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PROTECTING SENIORS FROM ABUSE AND NEGLECT

Phase 1 closing Submissions

to

The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System

by

The Interfaith Social Assistance Reform Coalition

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PROTECTING SENIORS FROM ABUSE AND NEGLECT

As Ontario's major faith-based social justice coalition, the Interfaith Social Assistance Reform Coalition (ISARC) welcomes this opportunity to present to the Commission, submissions in respect of the evidence presented to Phase 1 of the Inquiry, as well as recommendations to reduce the likelihood of exposure to abuse and neglect by residents of Ontario's long term care homes.

Our coalition represents Ontario's major faith communities, including the Anglican Diocese of Toronto, the Anglican Diocese of Niagara, the Anglican Provincial Synod of Ontario, the Association of Catholic Bishops of Ontario, the Canadian Unitarian Council, Catholic Charities of the Archdiocese of Toronto, Congregation Darchei Noam, Dicle Islamic Society, the Council of Imams, the Council of Canadian Hindus, the Eastern Synod of the Evangelical Lutheran Church in Canada, the Western Ontario District of the Pentecostal Assemblies of Canada, the Islamic Humanitarian Service, Mennonite Central Committee Ontario, North American Muslim Foundation, the Presbyterian Church in Canada, the Redemptorists in Canada, the Society of St. Vincent de Paul, the Toronto Board of Rabbis, and the United Church of Canada.

ISARC has worked for more than 30 years to promote public policies that can ensure all citizens are treated with dignity. In this regard in addition to our advocacy for more meaningful levels of income support as well as employment

justice, we have advocated for affordable and secure housing for those who are unable to speak effectively for themselves. This includes the approximately 75,000 residents of Ontario's long term care homes.

ISARC welcomed the establishment of this Public Inquiry and salutes the efforts of the Commission to have a full airing of the evidence surrounding what happened and why. While ISARC played only a limited role in the hearings in St. Thomas, we believe that we were able to bring out some important gaps in inspection processes and funding rules that contributed to the environment in which Ms Wettlaufer committed her crimes.

Our submissions set out 11 areas in which we make recommendations which we believe will increase the safety and security of residents in long term care homes and protect them from abuse and neglect.

1 Enhanced Whistleblower protections

i. Ms Simpson emphasized the importance of reporting instances of abuse and neglect to the Ministry. She conceded that there was insufficient reporting and that one contributing cause may be the concern of witnesses that the current whistleblower protection isn't sufficiently strong. Her recommendation was to increase education about the current protections. ISARC supports that recommendation but also has concerns about the adequacy of such protections.

ii. Section 26 of the Long Term Care Homes Act Exhibit 4 Tab 5 only protects disclosures to the Inspector and the Director. It does not provide protection in respect of disclosures to others (whether other public officials, elected representatives or the Media) even in cases where disclosure to the Inspector or the Director has not resulted in investigation and remedial action. This gap must be closed. Had it been permissible for a whistleblower, for example, to inform the media that the responsible coroner was refusing to conduct an autopsy, Wettlaufer may have been caught earlier.

iii. The Act only provides a process for remedying claims of retaliation against employees. It does not provide for a process to remedy retaliation against residents or family members or members of the Councils composed of such persons. While the Act recognizes manners in which residents can be subject to

retaliation, it does not recognize ways in which these other persons can be subject to retaliation. For example a family member can be barred from visiting residents in the home. These gaps must be closed.

iv. Section 27 provides that if an employee is disciplined or discharged, they can either challenge the discharge through the grievance procedure in the collective agreement or through the Labour Board. While there is a reverse onus provision requiring the Employer to prove just cause for its action, there is no provision specifying that if the whistleblower's disclosure was even part of the reason for the discipline, the discipline must be completely overturned and the employee provided full redress. More significantly the employee is without pay during the litigation process, which can be extensive. Police officers subject to claims of misconduct are placed on leave with pay pending the establishment of misconduct to the satisfaction of a neutral third party. Section 27 must be amended to provide that if an employee suspended or discharged provides to the OLRB evidence that the employee has made a disclosure under the Act, the OLRB by summary order should require the employer to place the employee on leave with pay pending establishing to the satisfaction of the arbitration board or the OLRB that the disclosure played no part in its decision to impose a penalty and

that the suspension or discharge was justified and not modified by the adjudicator. The summary order should also require the Employer to compensate the employee for any lost wages and benefits from the time of the disclosure and the implementation of the summary order.

