Submission to

Standing Committee on the Legislative Assembly

Regarding

Bill 175, Connecting People to Home and Community Care Act, 2020

submitted on behalf of **Kingston Health Coalition**

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Kingston Health Coalition is an affiliate of the Ontario Health Coalition. We monitor and mobilize in the Kingston metropolitan area and have supporters from a wide range of backgrounds. I have been active in the Kingston Health Coalition for over 15 years keeping track of health care developments and government policy related to health care. We communicate regularly with over 150 people in Kingston.

Our by laws define the purpose of KHC as
The Kingston Health Coalition (KHC) is an affiliate of the Ontario Health Coalition (OHC).
Its purpose is to promote the principles in the Canada Health Act (1984)
(universal, publicly delivered health care for all medically necessary health services. This health care must be portable throughout Canada and be accessible to all). It shall be bound by the requirements of the OHC for affiliates and work within the guidelines of the annual action plans of the OHC. It shall monitor health care delivery issues in Kingston and District in conjunction with the action plan.

Summary of our position on the legislation

This is a written statement that restates our oral presentation. It includes documentation for important assertions in our presentation, especially documentation that relates to the situation in Kingston.
We want to reiterate in this summary that we started from a view that the government is acting in good faith and believes it is doing the right thing. We made a sincere effort to understand the views of the government, and we opened our presentation with a respectful statement of what we believe to be the governments view.

We will make the case that the proposed legislation fails to build on the strengths of our health care system as demonstrated in Kingston during this crisis. As reflected in our observations in Kingston, it removes many of the protections that currently exist in legislation on home care and community care. It veers towards reinforcing the practices that have damaged certain aspects of our health care system, such as Long Term Care and Home Care. They have contributed to the crisis situation we have been observing and warning about based on experiences in Kingston. This legislation needs to be withdrawn. New policies and new legislation addressing health care reforms should take place only after full public scrutiny of the failures in long term care during the pandemic. This is because the legislation exacerbates, in home care and community care the for-profit model that was so destructive in long tgerm care. New polices and new legislation should only follow open and open-minded public consultation.

Contents:

A. Government Rationale

I considered the thinking of the government that led to this legislation. I perceive that they had three reasons for this Act. The increasing high cost and demands of health care, the inadequacies and failings in the current system and a view that health care represents an economic opportunity.

They think current costs are made worse by constraints of organized labour and bureaucracies. The capacity to react and reorganize the system is hampered by resistance to change. Demand can be managed if people pay their share.

They also think delivery of services have been impaired by reporting regulations, by under-utilized technologies that could be provided by the private sector and by uncoordinated services. Alternative

care patients in acute hospitals need to be moved into Home Care and Congregate settings that can provide lower cost care. People contracting for their services will lead to low-cost, good services.

They hope that allowing profit to be made in the health care system will be an economic boon. It will attract financial investment, professionals and innovation into Ontario. Lower taxes will make Ontario more attractive and encourage personal spending.

B. General Observation:

Sounds good. But not only is it not realistic and not only does it undermine public scrutiny and runs counter to health care for all on an equitable basis, it is a road to disaster. We have just seen the consequences of lax oversight of care delivered with a for-profit motive in the long term care sector. Thousands, yes thousands, of people have been killed by a lack of preparation for the crisis, by bottom-line motivations that have undermined staffing levels and availability of supplies and by four bedded wards for the poor and private accommodations for the more affluent.

C. The Importance of Inspections and Leadership

Kingston avoided having any case of Covid-19 in long term care. How? A public agency, the KFLA public health unit, set up a strict monitoring and reporting regimen in all health care facilities. The health unit mobilized its own and hospital and university resources to do testing early and well. The labs were provided with expertise and resources over the years that led to capabilities in place to do this right. This was done despite hospitals not being compensated for services outside the acute hospital mandate. But profit was not the motivator, devotion to public service was the motivator. The Public Health Unit generated co-operation and a common spirit in all, public and private. The existing system wasn't deformed, it was mobilized and unified by public leadership.

D What We Have Experienced with "Competitive Bidding" and For-Profit Care

Even prior to the pandemic we have seen in Kingston the consequences of for-profit care in Home Care and Long Term Care settings. Bad employment practices and precarious work models saved money and allowed profit, but at a cost. Staff recruitment difficulties; low care standards leaving patients sicker; increased rates of violence; injury from falls; failure to follow health plans. In home care reports are received of missed appointments because agencies fail to replace absent workers. People never know if they will get the same worker from appointment to appointment. Patients have refused to have workers back because of poor care practices. This is what we hear in Kingston. Is it different elsewhere?

