Submission to the Standing Committee on the Legislative Assembly
Bill 37: Fixing Long-Term Care Act, 2021

Submitted by:

The Regional Municipality of Peel

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The Regional Municipality of Peel (the Region) commends the Ontario government for taking important steps to (1) improve staffing & care; (2) protect residents through better accountability, enforcement & transparency; and (3) build modern, safe and comfortable homes by addressing home infrastructure & development. Given the enormous impact of the COVID-19 pandemic on long-term care (LTC) homes, and especially in Peel, infection prevention and control practices (IPAC) are an important fourth pillar of LTC improvements that should also be explicitly articulated through legislation.

This submission to the Standing Committee on Bill 37, the *Fixing Long-Term Care Act, 2021* (the Act) presents important considerations building on the Region's original submission prior to the release of the Act (attached as a separate submission) but also notes specific suggestions for the new Act (see Appendix I). The new Act is an important step towards strengthening LTC service delivery and protecting residents. However, we feel that a stronger commitment to and the explicit articulation of emotion-based care, enhanced infection prevention and control practices and continuous quality improvement will help to not only provide a clear and robust blueprint for the sector, but also set an important precedent for true long-term care transformation.

Key Opportunities to Strengthen the Fixing Long Term Care Act, 2021

Several of the Region's own recommendations align with the province's three pillars noted above. A fourth pillar focused on IPAC practices is also included. While some areas of opportunity may be addressed through specific regulations, this submission notes the broad opportunities that exist and presents specific language (where possible) to help strengthen the commitments that are set out in the new legislation. Specific language or changes to the Act are

detailed in both the original submission the Region submitted before the Act was released and noted in specific recommendations related to the new Act in Appendix I.

A. Improve staffing and care

The Act should set out staffing and care standards so that **emotion-based care** principles inform the staffing and contingency plans within a home and ensure that the staffing mix of the interdisciplinary team, skill set, and training requirements all support emotion-based care for residents. These amendments would also require staff to identify the emotion-based needs of residents when they enter LTC homes and ensure these needs are a part of the plan of care on an ongoing basis. While the *Fixing Long-Term Care Act, 2021*, highlights direct care hours and targets to inform staffing plans and the staffing mix in homes, there is no explicit mention of emotion-based care principles related to staffing.

To support emotion-based care, the Act should explicitly define what emotion-based care and emotional well-being mean in the context of delivering care. The Region recommends that the Ministry of Long-Term Care:

- Revise inspection tools/protocols to include specific emotion-based requirements so that inspectors can effectively address non-compliance; and
- Provide flexibility for increased innovation, reduced duplication, and streamlining of reporting requirements

Adapting these changes into the legislative framework in the Act will save time for LTC home staff to focus on delivering emotion-based care to residents.

Other specific improvements to staffing and care should include:

- **Ensure comprehensive vulnerable sector screening and yearly declaration for staff:** Protecting residents is central to the new Act. To ensure this, the legislation should require all new staff to get vulnerable sector police checks and mitigate any barriers to getting full

records (i.e. since some staff have been exempt, and some records may be suppressed at a federal level despite being relevant to screening for vulnerabilities related to performing duties in LTC). Yearly declarations by staff would also ensure new charges or convictions are identified. These changes would protect the safety of residents.

- **Improve supports for specific LTC staff:** The minimum minutes per resident per month required to complete clinical and nutritional care duties has historically not offered registered dietitians sufficient time to collaborate in the development and improvement of nutritional care, hydration management and dietary services. Efforts to address this should be reflected in any new associated regulation. Another example is the minimum staffing hours for food service workers. By changing the formula for calculating staffing hours for food service workers and ensuring an increase to the minimum required staffing hours per week, it will allow staff to support all aspects of the meal service and ensure personal support workers have adequate time to feed and assist residents as required.
- **Strengthen resident care:** The Region has made several recommendations to improve specific regulations pertaining to skin and wound care, pain management and menu planning. The recommendations (noted in our original submission also attached) indicate that greater specificity, clarity and where applicable, flexibility will allow LTC homes and staff to provide appropriate levels of support to meet residents' needs and align with the Residents' Bill of Rights.
- **Streamline the complaints process:** Building on prior recommendations, the Region suggests more explicit acknowledgement of verbal and written complaints (for example, email complaints do not have to be reported to the MLTC Director if they are resolved within a short amount of time). Further, LTC homes should be provided with protection against frivolous or unsubstantiated complaints by requiring a complainant to be accountable for their complaint submission. Accountability can be achieved through requiring the

complainant to provide details to support a thorough investigation and/or mandatory participation with the home staff to address the complaint.

As a municipal operator of five LTC homes in Peel, the Region calls on the government to allow for programming and spending flexibility to support increased innovation such as the emotion-based care, which Peel has been implementing with great outcomes. This should include flexibility around the commitment to an average of four hours of care, recognizing that as care needs continue to become more complex, an average of four hours will not be sufficient for many residents to receive high quality care.

Reducing duplication and streamlining of reporting requirements are themes in several of Peel's comments, which could save a significant amount of time for LTC homes that could be better spent providing quality care for residents. If not explicitly addressed in the Act, the Region feels that these recommendations may be incorporated in the regulations which are currently under development.

