-term care homes. Front line staff do not use incontinence products for their convenience. They would much prefer to treat residents with dignity and support residents with toileting. Instead, it is the management of the home who direct staff to diaper residents so that continence management will use less staff time. Operators have then compounded the problem by rationing incontinence supplies so that staff are unable to change residents when such changes are appropriate. Staff have gone to the point of setting aside loose diapers so that there will be more available when necessary and when access to the official supply cupboards are cut off. Staff are risking employer

discipline in order to better meet resident needs. To imply that the blame for lack of concern from residents comes from front line staff as opposed to elsewhere in the hierarchy is pure chutzpa by the Ministry given their outright refusal to step in and order operators to comply with existing regulations on diapering.

CUPE acknowledges that the Bill has already excluded pharmaceutical use from constituting a restraint if it is a part of a physician's order incorporated into a care plan. Nevertheless, it is possible for the draft regulation to build in safeguards against excessive and inappropriate use of pharmaceuticals. In the first decade, under the CMM/CMI regime, operators were obliged to report the number of occasions where psychotropic (mood altering) medications were used. Not only was this reporting requirement removed, but in the last two years, the government removed any requirement to report in the Facility Specific Report and in the Provincial Summary Reports, the number of different drugs that have been prescribed per resident per day. All these reporting requirements should be reintroduced so that there can be peer reviews on the use of drugs in order to assess whether or not they are being properly prescribed. Section 20 of the regulation could have and should have included such requirements.

As well, there have been differences of opinion between home's management and Ministry officials on the one hand, and professional regulating bodies on the other, about what constitutes a restraint. One example is whether a bed rail is a restraint. This conflict imposes inconsistent obligations on health care workers who are regulated professionals. Section 20 should clearly state that it applies to any device considered a restraint by a regulatory health professions body.

There are also serious gaps in the draft regulations with respect to the requirements of Sections 23 & 25 of the *Act*. Section 23 deals with complaints and Section 25 deals with situations where the Director either does or does not require the conduct of an investigation when in receipt of information concerning violations of the *Act*. The draft doesn't address these areas at all.

Section 23 of the *Act* requires that the Licensee report to the Director the results of investigations of a complaint and the corrective action taken. There needs to be a requirement in the regulations that summaries of this material (with protection for the privacy of complainants and residents) be publicly available, including on the web.

Furthermore, regulations are required to govern the conduct of an investigation under Section 25, the outcome of the investigation and the determination not to conduct an investigation. Specifically, the regulation should adopt the processes set out in the *Occupational Health and Safety Act*. There is no justification to deprive residents of long-term care homes the same procedural safeguards that exist for the protection of workers. Such a regulation should require that an inspector seek to be accompanied by representatives of residents and their families as well as by representatives of front line workers and any certified bargaining agents. The regulation should require the inspector to give to the Residents Council, the Family Council and each of the certified bargaining agents, a copy of the inspection report and any resulting remedial orders. These parties should have the right of appeal to an independent tribunal should the orders be deemed to be inadequate or should the Director decide not to require an investigation. All these groups should have the right to be party to any appeals filed by the licensee or the Ministry.

Finally, the draft regulations fail to address the gaps in Section 37 of the *Act*, the office of the Resident Advisor. Until this area is comprehensively addressed, the government should give formal jurisdiction to the Ombudsman to receive and respond to concerns.

Conclusions

We conclude on the issue upon which we started – the need for and yet absence of any clear requirements for residents to get the care they need, and the massive removal of protections that are part of the new deregulatory approach. Nothing could more clearly underline the abandonment of the interests of residents than the failure of the

government to renew one existing regulation. Section 60(6) of the current Nursing Home regulation provides:

> (6) A licensee of a nursing home shall ensure that there is a sufficient number of registered nurses, registered practical nurses and health care aides on duty in the home at all times to provide the nursing care required by the residents of the home. O. Reg. 340/96, s. 4.

This section does not appear in the new draft nor is any explanation given for its absence. What possible justification could exist for its removal? How could anyone conclude that seniors are being properly cared for if operators are relieved from the requirements to ensure that "at all times" there are sufficient staff to provide required care?

On May 21, 2009, the Globe and Mail carried a story on an initiative in Quebec to address care needs in long-term care homes. The Government of Quebec has allocated $293,000 to pay for clowns to cheer up the elderly. At least that government was above board in drawing public attention to the unusual means it was adopting to address resident need. In Ontario, the government is instead trying to pretend that it is pursuing a serious effort to improve care in our homes for seniors. Ontario residents will not stand for being the butt of this joke and will not let the last laugh be on them.