And the model you are proposing will likely exacerbate the inadequacies. Bringing outside workers to deliver care in hospitals will undermine the authority of the hospital boards and extra fees will make services less accessible. We often hear from home care workers of their frustration at not being able to provide needed help to clients because it is not mandated. The private sector is enamoured with monitoring workers and tight scheduling, often unrealistic.

But who will determine those service mandates. This legislation allows private companies delivering the services to manage care assessments that will determine work loads and costs. Is this not a conflict of interest.

E. Alternative Care and Inadequate "Congregate Care"

We in Kingston are quite conscious of the issue of freeing up hospital beds. Queen's University and Kingston Health Sciences staff have been strong and early proponents of moving care into the

community. But we have seen how governments and agencies have dealt with such a mandate in the past. Over the years I have followed the way psychiatric patients were deinstituitionalized. I have followed them right into the prisons in which I worked. I have seen them homeless on the streets of Kingston, we have rooming houses with five or six in cramped sub-standard quarters. Where were the support services promised?

There is an assumption that the people waiting for alternative placement need less care. People in hospital may not need acute care, but they often need rehabilitative services and significant care for chronic illnesses. We lack chronic care beds. Instead, this act foresees creating congregate care facilities that will provide even less care and more warehousing than our long term care facilities. Where is the analysis of the real care that would be required by those pejoratively called "bed blockers". And the Act allows for fees charged to those housed in these congregate care facilities. Burden the sick and lame, what a shame.

F. The Market Economy and Health Care

Finally, I want to deal with the economic philosophy underlying this Act. I agree that the not-for-profit sector does not have a monopoly on good intentions. There are many excellent, caring and moral entrepreneurs. But the market place also rewards those who rise to the top through legal malpractices. Think of Boeing and the Max jet. Think of the tobacco industry, think of inflictors of the 2009 substandard mortgage crisis and the rating agencies who gave them the green light. And think of Sierra Homes.

In reality private services cost more in the long run. The Auditor General reviewed the costs of P3's and concluded that the P3's were going to cost billions of dollars more because of the costs of

financing. We understand that governments like hiding the real costs of care. Contractural fees are assigned to the year of the expenditure whereas debentures are a visible public debt. We also understand the attraction to government of lowering taxes by directing costs to the user. But health care is not a discretionary expenditure. Taxes represent a public health insurance plan. Everyone pays a little at a time based on what they can afford so that the care is there when they need it. It is a "sacred trust" that equal health care will be there for all no matter what their financial circumstances. Leadership involves bringing the public on side with necessary and well managed expenditures.

We recognize that there are areas of medical needs that are best provided by the private sector. And these areas provide ample opportunity for profit. Medical Equipment is produced by the private sector. PPE's are supplied by the priavte sector. New technologies and information systems may be enhanced by private innovation. Nonetheless, it is essential that the use of these technologies for medical care be insulated from profit. Profit for health care is not the cure.

G. Conclusion

We need to see what a public inquiry shows us about the impact of for-profit care on safe and good care. This Act needs serious revamping and a pandemic does not facilitate this. In fact, there are so many changes needed that the bill should be withdrawn. As the Fram Filter advertisement warned, Pay now or pay later such as the thousands of deaths in LTC.

Appendix A Two Recently Solicited Testaments on LTC and Home Care.

The following statements were in response to a request sent out a couple of days ago. They are exemplary of what we have been hearing regularly over the years although we haven't kept a record of such accounts. We are keeping the identities of these correspondents confidential out of respect for their privacy. You can be sure they are real. Most of us have had similar personal observations for someone close to us. (One response we received said "All my personal experience has been positive." I include this to be ethical and forthright)

ACCOUNT 1

I would like to share two separate home care experiences, one involving my late husband, and one involving a close friend.

I cared for my husband at home for 3 years following his dementia diagnosis.
I appreciated in-home respite hours through X Company, but using their services was stressful, as I never knew who would arrive. Often, it was someone new to us, so I couldn't leave until I had oriented her to our home and routines and allowed my husband time to adjust. That could take up a half hour of 2 or 3 hours respite time. More than once I had to ask X Company not to send a particular PSW again, as I didn't feel safe leaving him. Some arrived smelling so much of scented products or smoke that it aggravated his asthma. Of the many PSWs sent to us, only a very few had any training with dementia.