The Region also calls on the Standing Committee and Ministry of Long-Term Care to consider how to enhance support across the LTC sector, including re-evaluating the funding model for homes (especially those providing care to residents with dementia) to ensure that base funding better matches staffing resources to resident care needs. Adequate funding will be the underpinning for several important shifts which have been introduced in the new legislation; ensuring system transformation will also require explicit enunciation in the regulatory framework which will accompany the new legislation to ensure operationalization and sustainability of these important changes across the sector.

B. Protect residents through better accountability, enforcement and transparency

While the Region supports the *Fixing Long-Term Care Act, 2021* for recognizing person-centered care in the preamble and Resident's Bill of Rights, there is still a need in the Act for a

clear commitment to requirements for emotional well-being in plans of care. More specifically, emotion-based care should be included in the preamble, the Residents' Bill of Rights (in consultation with Residents' Councils), and in the requirements for admission and plans of care. Key opportunities include:

- **Incorporate emotion-based care needs into the Residents' Bill of Rights:** To enhance the commitment in the current legislation, the Residents' Bill of Rights should ensure that emotion-based care needs are met and that every resident's lifestyle and choices are respected. Specific language as noted in Appendix I will ensure that commitment to resident well-being is made explicit and provide an important template for homes to build their own policies.
- **Provide a supportive and enabling approach to compliance and inspections:** Establish a compliance and inspection approach that encourages and assists with training tools, coaching and developing a robust community of practice to share learnings and sector improvements, in alignment with Recommendation 73 of the LTC COVID-19 Commission. Any enforcement tools (including monetary penalties) should only be used in a way that does not negatively impact care.

Specific changes recommended by the Region are outlined in Appendix I.

C. Build modern, safe and comfortable homes through infrastructure and development

The *Fixing Long-Term Care Act, 2021*, should articulate a clear commitment to designing spaces with an end-user focus to address the challenges that are associated with dementia and progression of the disease, as this is not currently outlined in legislative requirements.

- **Revise design standards for homes:** The new Act should present clear mandates and building design standards to ensure that living environments are smaller (10 to 12 people), dementia friendly, and more 'home-like'.

With improved quality of care being a central focus of the new Act, the Region also recommends the following changes:

- **Ensure a comprehensive quality program:** All LTC homes should be required to implement a comprehensive quality program rather than a Continuous Quality Improvement (CQI) initiative which encompasses all aspects of quality management, such as continuous quality improvement, resident safety, quality assurance and enterprise risk management.
- **Standardize Resident and Family /Caregiver Experience Surveys:** All LTC homes should be required to use a standardized resident and family/caregiver survey tool that is developed for the sector utilizing an evidenced-informed framework and in consultation with LTC homes given their experience in conducting the annual survey. These surveys should also incorporate the concept of emotion-based care, measuring emotional wellbeing.

D. Infection Prevention and Control

Improved Infection Prevention and Control (IPAC) and measures to manage and mitigate outbreaks are also a central focus. Given the impact of COVID-19 in Peel, the Region supports strong measures to ensure all LTC homes are equipped to respond to future outbreaks including:

- **Ensure appropriate staffing to manage IPAC requirements:** This includes sufficient staffing levels to respond to outbreak and cohort residents and staff, as well as a requirement for homes to have a dedicated IPAC lead in association with local public health units. Further formalization with the local medical officer of health and local public health unit will ensure that each home is responsible to have an IPAC lead that possesses the qualifications provided for in the regulations.

- **Mandate revised ward layout to two beds per room:** Ward rooms in LTC homes should not allow more than two beds per room. The design of the home is not only important for resident well-being but an important component of IPAC especially during outbreaks.
- **Enhance audit IPAC measures:** These measures should include requirements to audit staff IPAC activities, regular monitoring and auditing of personal protective equipment (PPE) and other necessary supplies.
- **Connect IPAC requirements with the *Health Protection and Promotion Act*:** So that protocols linked to outbreaks and other infection diseases including required outcomes and accountability measures, are appropriately provided for in associated regulations.

Conclusion

As a municipal operator of five LTC homes in Peel, the Region of Peel is very familiar with the challenges facing the LTC sector, and these recommendations regarding emotion-based care, enhanced infection prevention and control practices, as well as continuous quality improvement. Have been compiled based on firsthand experience.

The Region appreciates the opportunity to provide input for the Committee's consideration as the new Act is an important step in the transformation of the LTC sector to ensure that residents are protected and afforded the care and respect that they deserve.

Appendix I.