v. In the case of an employee of an agency or third party, Section 27 only defines the employer to be the agency or third party and not the facility as well. This gap allows the Facility to direct the agency/third party to remove the whistleblower from its premises. There is no guarantee that the whistleblower will be assigned alternate employment at no loss of compensation. As well, the “chill” will be felt by other employees of third parties/agencies working at the facility, in that they will conclude that they are not protected from retaliation. The Act needs to be amended to add the facility operator to the definition of employer in such circumstances and make them jointly and several liable.

2. **Direction to Undertake Study** to identify **daily hours of care** by each type of care provider **required by each resident** based on every type and combination of health condition, if that condition is experienced by at least 5% of the provincial population of long term care residents.

    1 Ms Stephens acknowledged that the setting of the per diem funding for the Nursing and Personal Care envelope was not premised on providing in such envelope sufficient funding to deliver all the nursing and personal care required by the residents at that home. She conceded that some homes may be supplementing the funding from the Nursing and Personal Care envelope with funds from the Other Accommodations envelope in order to provide needed extra hours of care. Finally she conceded that she was not aware of any study that tabulated the amount of care needed by any residents in relation to their specific conditions.

    2 The Government of Ontario commissioned PriceWaterHouse Coopers to conduct such a study as part of a more involved inquiry. PWC produced a report in 1992/3 documenting average acuities and staffing levels in different jurisdictions but never published the data collected with respect to actual care need.

3 The recommendations from the Coroner's Jury into the Casa Verde Inquest proposed that the study, that was supposed to have been conducted and released by PWC, be redone.

4 Without data on the amount of care required by each type of resident with a combination of specific health conditions, it is difficult for facility operators to ensure that they comply with the requirement in Section 19 of the Act not to neglect residents and without this data it is difficult for Inspectors to enforce Section 19.

5 In order to properly identify the care requirements necessary to comply with Section 19, the hours must be broken down by classification of provider. It is also necessary for the report to indicate that such hours are to be "touch time" hours and not paid hours, as residents are not receiving care when employees are paid for off duty time such as vacations and sick absences.

6 The factual underpinning for the focus in these recommendations on hours of care which will require extra staffing, is that the crimes were committed on the night shift where staffing is lowest and Ms Wettlaufer was working alone. There was little risk of interacting with other staff and thus little risk of getting caught. Getting back to the issue of hours of care requirements need to be enacted in terms of "touch time", hours that are simply paid without having the staff person on duty will not provide the witness that may discourage and prevent illegal activity.

3. **Interim regulation tying** overall average daily **hours** of nursing and personal "touch time" **to** the proportion of the **Home's CMI** to the average provincial CMI with 4 hours for a home with a CMI of 1.02

    1 It will take some time to undertake and complete the repetition of the study that was expected form PWC and then to enact regulations to implement it. In the meantime residents are not getting the care for which Homes are being funded.

    2 Ms Stephens conceded that there is no guarantee that increases in the Nursing and Personal Care envelope based on increased CMI levels will result in increased hours of care.

    3 It is logical to assume that the current flexibility in use of the Nursing and Personal Care envelope funds (for Nursing management, for non active duty hours of front line staff, for training, for equipment and supplies and for transfer to the PSS and RF envelopes) means that residents are not getting the care for which the CMI funding is flowed.

    4 The Ministry has stated that they are currently funding Homes with the average provincial CMI of 1.02 to deliver an average of 4 hours of care per resident per day.

    5 Without such a regulation it will not be possible to enforce even a weak application of the duty not to neglect from Section 19.

4. **Requirement to post** at least semi annually on Ministry website the actual **average touch time hours of care** per classification and status per resident by each long term care home

    1 Homes are required under their Service Agreements to report to the Ministry to report periodically on the number of hours of each classification of staff they have provided to their residents on average. The report requires the operator to break down the hours between full-time, regular part-time, casual part-time and agency.