Trying to reach X Company re scheduling was always a challenge. I spent long periods on hold or waiting for a call back. Their service always seemed to be in near chaos That made it difficult to plan my own outings and appointments.

There was very little help from the LHIN to navigate services. For example, I needed help getting my husband to appointments, after he would no longer get into my car. It was left to me to call the various services for help, and in the end I had to hire a private van driver. That was an additional burden when I was already coping with the demands of caregiving. Had I received better in-home supports, particularly overnight help (none was available), I would have been able to delay sending my husband into LTC.

Our family friend (aged 89) was hospitalized at KGH for surgery last year. After a week he was discharged to his retirement home, although he could barely walk and no home care was in place. Although the hospital had phone numbers for his family and friends, no one was alerted and he was sent home alone in a taxi, with his walker in the trunk. The retirement home was not notified that he was coming, so he had to get himself up to his 3rd floor room without help. The risk of him falling was high. After 3 days, he got a week of twice daily home visits, but that ended before he felt he was ready to manage on his own.

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Good Morning,

You asked, so I shall provide an incident which demonstrates the lack of compassion, commitment to place patients well-being above all others considerations here at our local level. Last July, I had to call an ambulance to my friend of 40+ years apartment as I was unable to arouse him from what I assumed was a booze induced coma, or possibly a stroke due to the incidence of TIA's he has suffered for some years. Happily, it was not a stroke however by the end of the next 6-8 weeks in I was selfishly wishing it were not because of his drinking issues but because of what we experienced in our local hospital. My

friend spent his first week in a squalid, overcrowded, emergency ward. This was a hospital, and I remember when our hospitals were places of healing, places of compassion, not the meat grinders they are today in which the process appears to be focused simply upon getting this patients out of the building, yesterday. This man, once a robust six-plus foot business man, had deteriorated into a 138 lb. skeleton , who was incoherent, disoriented, confused, suffering badly for booze induced misery as the horrid drying out proceeded. By the end of day three all We heard from the Doctors was they expected to send him home the next day. Unwittingly, I morphed into my friends sole ADVOCATE engaged in a battle of wills with a cadre of skilled medical pros intent on moving him out of their hospital and sending him home, where they new he lives alone while all my energy was focused on keeping him there for much longer than they would prefer. My Friend, we'll call him Joe for simplicity, simply could not get out of the bed to do his toilet and they wanted to send him home, alone. I witnessed compassion dying that day, I witnessed an organization intent on putting profit before well being by professionals I once held in the highest esteem, not so much anymore. The story does not end here. Against their mutual efforts to send Joe home and my insisting they could not consciously send a man home in his deteriorated condition they relented to finding Joe a room. Most of the nurses and staff at the Nursing Station were the dedicated professionals Canada is renowned for sprinkled with a few who have given up on the compassion side and now show up because they have to earn a living. Joe, over the course of the next few weeks began the slow process of rejoining the rest of the world having not a drop of his favorite, nor one puff off a cigarette. To their everlasting credit these overworked folks were doing a superb job of rebuilding Joe, even if he was only a shadow of his former self. He was getting well, his sense of humor was returning and admiringly he was mor Ethan content to languish in this paradise in which he had nothing to do but heal. THEN, one morning, the same Doctor who had insisted he was going to leave the Hospital while Joe was down in emergency began his entrance int the room with , your going to be discharged TOMORROW, our nurses and physiology folks think you are

well enough to go home. Joe was obviously stunned at this news and remained quiet. While discussing with him how he arrived at this decision the Doctor was insistent that all would be well. I continued to suggest that Joe was NOT in any shape to go home, that his current apartment was not suitable for someone in his weakened condition, had a very steep staircase to the upper floors where his bedroom was, that Joe was unable with the aid of a walker to go more than a few feet out the door and down the hospital corridor, assisted, how was going to manage ALONE, at home with those stairs to contend with and reminded the Doctor that all the nasty bruising he had seen upon Joe's admission where mostly the result of falling down those very stairs while also drawing his attention to the missing couple of teeth resulting from such falls. Doctor NO was unpersuaded and remarked that I was being unreasonable and that he and his staff had conclude Joe was up to the challenge. The dialogue was becoming testy for both of us. I suggested to the Doctor that he ' SHOW ME ' that Joe is capable of managing this feat at which he said to Joe, get out off bed, use your walker and lets go for a walk down the hall. Joe was perplexed but at the continuing urgings if the Doctor attempted to get out of the bed and stand up with the walker, he could not and physiology was called to assist Joe who made it , WITH THEIR HELP, about twenty feet down the corridor at which point he was trembling and physio. helped him sit down, as Doctor observed. I remained silent throughout this entire test but now even more adamant that Joe was not leaving anytime soon. To his immense credit the Doctor turned to the two physio folks and ask them if they thought Joe was ready for discharge, they both said no, the Doctor said I agree, turned, shook my hand and said we will be contacting Providence Care, have Joe evaluated for continuing physio. One month later Joe, a much improved, much happier man, left Providence Care under his own steam, got into my car by himself and we drove to a Rehab. Facility out of town where Joe spent the next month learning how to stay well, stop drinking, and reconnect with the rest of the world. Joe and I talk every day , just for a few minutes, to ensure we are BOTH doing well. I am absolutely happy to report that today Joe has not had a drink in all this time, happily attends