Region of Peel Recommendation and Details	Relevant sections of Fixing Long Term Care Act, 2021	Evidence / rationale
Recommendation: Revise the Residents' Bill of Rights to include the right to have their emotion-based care needs met. e.g. Every resident has the right to have their lifestyle and choices respected, and their emotion-based care needs met.	s. 3(1) 2.	2. Every resident has the right to have their lifestyle and choices respected.
Recommendation: Incorporate all aspects of care noted in s. 3(1) 1 & 2. (Residents' Bill of Rights) into the requirements of the plan of care (initial and ongoing).	s. 6(3) & O.Reg. 79/10 s. 25&26	**s. 3(1) 1. & 2. Residents' Bill of Rights** Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. 2. Every resident has the right to have their lifestyle and choices respected.
Quality		
Recommendation: The update to a continuous quality improvement initiative is vague. Recommend that the essential components of a quality management program such as quality	s. 42	**Continuous Quality Improvement** Every licensee of a long-term care home shall implement a continuous quality improvement initiative as provided for in the Regulations.

improvement, quality assurance, performance & risk management are included.		
<u>Recommendation:</u> A standardized resident and family/caregiver survey tool should be developed for the sector utilizing an evidenced-informed framework and in consultation with LTC homes given their experience in conducting the annual survey.	s. 43	**Resident and Family/Caregiver Experience Survey:** Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once a year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.
Infection Prevention and Control		
<u>Recommendation:</u> Specify the need for joint inspections and collaboration with the local public health unit during outbreaks or in response to IPAC complaints or concerns. Reports described under sections 152 (1) and 152 (3) should be shared with the local public health unit when IPAC or other public health concerns are identified.	part X & s. 152 (1) & s. 152 (3) & s. 23 (5)	LTC inspectors should also inform the local Medical Officer of Health of IPAC lapses or issues identified in their inspection and share inspection reports.
<u>Recommendation:</u> Reporting requirements to the local Medical Officer of Health under the Health Protection and Promotion Act should be referenced.	s. 23 (2)	Bill 37 covers only some of the reporting requirements for LTC homes. The requirements for reporting to the local Medical Officer of Health should be referenced in the event that inspections reveal issues of public health concern.
<u>Recommendation:</u> There should be direction and funding provided to maintain staffing levels at numbers that would allow each home to provide effective response in the event of any outbreaks and to cohort	s. 21	Every licensee of a long-term care home shall ensure that the home meets the staffing and care standards provided for in the regulations

residents and staff appropriately.		
Recommendation: The requirements for the qualifications of the infection prevention and control lead should be developed in association with local public health units and include a minimum training/certification.	s. 23 (4)	Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.
Recommendation: In accordance with current regulations, infection prevention control leads and staff should have knowledge of the reporting requirements to the local Medical Officer of Health and the processes for collaboration with local public health units. This should be part of the training for the infection prevention control leads and staff.	s. 23 (5)	Every licensee of a long-term care home shall ensure that the infection prevention and control lead possesses the qualifications provided for in the regulations.
Recommendation: Ward rooms with 3-4 beds per room should not be reinstated.	s. 5 & s. 23	(5) Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. There are significant infection prevention and control challenges associated with this type of design and organization of rooms that leave residents vulnerable to infectious outbreaks
Recommendation: The infection prevention and control program should include requirements for regular auditing	s. 23 (2)	There should be a system for routine monitoring of compliance with infection prevention and control activities. Agency staff, essential caregivers and volunteers should be

of staff infection prevention and control activities.		considered in all infection prevention and control activities.
Recommendation: There should be reference included for the need to maintain adequate personal protective equipment (PPE) supplies and monitor these supplies on a routine basis	s. 23 (2)&(3)	The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes and accountability measures, provided for in the regulations.
Recommendation: There should be direction included for the infection prevention and control program to develop connections with the local public health unit and IPAC hub.	s. 23	Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home
Recommendation: The standards for the infection prevention and control program should reference requirements under the Health Protection and Promotion Act, such as the respiratory outbreak protocol and other infectious diseases under the infectious diseases protocol.	s. 23 (3)	The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes and accountability measures, provided for in the regulations.

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Region of Peel Submission

Amendments to the Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulations 79/10

Introduction

The Region of Peel welcomes the opportunity to provide feedback with respect to proposed legislative and regulatory changes to the long-term care (LTC) sector under the *Long-Term Care Homes Act, 2007 (LTCHA).* As a municipal LTC operator, the Region cares for people with complex care needs, fills gaps in service to address community need and, as a decided leader in the sector, is transforming care through an emotion-based, person-centred approach. Currently, the Region owns and operates 703 LTC beds, across 5 LTC homes. From 2010, there has been a 50 per cent increase in the proportion of people living in our LTC homes with dementia, with nearly 2 out of 3 people in the Region's LTC homes impacted by dementia. It is critical that LTC homes are provided with the necessary tools to deliver emotion-based care to this increasingly complex resident population.

Since 2017, the Region has been implementing the Butterfly model of care. Emotion-based models of care, such as the Butterfly model, shifts the way in which care is provided, from being task-oriented to truly put the person at the centre of care and focus on their overall wellbeing in addition to their clinical needs. The Butterfly model also creates a home-like environment with dementia friendly design. With Regional Council's unanimous endorsement, the model is currently being rolled out across all five Regional homes. LTC homes that have implemented the model have seen significant improvements in resident quality of life, particularly in the areas related to the early identification and management of responsive behaviours, resident and staff safety and mitigation of high-risk incidents.

The Region has been a sector leader in transforming LTC through an emotion-based care approach. That is precisely the reason why the Region is well positioned to provide feedback on legislative changes being considered for the LTCHA given our role as a municipal LTC home provider and focus on enhancing supports and services for seniors.