CUPE members will support efforts by long-term care residents and their families and community supporters to obtain real action. We call on the government to scrap this farce and finally respect the inquiry process of the Ombudsman and commit to broad public consultations on the nature of regulations required once the Ombudsman's report is released.

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APPENDIX A

Section 9 – Required Programs

Interdisciplinary programs would be developed and implemented for falls prevention and management, skin and wound care, continence care and bowel management, pain management responsive behaviours and altercations. Each program would include relevant written policies, procedures and protocols and would be developed, implemented, evaluated and updated using appropriate evidence-based practices or in accordance with prevailing best practices. Each program would require the use of clinically-appropriate assessment instruments and establish protocols for the referral of residents to specialized services. Programs would provide for methods to reduce risk and monitor six outcomes and would be evaluated annually by the licensee to identify changes required for improvement. The changes identified would be implemented.

Section 10 - Falls Prevention and Management

This program would provide for screening protocols and assessment instruments as well as strategies to reduce or mitigate falls, including the monitoring of residents and the use of pharmaceuticals, equipment, supplies, devices and assistive aids. Residents who fall would be assessed, and unless the condition or circumstances clearly do not require, a post-fall assessment would be conducted using a clinically-appropriate assessment instrument designed for falls. The equipment, supplies, devices and assistive aids would be readily available at the home at all times.

Section 11 - Skin and Wound Care

This program would provide for screening protocols and assessment instruments, strategies to maintain skin integrity and reduce and prevent skin breakdown and wounds, routine skin care and treatments. Routine skin care would include the care of nails, feet and mouth as well as safe and effective techniques for care, repositioning and transferring residents. A resident at risk of altered skin integrity would receive an assessment by a member of the registered nursing staff within 24 hours of admission, upon return from hospital, and upon return from an absence of greater than 24 hours. A resident exhibiting skin breakdown, pressure ulcers, wounds, or skin tears would receive a skin assessment by a member of the registered nursing staff, immediate treatment and would be reassessed at least weekly, unless clinically contra-indicated. Residents dependent upon staff for repositioning would be repositioned every two hours or more frequently depending on their condition and tolerance of tissue load. However, residents would only be repositioned while asleep if clinically indicated.

Section 12 – Continence care and bowel management

This program would include screening protocols and assessment instruments and treatments and interventions to promote continence, toileting programs, including

protocols for bowel management and strategies to maximize residents' independence, comfort and dignity. Individualized plans for residents would be based on their assessments. Toileting and, where necessary, continence training, should be provided to all residents who so request unless it is clear that the resident is incapable of benefitting from such assistance. Residents who use continence products would have sufficient changes to remain clean, dry and comfortable and there would be appropriate numbers and types of products available to do so. In particular, residents whose continence products are wet or soiled should be changed upon request. Continence products would be evaluated annually by residents, family members, substitute decision-makers and staff to determine residents' satisfaction and the evaluation would inform purchasing decisions.

Section 14 – Responsive Behaviours

The needs of residents with responsive behaviours would be met by assessment and reassessment, identification of triggers for the behaviour and proactive measures to reduce risk, strategies and interventions designed to minimize as much as possible and, if possible, prevent the behaviours, resident monitoring and establishing protocols for the referral of residents to specialized resources. All approaches to care would be designed to meet the needs of residents with responsive behaviours and staff would be advised of the residents who require monitoring. The use of pharmaceuticals as a remedial measure should only be used as a last resort where no other intervention will assist and only where there are likely to be achieved on the basis of evidence positive outcomes which clearly outweigh any potential negative outcomes.

Section 15 – Altercations

The risk of altercations between residents would be reduced by identifying factors that could trigger the altercations and identifying and implementing interventions. The use of pharmaceuticals as an intervention should only be used as a last resort where no other intervention will assist and only where there are likely to be achieved on the basis of evidence positive outcomes which clearly outweigh any potential negative outcomes.

Section 16 – Policy to Promote Zero Tolerance

In addition to Section 20 of the *Act*, the licensee's policy to promote zero tolerance would comply with the *Act*, contain procedures and interventions to assist and support residents who have been, or have allegedly been, abused or neglected and contain procedures and interventions to deal with staff members and "other persons connected to the Home" who have neglected or abused residents or have allegedly done so. "Other persons connected to the Home" include employees of the corporate entity owning or managing the Home, their officers, Board members and shareholders. "Other persons connected to the Home" also include officials of the Ministry of Health and Long- Term Care responsible for taking any actions under the *Act* and regulation, their immediate supervisors and persons higher in the Ministry ladder of responsibility up to and including the Minister. Finally, "Other persons connected to the Home" also include

officials of the Local Health Integration Network (LHIN) with any responsibility for decisions on the funding or operation of the Home, their immediate supervisors and persons higher in the LHIN ladder of responsibility up to and including the members of the Board of the LHIN.