AA as well as other support groups, and is the pride of his instructors together which they are a mutual admiration society. Now just imagine, if Joe had not had someone to be his advocate, how might this have turned out, if the Doctor had succeeded in sending this broken man home before it was time. The purpose of this long example is to demonstrate that all of us working for a common purpose, the wellbeing and reconstitution of a broken human, VS the unconscionable drive for EFFICIENCY and PROFITS must be the GOAL of our Health Care System. Contrary to neoliberal-capitalist belief systems, Health Care must indeed mind the store but recognize the wellbeing of the PRODUCT, is the overwhelmingly most important function and is not a place where mindlessness for PROFIT overrides. The very best of luck KHC in your support for Humanity over Insanity !

Another example, my 84 year old sister, had to be placed in a LTC In late April, in XTown Ontario her needs , not through lack of trying, but due to his own substantial infirmities . Her children have been managing their parents healthcare needs for a considerable time however are unable to cope with their mothers particular issues necessitating her being placed in a LTC on the advice of medical professionals who evaluated her. The only good news I am able to report is that this facility has not had any incident of Covid-19 infection which I sincerely hope is due to good management, adherence to the prescribed protocols In the ensuing weeks my sister has grown progressively worse as her disorder takes control of her daily life. There have been incidents in which she has physically struck other residences, becoming increasingly disoriented by her surroundings, and making it difficult for the staff to control her. The LTC is relatively small and does not have a secure section in which she can be isolated from others. Consequently, the LTC has been trying to locate another healthcare facility that has a “ Lock Down “ to which she can be sent and which is far better quipped to manage her needs. I broke my Pandemic isolation/quarantine ritual yesterday to visit my sisters family, a ninety minute drive, to deliver a “ Walker “ which she will need for mobility and to provide some much needed

emotional support. During this short visit they shared their continuing frustration working with this LTC and its staff. My sister refuses to eat, take her much needed meds, is getting progressively weaker and unable to get out of bed without a mechanical lift device, a problem that has been getting progressively worse over the last several days. I asked my nephew who has P.O.A., why they have not put his mother on an intravenous feeding tube ? He immediately called the LTC spoke with a staff member and questioned why this had not been done. She was unable to explain and turned the call over to another staff member whose response when asked why this has not ben done replied, “she is big enough that a few days without food is not a serious issue “. On the question of meds being missed his response was that they are keeping here calm with some particular narcotic which was injected.This conversation was over speaker phone so all present heard the entire back and forth dialogue. Needless to say, our reaction was to be appalled. These people were unprofessional, appeared disinterested, gave vague answer to questions asked all while talking to this ladies children. An additional issue with this facility is its apparent inability to receive requests for information , all of which has been sent to them via email records of which my nephew has kept. Example: they claimed they did not receive a copy of the requested P.O.A. so they had to drive to the LTC with the original copy which was then photocopied. Other emails again were not received at their end yet the senders computer indicated it had. I, myself, had sent the LTC an email several weeks ago, identifying I was the patients brother, simply requesting an update after her first few weeks. No reply has been forthcoming. Repeated requests for the status of the pending move to a hospital in Belleville are met with seeming disinterest and that it should happen soon. All of this is unfolding as our world experiences its worst Pandemic in a hundred years, in which the population is in mandatory quarantine/isolation while our governments dither, while our Health Care Professionals and their equally diligent Support Workers are experiencing overwhelming exhaustion providing compassionate care to the sick, and dying, while the For Profit LTC enterprises throughout Canada show all of us why the are considered to be the worst providers in

the World, have the highest incident of infections and resulting deaths in the World. Meanwhile, behind the scenes our Premier, and his inner circle of stalwarts, work most diligently to further dismantle, render unworkable, and deregulate our cherished , once, very proud Health Care System. Despicable conduct, unbecoming to those who purport to place the needs of the People above all other considerations in their disingenuous MSM pronouncements.