Submission Overview

This review of the LTCHA is an important opportunity to identify and reduce barriers for persons with complex care needs and introduce clear requirements and flexibility to allow LTC homes to deliver emotion-based, person-centred care by transforming the current legislative and regulatory framework.

The Region of Peel applauds the Government of Ontario's recent commitment to implement a minimum of four hours of direct care per resident, PSW and nursing training and additional supports throughout the COVID-19 pandemic. However, these are partial measures to complete the transformation of the sector and ensure consistent and sustainable emotion-based models of care across the Province. Legislative change is needed to remove barriers such as reducing administrative burdens and duplication for LTC homes to dedicate more time to front-line care. The Region also continues to call on the Province to address the long-standing challenges related to underfunding of resources to implement emotion-

based, resident-centered care and ensure the safety and wellbeing of vulnerable seniors, their caregivers and LTC staff.

There are aspects of strong alignment between the COVID-19 Commission's final report and recommendations, AdvantAge Ontario's recent submission regarding proposed changes to the LTCHA, and the Region's recommendations. Specifically, there is a need to allow for increased flexibility to deliver emotion-based models of care and shift the culture of enforcement within the Act from punitive to one that prioritizes emotional well-being and quality of life for residents. Based on our review of the legislation and regulation of the LTC sector, additional, more specific changes to the LTCHA and Ontario Regulation 79/10 are highlighted in Appendix I.

Recommendations

The Region of Peel is well positioned to provide robust recommendations for changes to the LTCHA and regulations given our role as a municipal LTC home provider and focus on enhancing supports and services for seniors as a current Term of Council priority.

Recommendations for the Ministry's consideration are organized into three themes below.

Enable emotion-based models of care in the LTCHA

Delivering emotion-based care currently requires homes to creatively work within the existing legal frameworks that govern requirements and apply to LTC homes across the province. As public sector organizations, Ontario's LTC homes operate in a complex statutory and regulatory environment. In addition to the LTCHA, LTC homes are subject to a number of health sector specific pieces of legislation, including the *Connecting Care Act, 2019*, *Excellent Care for All Act*, *Personal Health Information Protection Act, 2004*, and the *Regulated Health Professions Act, 1991*, among others. Taken together, LTC homes are mindful of the complex and often overlapping frameworks that have resulted in significant barriers to implementing emotion-based models of care. It is essential that any future amendments to the LTCHA meaningfully enhance emotion-based care as an outcome for residents and avoid duplication that is a barrier to quality care.

The Region recommends prioritizing emotion-based model of care within amendments to the Act to enable health service providers to improve quality of life outcomes for seniors. These amendments will require staff to identify the emotion-based needs of residents when they enter LTC homes and will allow for these needs to be a part of care planning on an ongoing basis. This type of care can be measured and reported through revised inspection protocols, inspector observations, Residents' and Family Councils, and Satisfaction Surveys that can account for and assess the quality of emotion-based care being offered.

As an example, currently, despite having a definition of emotional wellbeing within the LTCHA, the definition is very broad and is not supported in the assessment of care at the home level. There are no clear criteria on what constitutes emotional wellbeing, a validated way of measuring it, or a consequence for not meeting it. People can sit in front of a television all day devoid of meaningful engagement, which research has shown reduces life expectancy by three years, but this still meets the ministry's requirement for providing safe care. Moving forward to include emotion-based care in the LTCHA is essential to set the

tone for a shift in values and principles on which the structure of the LTC home system is based. The LTCHA should be an enabler for emotion-based care, not impeding the adoption.

The Region of Peel Recommends:

Introducing sweeping changes to the *Act* that will enable and encourage emotion-based care and inform inspection protocols. Such changes include amending the preamble, the Residents' Bill of Rights (in consultation with Residents' Councils), requirements for admission and plan of care.

Address Staffing and Staff Training

Emotion-based care requires LTC homes to transform how staff roles are developed and ensure staff and volunteers receive appropriate training. Without an adequate number of staff, many LTC homes struggle with their capacity to provide quality care within policy constraints. To address this, the focus should not only be on increasing the ratio of staff to residents, but also ensuring the current staffing complement allows and facilitates staff to build relationships with residents to provide emotion-based care, that there is staff continuity (reduced staff turnover, increased staff retention and satisfaction) and that staff have time to provide emotion-based, person-centred care. These changes require a complete cultural change within LTC homes and also legislative support so that LTC homes are encouraged to work collaboratively with staff, volunteers and family caregivers to achieve an emotion-based, person centered model of care.

In addition to legislative requirements, dedicated funding is necessary to help LTC homes train staff, volunteers, and families in supporting emotional wellbeing for residents, and to account for increased hours of care that are required to achieve high quality emotion-based care.

The Region of Peel Recommends:

Amending the regulations in the LTCHA that set out staffing and care standards so that emotion-based care principles inform the staffing and contingency plans within a home and ensures that the staffing mix of the interdisciplinary team, skill set, and training requirements all support emotion-based care for residents.

Support Emotion-Based Physical Design of LTC Homes

The COVID-19 Commission's final report recommended (recommendation #64) that new LTC home design standards should ensure IPAC design standards are in place and maintained. With emotion-based, care becoming a central principle to the quality of care delivered in LTC homes, the design standards outlined in the LTCHA should also specify requirements on dementia-friendly design and support the needs of interdisciplinary team environments that support and enhance collaboration to deliver emotion-

based models of care. Building and designing for emotion-based care will support good public health measures for infection control and IPAC requirements as many of the strategies support both such as individually directed activities and dedicated supplies that are not shared.