The licensee's policy shall provide effective whistleblower protection for persons who report suspected abuse or neglect. The policy shall include provisions addressing the process for discipline of employees by the licensee or any of its supervisory staff for misconduct where the employee has made reports of suspected abuse or neglect. No discipline may be imposed until the licensee or its officials have first satisfied the Ontario Labour Relations Board (OLRB) (or grievance arbitration board where the employee is covered by a collective agreement), that the discipline was not in any way connected to the report of abuse or neglect, that there was misconduct on the part of the employee, and that the misconduct warrants the proposed discipline to be imposed.

Section 67 - Infection Prevention and Control Program

Every licensee would ensure that there is an interdisciplinary team approach in the coordination and implementation of the program and that the team meets regularly. The licensee would be required to designate a staff member to coordinate the program who has education and experience in infection prevention and control practices. The staff member so designated shall not be a member of the management of the home. All staff would participate in the implementation of the program. Daily monitoring, recording and analysis of the presence of infection in residents would be required. Licensees would be required to implement any surveillance protocol provided by the Ministry. The section includes provisions related to the availability of personal protective equipment, hand hygiene programs, training, pets, and immunization and screening measures.

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APPENDIX B

THE GLOBE AND MAIL

Quebec sending in the clowns

The provincial government has signed an agreement with a non-profit group to use so-called 'therapeutic clowns' in nursing homes, even though critics say basic care for the elderly is woefully inadequate

Rhéal Séguin
Quebec City — From Thursday's Globe and Mail, Saturday, May 23, 2009 03:22AM EDT

After failing for years to meet urgent demands for more staff to wash and feed the elderly in nursing homes, Quebec is hiring clowns to entertain them.

The provincial government is signing a four-year, $293,000 agreement on Monday with Dr Clown, a provincial non-profit organization that sends clowns to visit re in nursing homes.

For the province, this is no joking matter. Hiring *Patch Adams* is seen as a real solution. The so-called "therapeutic clowns" are part of a program aimed at breaking isolation and loneliness of nursing-home residents.

"Since the public consultations on the living conditions of the elderly [in 2007], our government has injected $2.3-billion to improve their living conditions, " Marguerite Blais, the Minister for the Elderly, said in the National Assembly yesterday.

However, most of the money has gone to maintaining salaries and a minimum level of staff and services. Hundreds of private nursing homes as well as homes for elderly are without properly trained staff, according to patients' rights groups who contend that the elderly can go days without being washed. They are often left alone to eat and they receive inadequate care for some of their most basic needs.

Lisette Lapointe, Parti Québécois critic for the elderly, noted yesterday that the vast majority of private residences that care for more than 100,000 patients operate without proper certification. "What are you going to do to make sure our elderly get proper care from trained personnel?" Ms. Lapointe asked Ms. Blais in the legislature.

Part of the problem, the minister argued, was that too many people are negligent and forget to visit their aging parents or family members who live in nursing homes. "We all have a responsibility in overseeing the living conditions of the elderly," Ms. Blais said in explaining the usefulness of hiring clowns.

The solution does not lie in having clowns as part of therapy to break the loneliness, said Paul Brunet who heads the Council for the Protection of Patients. There's nothing

wrong in wanting to entertain people, he said, but that certainly isn't the priority expressed by the more than 400 local user committees in the province's nursing homes.

"If anybody thinks this is a priority, then they must be living on Mars," Mr. Brunet said in an interview yesterday. "There are some elderly residents that stink. They aren't bathed because there isn't enough staff to do the work. They lose their dignity and, when that happens, they lose the desire to live. Their basic needs aren't being met. And that's what they need more than clowns."

The clowns are just a cheaper way of tackling the problem, Mr. Brunet said, adding that the real solution would cost a great deal more.

Reform of services for the elderly has been a long, drawn-out process. In 2002, the provincial auditor underscored the serious problems involving the lack of proper care in nursing homes as well as homes for the elderly. Coroners' inquests into the deaths of elderly patients cause by abuse and improper care prompted the government to hold public consultations in 2007.

The government required owners of private nursing homes and residences to improve basic services in order to obtain a licence to operate their businesses. But since then, the certification process has proceeded at a snail's pace and little has been done to ensure that properly trained staff are hired to care for the elderly.

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