Appendix B Documentation and further commentary on the Long Term Care situation and the impact of for-profit care on the way it operates.

Last year in preparation for a media event on Violence in Long Term Care the Kingston Health Coalition searched the home reports on the Ministry of Health website and came up with the following tabulation.

(Three municipal, 1 not-for-profit and six private facilities were included. If requested, we can supply the raw data.)

Tabulation of incident reports from Kingston and area long term care facilities 2017 and 2018

	A	B	C	D	E	F	G	H
Gleaned from Inspection reports 2018 and 2017	# beds	Falls and falls with injury	falls with tfr to hospital	abuse - unspec. or verbal	including rough handling	resident abuse - unspec or verbal	inc with injury) -not sexual	including verbal and touching)
Public and Not for Profit	709	20	9	11	0	9	2	7
For Profit	788	7	17	12	4	9	5	11
Total	1497	27	26	23	4	18	7	18
		A + B		D + E		F	G + H	
		53		27		18	25	

	I	J	K	L	M	N		
	including missing meds	follow case plan	charges without notice	unexpected death	unspecified	staff abuse verbal	groping, etc	
Public and Not for Profit	9	16	2	2	1	0	0	
For Profit	18	25	0	2	0	1	1	
Total	27	41	2	4	1	1	1	
	I+J		K	L + M		O + P		

I am pasting below the KHC commentary on this data. Note that we highlighted the dangerous state of long term care at that time (prior to the current pandemic). Note also that the recommendations run counter to the direction this Bill 175 is going.

1Thank you all for coming to this media conference. My name is Matthew Gventer and I am a co-chair of the Kingston Health Coalition. My role will be to link the report, **Situation Critical**, and our local situation.

I have observed that the emphasis in the media given to the report since it came out last week has been on the violence and especially the number of homicides. While that has been useful to get the public's attention to the immediacy of the situation, without the next step nothing has been gained. The purpose of the report is to make clear that the situation can be made better. There is an easily commuicated action represented by the number 4.1. Each resident needs 4.1 hours of individual attention. I will explain where this number comes from and what difference it would make.

Let me highlight the data on the situation in our local communities.

At the end of these notes is a summary of data I gleaned from the inspection reports on the ten most local long term care facilities. (6 for profit and 4 municipal or not for profit) These homes have a total of 1497 beds. If you look at the chart you will see that I counted 25 cases of physical abuse by one resident against another, 18 of which were of a sexual nature. There were 27 cases of staff experiencing abuse four which were of a physical nature. As important as these numbers are, it should be noted that there were 53 cases of residents falling 26 of which led to transfer to hospital and there were 68 reports of neglect or failing to follow a case plan 27 of which were medication errors. A number of these events had serious consequences for the residents or at least created significant discomfort for them. This is over a two-year period. Frankly, these numbers probably understate the situation and this will become clear when you hear from the other speakers. These are the cases that have come to the attention of the inspectors but many day-to-day interactions where staff are insulted or residents become agitated and act out are not recorded anywhere. [1]

As a layperson getting to know about the situation I was quite impressed with the guidelines that summarize the regulations controlling long-term care. [2] It is expected that there be an emphasis on restoring residents capacity to function to whatever extent possible. For example where a resident has become incontinent approaches are to be taken that will help them regain continence and resulting independence. It is mandated that staff use methods to manage what are called responsive behaviour. Responsive behaviour refers to residents becoming upset at interventions or assistance being offered by staff. The problem with the guidelines is that there are no timeframes included. Without adequate staff, implementing these guidelines becomes a nightmare. Hence the reports of failings and harm.

The Center for Medicare and Medicaid Services is the U.S. federal agency that administers the Medicare program and also is mandated to set standards for long term care. There are studies of how much time it takes nursing staff to carry out functions. For example, one study found that it takes 60 minutes a day to monitor and help with dressing functions of a resident if the resident needs a little help. Thus the need for sufficient staff. “CMS’s recent analysis of expected staffing levels taking into account acuity indicates that the average U.S. nursing home should have 4.17 total nursing hprd, including 1.08 RN hprd.” [3,4] (hours per resident day)