The physical design of LTC homes is central to ensuring that the environment emphasizes both safety and quality of care. Through emotion-based models of care, such as the Butterfly model, residents are provided with a positive, engaging, and socially connected environment that reduces isolation, promotes positive social connections, and creates a 'home like' environment where residents are made to feel comfortable and supported. For example, the Region has made structural modifications to their homes such as painting them vibrant paint colours and re-designing the home areas to offer more intimate spaces for eating and engaging in activity. Our Butterfly homes are also divided into smaller homes so people who live there feel less like they're living in an institution and in addition, ensuring their space is purpose-built to support their stage of dementia. For example, people in the later stages of dementia require smaller, quieter and calmer spaces that reduce irritants and stimulants. Dementia-specific home areas have been shown to reduce incidents between residents and towards staff.

The Region of Peel Recommends:

Establishing clear mandates and building design standards to ensure that living environments are smaller (10 to 12 people), dementia friendly, and more 'home-like'. Spaces should be end-user built to address the challenges that are associated with dementia and progression of the disease.

Enablers of emotion-based care

Flexibility within the LTCHA Standards

Central to the implementation of emotion-based, person-centred care is the need for resourcing as well as a supportive regulatory environment. The LTCHA should enable innovative models of care by establishing appropriate parameters for staff to be able to meet resident needs and providing enough flexibility to enable the provision of emotion-focused models of care and provide specialized care as care needs become increasingly complex. Regulatory flexibility has also been echoed by AdvantAge Ontario and will be the key to innovation and culture change within the LTC sector.

For example, the Act sets out restrictions on when food can be served to residents despite residents' preference for more dining options and flexible times. As a result, staff may be fearful of meeting a resident's dining request where it is not in compliance with the regulations, because the home could be sanctioned for breaking the law. Empowering staff to make choices that are aligned with residents' needs would go a long way to improve the culture of the workplace by giving staff the space they need to do their job. Providing staff with the flexibility to determine the appropriate schedule based on resident needs and desires would allow residents to feel less constricted in their homes.

The Region of Peel Recommends:

Amending the LTCHA to provide flexibility for increased innovation, reduce duplication, and streamline reporting requirements to save a significant amount of time for LTC homes that could be better spent providing quality care for residents.

Linking Emotion-Based Care to Safety and Quality Requirements

For emotion-based care to be adopted as a universal care model in LTC homes, the LTCHA requirements and regulations must ensure a mechanism that reinforces principles of emotion-based care and clearly outlines those principles as requirements within quality-of-care standards.

The current compliance model outlined in the LTCHA regulations are punitive and there is broad sector agreement that current regulations outlined in the LTCHA need support to be implemented. In addition to outlining emotion-based care requirements within the Act and regulations, there also needs to be resources that can support the sector with implementation (guidance materials, interpretive support, help navigating regulatory requirements), and tools that can help leverage expertise across the sector – such as the expertise of LTC homes that have implemented emotion-based care with other homes a train-the-trainer type model.

The Region of Peel Recommends:

Amending the LTCHA to introduce a supportive and enabling approach to compliance and inspections that encourages and assists with training tools, coaching and developing a robust community of practice to share learnings and sector improvements, in alignment with Recommendation 73 of the LTC COVID-19 Commission.

Enhanced Funding

Achieving emotion-based care requires both funding to train staff, volunteers and families supporting the emotional well-being of residents, but also clear mandates within the LTCHA requiring that LTCHs ensure that training requirements are met. Ongoing annual costs (above base budget) to sustain a Butterfly Home and enhance person-centred emotional care is approximately $25,000 per bed for the additional staffing (PSW, Dietary, Activation) and approximately $36,000 to support enhanced staff training (new hires, continuous improvement) to ensure sustainability. One time start-up costs are also required for staff training, space reconfiguration and engagement supplies. As the Province moves towards reaching its four hours of care commitment for residents in LTC, there must also be consideration for homes that are delivering emotion-based care to their residents. Homes that provide emotion-based care require higher staff to resident ratios, and this should also be incentivized as the government moves forward with modernizing care delivery and reaching the targets of their staffing plan.

Enabling Community Supports

Unmet demand for LTC has been accelerated by the COVID-19 pandemic and the need for homes to move away from three and four bed living environments. Many clients who access community support services are awaiting LTC placement and have increasingly complex care needs, including advanced dementia. It can be challenging for families to manage these care needs, and individuals may end up in hospital waiting for a LTC bed to come available, creating further pressure on the acute care system. According to a recent report by the Canadian Institute for Health Information, one in nin residents could be supported in the community with appropriate supports (i.e. not requiring LTC). If home care and community support services are appropriately resourced, this can help to delay, or even eliminate, the need for LTC placement, support aging in place and allow for better use of finite resources in LTC. The ability to respond to the evolving nature of client needs in the context of the pandemic and increasing pressures on caregivers is impeded by the ongoing need for redeployed staff to address new pressures on LTC operations. This is in addition to the fact that LTC homes in Peel are chronically underfunded and current funding formulas do not accurately account or compensate for high-growth and high-demand communities, leading to increasing waitlists and unmet demand.

The Region of Peel Recommends:

Enhancing supports across the LTC sector including re-evaluating the funding model for residents with dementia to ensure that base funding better matches staffing resources to resident care needs;

Funding research-based, dedicated and sustainable training to build staff competencies related to emotionally focused and person- centred care to manage dementia and responsive behaviours; and

Adequately resourcing a minimum daily standard of care of four hours or more per resident based on the level of acuity.

Conclusion

To ensure both the safety and wellbeing of vulnerable seniors, their caregivers and LTC staff, the Province needs to take swift and significant action to support seniors through comprehensive reform to the LTCHA. The Region of Peel has reviewed the legislative framework of the LTCHA through the lens of a municipal health service provider, and with the needs of the community and seniors populations at the forefront. The recommendations and suggested legislative changes outlined above will enable emotion-based and innovative models of care. The Region looks forward to continuing to engage with the Ministry of Long-Term Care and supporting the development of legislation, regulations, policy, guidelines and supports that will enable the transition to and enhance existing emotion-based models of care for the LTC sector.

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APPENDIX I: Region of Peel Recommendations for Amendments to the Long-Term Care Homes Act, 2007 & Ontario Regulation 79/10

	DESCRIPTION AND DETAILS	Relevant sections of LTCHA and Reg to be amended	Evidence / rationale
	STAFFING & STAFF TRAINING		
1	**Criminal Reference Check:** The current legislation only requires a signed declaration of criminal offences for new hires or when an employee has been charged or convicted. <u>Recommendation</u> Revise (suggestions bolded below): a) A Signed Declaration should be signed prior to commencement of duty (new hires) and **annually** by a staff member, volunteers, independent contractors **in addition** to after the person has been made aware that they have been charged or an order has been made and after the person has been convicted or a charge is otherwise disposed of. New (Add): b) Auditing should be conducted at a minimum, annually of all personnel charts/contracts to ensure there are no discrepancies between the Criminal Reference Check/Police record check and the signed Declaration.	O. Reg. 79/10 s. 215 (4)	a. This change, having staff, volunteers and independent contractors signing the Declaration of Criminal Offences, Charges, Convictions or Orders annually will ensure due diligence is in place to protect our vulnerable residents. Placing the onus on staff, volunteers or others to independently declare a criminal offence, charge, conviction or order is risky. Signing the declaration annually allows the home more autonomy as they can hold staff, volunteers and others accountable if they are signing off on information that is not true. b. Auditing allows the homes to verify accuracy of information provided and to take actions if needed to protect our vulnerable residents, staff, visitors and volunteers.

	DESCRIPTION AND DETAILS	Relevant sections of LTCHA and Reg to be amended	Evidence / rationale
2	**Vulnerable Sector Screen** RCMP is beginning to enforce the Criminal Records Act s. 6.3(3). According to this requirement, the only individuals that would qualify for a vulnerable sector check are those in direct authority or in a position of trust. Registered staff and PSWs are the only groups for long term care (LTC) that would be eligible based on these requirements. <u>Recommendation</u> Revise: a) Align the LTCHA, 2007/O.Reg. 79/10 with the Ontario Provincial Police (OPP) expectations or collaborate with the OPP to apply a broader definition for direct care staff which would ensure all staff who work with vulnerable residents in long-term care homes are required to complete a vulnerable sector check. b) To clearly define which staff requires a vulnerable sector section. The Regulations should identify whether a vulnerable sector check is required for all staff or only direct care staff (nursing, PSWs, Physio. staff, etc.).	O. Reg. 79/10 s. 215 (3)	Currently the OPP in some communities (Caledon for example) does not conduct a vulnerable sector check for specific long-term care staff who they believe do not fall under the definition for vulnerable sector check (e.g. dietary staff, maintenance staff) in accordance with the Criminal Records Act s. 6.3(3). To conduct a vulnerable sector check for these staff, the home has to provide a letter indicating these staff members are direct care staff in order for the OPP to conduct the vulnerable sector check. Clarification of the regulation or alignment with the OPP legislation is needed to verify if only the direct care staff require a vulnerable sector check or all staff in LTC. A third option is to work with the OPP to enforce a broader definition of direct care staff that would encompass all staff within long term care homes in light of the vulnerability of the residents served.
3	**Registered Dietitian** The regulations require licensees employ a Registered Dietitian for a minimum of 30 minutes/resident/month to carry out clinical and nutritional care duties.	O.Reg. 79/10 s. 74(2)	The current allotment of minutes does not allow the Registered Dietitian sufficient time to collaborate in the development of improvement initiatives that support nutritional care, hydration management and dietary services. These initiatives include participation in care committees, delivering education to staff, and participation in CQI.