Another important message in **Situation Critical** is that the for-profit model for long term care is making the situation worse. The impact is not just the occasional derelict function of a for profit home as has happened recently in our community with the forced closing of an ltc facility. It is not just putting staff and residents in difficulty where a for-profit institution chooses to run short when staff are

not available. No, an even more worrying phenomenon is the impact the for-profit companies are having on the not for profit and municipal homes. I was walking down the street a few months ago past long-term care facility and found the workers on a picket line in front of the building. I asked why they were there and they said they were protesting staff cuts that were going to make their work situation worse. They said that, when they talked to the management about it, management argued that the facility was just moving to the same standards as in the private sector. It is the industry association dominated by the for profit sector that is pressuring the government not to introduce minimum hours of care standards. [5] They are asking for more funding without ties as to service implementation. It is rumoured that operators are pressuring the government to end the practice of surprise inspections. The Ontario Long Term Care Association did recommend publicly that the annual Resident Quality Inspection be carried out only every three years (in a submission to the Wetlaufer Inquiry). [6]

I don't want to take more time from the speakers, except to emphasize one other major message from the report. The need is growing. The waiting list and delay in finding a placement is increasing. There is lots of evidence that the functional level of the residents of nursing homes is falling and the severity of impairment is increasing. We know that there has been a reduction in psychiatric beds and in alternative care beds. It was only a few years ago that Kingston saw a decrease of about 120 such beds. Without adequate community services for the people who were displaced these people are ending up in long-term care facilities which increases the acuity of care needed by residents such facilities. We need more beds, we need them to be public, and we need adequate staffing with a clear standard for hours of direct personal care per day per resident. It is important for the people of the province to recognize that the moral imperative is for us not to try to do this “on the cheap” and to make this known to the government.

1.
“Official reporting of violence Research suggests that the vast majority of violence in long-term care goes unreported. Studies indicate that official reports are generally completed only if medical attention is required.”
“For the most part, either nothing is said, or a comment might be made to a nurse. Such comments, however, are unlikely to result in a formal, written report. Donna Goodridge and her colleagues, for instance, estimated that of the 15,000 incidents of violence experienced over a six-month period, less than one per cent (0.27%) had been reported.”
https://www.longwoods.com/articles/images/Violence_LTC_022408_Final.pdf
“**Out of Control”: Violence against Personal Support Workers in Long-Term Care** [3]
Albert Banerjee, Tamara Daly, Hugh Armstrong, Pat Armstrong, Stirling Lafrance, and Marta Szebehely
February 23, 2008, York University and Carleton University

2.
A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10
Ontario Ministry of Health
http://health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf

3.
Expert recommendations for minimum staffing levels

“A Centers for Medicare & Medicaid Services (CMS) study in 2001 established the importance of having a minimum of 0.75 RN hours per resident day (hprd), 0.55 licensed nurse (licensed practical nurse [LVN]/licensed vocational nurse [LPN]) hprd, and 2.8 CNA hprd, for a total of 4.1 nursing hprd to meet federal quality standards.30 As part of this study, a simulation model was used to determine the minimum number of CNAs needed to provide 5 basic activities of daily living care. The results found a minimum of 2.8 CNA hprd to ensure consistent, timely care to residents. These findings were later confirmed in an observational study “

Health Serv Insights. 2016; 9: 13–19.
Published online 2016 Apr 12. doi: 10.4137/HSI.S38994
PMCID: PMC4833431
PMID: 27103819

The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes

Charlene Harrington, John F. Schnelle, Margaret McGregor, and Sandra F. Simmons

4.

Failure to Meet Nurse Staffing Standards: A Litigation Case Study of a Large US Nursing Home Chain

Charlene Harrington PhD, RN, Toby S. Edelman, J.D.
First Published July 20, 2018 Research Article
https://doi.org/10.1177/0046958018788686

5.

Quote from the Chatham Daily News.

“Candace Chartier, chief executive of the Ontario Long-Term Care Association, said a minimum standard of care is a “cookie cutter” approach that may not make sense.

‘Not every resident in the province needs the same level of care,” she said. “We are optimistic with this new government, they are putting more beds in the system.’”

High rate of homicides among concerns raised in report on Ontario's long-term care system, Ellwood Shreve and Canada Press, Jan 21, 2019

6.

PUBLIC INQUIRY INTO THE SAFETY AND SECURITY OF RESIDENTS
IN THE LONG-TERM CARE HOMES SYSTEM
CLOSING SUBMISSIONS OF THE ONTARIO LONG TERM CARE ASSOCIATION
Pursuant to Rule 68 of the Rules of Procedure for the Public Hearing
September 20, 2018pp 19-25