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	Recommendation Revise: Increase the Registered Dietitian minimum minutes/resident/month to carry out clinical and nutritional care duties.		
4	**Food Service Worker, minimums** The minimum staffing hours for Food Service Workers is calculated based on M=Ax7x0.45 as per the regulations. Recommendation Revise: Change the formula for calculating the staffing hours for Food Service Workers to increase the minimum required staffing hours per week.	O.Reg. 79/10 s. 77(2)	Dietary services should be able to achieve staffing levels that provide full service of meals and allow Personal Support Workers to feed and provide assistance to residents as required. The current formula does not allow enough dietary staffing hours to support the full meal service. With increased complexity of LTC residents, this needs to be re-evaluated. Also, the current allotment of hours does not include enough time to maintain cleanliness of kitchens.
	RESIDENT CARE		
5	**Skin and Wound Care:** The regulations require a resident with **altered skin integrity (defined as potential or actual disruption of epidermal or dermal tissue)** to receive an assessment by a Registered Dietician and a weekly assessment if clinically indicated. Recommendation Revise (suggestion bolded below):	O.Reg. 79/10 s. 50(2)(b)(iii)&(iv)	a. Registered Dietitians indicate that there are no specific nutritional interventions for healing altered skin integrity that involves bruising or rashes. Nutritional interventions primarily address wounds, skin tears, and ulcers (all types). Additional assessments for rashes, bruising etc. are an administrative burden on the limited time available for Registered Dietitians. This time would be better spent on timely assessments and implementation of interventions to meet the clinical needs for residents at risk or with actual skin/wound care concerns.

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	a. Require Registered Dietitian assessments for residents with ulcers (all types i.e. stasis, pressure injury, diabetic, etc.), skin tears, wounds and other types of **non-healing** altered skin integrity. b. Clarification or a definition for "clinically indicated" as per s. 50 (2)(b)(iv). Revise this requirement which specifies that a weekly assessment is required for residents with ulcers (all types i.e. stasis, pressure injury, diabetic, etc.), skin tears, wounds and other types (for example, bruises) of **non-healing** altered skin integrity. c. The regulation refers to pressure ulcers; the National Pressure Ulcer Advisory Panel has replaced the term "pressure ulcer" with "pressure injury" in April 2016. Align the regulations with this term. As has the RNAO LTC-BPSO Best Practice Guidelines.		b. Due to a lack of clarity, registered nursing staff is conducting weekly assessments of all altered skin integrity using a validated tool regardless of clinical indication resulting in a significant documentation burden on staff for skin conditions that would otherwise only require monitoring, for example, bruising, rashes etc. Ministry inspection results do not consistently focus on the clinical indication, non-compliance is issued for a lack of a weekly assessment regardless of clinical indication demonstrating the lack of clarity not only in the sector but also for MOHLTC inspectors. In addition, streamlining documentation requirements will still ensure regulatory compliance from a Regulated Health Professionals Act (RHPA) perspective and continuing to meet evidence-informed best practices for documentation. We should be documenting on an exception basis, when there is a change in the resident's clinical condition. MLTC Inspectors like to see documentation for everything and as Nurses (which at least 80% of inspectors are RNs), they should know the College of Nurses of Ontario (CNO) documentation standards and should not be issuing a non-compliance. It is unreasonable the amount of documentation required as per the LTCHA/O. Regs and it prevents nurses and PSWs from being at the resident's bedside, which is where most of their time should be spent. Unfortunately, the LTCHA/Regs. does not allow for clinical judgement and it boils down to quantity

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			vs quality, which again is not the standard of practice.
6	**Pain Management:** The regulations require that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment. <u>Recommendation</u> Revise: Include in the provision clarification related to residents with chronic pain who are able to articulate their preferences for pain management. Therefore, a pain assessment would only be required for new pain or when a resident's goals for pain management changes.	O.Reg. 79/10 52(2)	Due to a lack of clarity, residents with chronic pain, regardless to their pain management goals are continuing to be assessed and reassessed as they have existing conditions that will not result in complete pain relief. These additional assessments do not result in changes to interventions or lead to increased pain management for residents but are a documentation burden for registered nursing staff. If a resident is able to articulate their personal goals for pain management and this is monitored regularly (through screening as per Registered Nurses Association Ontario best practice guidelines) in conjunction with the resident being reassessed/evaluated on a quarterly basis through non-triggered Resident Assessment Protocols (RAPs) in Resident Assessment Instrument (RAI-MDS), resident needs are met without the documentation burden currently imposed.
7	**Menu Planning** The regulations require the menu to provide for a variety of foods including <u>fresh</u> seasonal foods each day based on <u>Canada's Food Guide</u> (CFG). <u>Recommendation</u> Revise (suggestions bolded below): a) Remove the requirement of meeting **Canada's Food**	O.Reg. 79/10 s. 71 (2)(b)	a. Menus that meet CFG in many cases will not meet all DRI without increasing portions or substituting with less appetizing food choices based on analysis and feedback from our residents. In addition, when following CFG alone, the volume of food exceeds what most residents require or want resulting in food wastage. b. The requirement to provide variety of <u>fresh</u> seasonal foods <u>each day</u> is challenging due to access and budget constraints. Also, the nutrient value of items such as Individually Quick Frozen (IQF) strawberry is comparable to fresh strawberry and is more cost effective.

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	Guide each day and leave in s.71 (2)(a) which requires menus to meet the Dietary Reference Intakes (DRIs) for adequate nutrition only. Remove **fresh** and just state **variety** of seasonal foods every day.		
	COMPLAINTS & PREVENTION OF RESIDENT ABUSE		
8	**Complaints:** The legislation/regulations require every written complaint concerning the care of a resident to be forwarded to the Director of the MLTC. It also indicates that a verbal complaint that the licensee is able to resolve within 24 hours is not subject to the requirements of written complaints. <u>Recommendation</u> Revise (suggestion bolded below): Clarify s. 22(1) to only apply to written complaints that are not resolved within 24 hours. Extend the provision of s. 101(4) related to resolution of verbal complaints to also include written complaints that are resolved within 24 hours. Subsections (2) and (3) do not apply with respect to verbal **and written** complaints that the licensee is able to resolve within 24 hours of the complaint being received. Provide LTCHs with protection against frivolous or	LTCHA, 2007, s. 22(1) & LTCHA, 2007 s. 22(1), O.Reg. 79/10, s. 101(4)	Electronic communication i.e. email is increasingly the method by which families and residents are communicating with staff in long term care homes. Issues that would normally have been communicated verbally are now easily sent via electronic means. As a result, the requirement to submit every written complaint has become an increasing administrative burden for licensees attempting to comply with the requirements. Additional requirements (e.g. s. 103) are already in place for the submission of complaints that involve mandatory reports such as abuse and neglect to ensure the Director of MOHLTC is notified of these significant concerns regardless of resolution. It is not unusual for homes to receive a complaint from many sources

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	unsubstantiated complaints and the complainant needs to be accountable for their complaint submission. Accountability can be by the complainant providing thorough details to be investigated and/or mandatory participation with the home staff to address the complaint(s).		and the person or family member does not and will not participate in the investigation by providing details and don't want to be a participant in resolving the complaint(s). In these cases, the homes end up unilaterally investigating the complaint and submitting to CIATT.
	FLEXIBILITY WITHIN THE LTCHA STANDARDS		
9	**Coercion Prohibited:** To change the language of the legislation to ensure signed accommodation agreements are in place for the admission of residents into LTC homes. <u>Recommendation</u> Revise (suggestion bolded below): Provide exclusion criteria as indicated below: Section 83 (1) - Every licensee of LTC home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because: a) a document has not been signed **(excluding accommodation agreements)**	LTCHA, 2007, s. 83 (1)	There are some residents/Substitute Decision Makers (SDMs) that refuse to sign the accommodation agreement or other agreement if they are aware that the home cannot refuse admission or discharge the resident if such agreements are not signed in the home. If the resident/SDM does not sign, the home will have a difficult time holding the resident/SDM responsible or accountable particularly related to payment of fees. For example, a resident/SDM that is currently not paying accommodation fees - How does the home legally pursue the collection of fees if there is no evidence of a signed accommodation agreement?
10	**Specialized Care Unit** <u>Recommendation</u>	s. 39 (3) O. Regs 79/10: s. 198 (2)(b)	The current definition does not reflect that the specialized care unit is a transitional location for residents with advanced dementia with responsive behaviours. Unlike the current Specialized Care Centre at Toronto Grace, residents do not turnover within these units as there

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	Revise the term from Specialized Care Unit to Transitional Behavioural Support Unit. Update Local Health Integration Network (LHIN) to Home and Community Care Support Services (HCCSS) and include Ontario Health (OH) Revised title of s. 199 to HCCSS or OH and clarify in the agreement terms and conditions with HCCSS and/or OH. Revise eligibility criteria for TBSU to include Dementia/BPSD diagnosis; specific types of assessments required. Should include in the s. 201 (a-e) requirements for Substitute Decision Makers (SDMs) to sign agreements that they will comply with and in consultation with the interdisciplinary team of experts, if refused then the residents should not be eligible for the specialized care and services. In addition, once the resident's goals of care have been achieved, the resident would be transferred / discharged to their origination location.	& (3); s. 199 (1) & (2); s. 201 (1) (a – e).	are no agreements in place when SDMs do not comply with the treatment plans. As a result, residents linger in these units, which increases significantly the length of staff and causes a backlog on the waitlist for those residents that would be compliant with the proposed treatment plan by the experts in the interprofessional team. There's no enforcement within the traditional units to ensure that when goals of care have been reached or will not be reached for reasons explained above, that residents are transferred/discharge from this unit to their originating location (e.g. home, another LTCH, hospital, etc.). By having agreements in place, similar to the Specialized Care Centre at Toronto Grace, then it will assist with the turnover in the Transitional Behaviour Support Unit (TBSU). Have the sending facility/location/provider sign an agreement to take the resident back when goals of care have been achieved.
	Documentation <u>Recommendation</u> Personal assistive devices, hourly safety checks – monitoring and documenting every shift. Document by exception for this instead. Change to quarterly for a regular documented		Unnecessary documentation takes away from time with and care of Residents. Charting by exception is the standard of practice for nurses as per the College of Nurses of Ontario.

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	assessment. Review all opportunities for documenting by exception in the Act & Regulations. It is threaded in both the Act & Regs. Add an exception clause for Bladder Restorative Assessments when not applicable, such as a resident who is palliative or receiving end of life care.		