    2 There is a difference in continuity of care depending on whether the care is provided by a full-time, regular part-time, casual part-time or agency staff person.

    3 There is a variation in Homes on the breakdown of the complement of staff amongst these different categories.

    4 The Ministry does not make staffing level data automatically available to the public. In response to Freedom of Information Inquiries, the Ministry will not release staffing level data in relation to individual homes but will only release data in respect of category of home, being municipal, not for profit, and for profit homes.

    5 There is a variation in the levels of staffing for the same CMI between different categories of homes.

    6 Residents, family members and the community need to have access to this information in order to make informed decisions as to where to seek

admission and remain in such homes. Ontarions concerned about living in a long term care home where they may be under the supervision of staff members working alone, because of the increased risk of exposure to abuse and or neglect, need this information. The public needs such information in order to hold the Homes and the government accountable.

7 Such information is available on the web for publicly funded long term care homes in the USA.

5. The **funding formula** should be adjusted to **remove the perverse incentive** not to work harder to improve resident condition.
    1 At present if staff are diligent with their care so that resident condition improves, that reduces the acuity/care need of residents which results in a relative lowering of the Home's CMI and thus the Home's NPC per diem. The result is that funding is cutback which could cause reductions in staffing and thus increased risk of exposure to abuse and or neglect.
    2 The formula should be changed so that the NPC funding of a home should only be lowered if and by the degree to which its CMI over what it was the previous year, was reduced because the acuity of newly admitted residents is less than the acuity of the residents who they replaced.

6. **Changes to inspection process** to require interviews with representatives of workers in all RQI inspections and to require interviews with Residents Councils, Family Councils and worker's representatives in all other inspections unless there is a privacy issue and the complainant declines to waive privacy

1 Ms Simpson gave evidence that inspector-conducted interviews with representatives of Residents Councils and Family Councils, provide important and valuable additional evidence and perspectives in terms of the overall situation of the facility, which may not be within the knowledge of individual residents and family members who are interviewed.

2 The same additional evidence and perspective may be within the knowledge of workplace representatives of the workers and not within the knowledge of individual workers who are interviewed. All workers in long term care homes already have organized worker representatives, either because they are unionized or because the Occupational Health and Safety Act requires the establishment of an joint health and safety committee with the worker representatives chosen by the workers. Indeed inspectors under OHSA are required to be accompanied throughout their inspection by worker representatives.

3 Individual workers interviewed may be reluctant to share the full scope of information within their possession, because they are afraid of retaliation from their supervisors and managers. Worker representatives because of their extra statutory protection may be less reluctant.

4 The same reason for the inclusion of interviews with Residents Councils and Family Councils in RQI inspections, could also apply in complaint and critical incident inspections. The one difference is that the complainant may wish to preserve privacy and so should be asked if they are willing to include involvement of Residents Councils and Family Councils. Similarly the same reasoning would result in inclusion in complaint and critical incident inspections of representatives of workers in the facility.

7. **Changes to review of orders** entitling resident, Residents Council, family member, Family Counsel, involved staff member, worker representative under the Labour Relations Act or the Occupational Health and Safety Act for the involved person identified above, to seek review of Officer's order, to be a party to any review, to appeal Director's decision and to be party to any appeals.

    1 There is a human predisposition to avoid conflict. Given that orders from inspectors under the Long Term Care Act can only be reviewed by operators, some inspectors may seek to make their orders less open to review, by exercising their discretion to issue orders that are less comprehensive in scope and weaker in consequences. The same concern can exist with appeals from decisions of the Director. Indeed there is no guarantee that the Director will solicit the opinions of residents and their advocates when engaging in her review, nor are residents and their advocates entitled to party status in appeals of decisions of the Director.

    2 Justice must not only be done but must be seen to be done if the regulatory role of the Ministry of Health and Long Term Care is to regain public trust and confidence.

    3 The Occupational Health and Safety Act deals with the process of setting and enforcing standards to protect the health and safety of workers including workers employed in long term care homes. Workers and their representatives have the right to appeal any decision of an inspector and even the refusal of the inspector to issue an order.

4 OHSA entitles workers and their representatives to be automatically designated as parties under appeals of orders of inspectors filed by any other party.

8. **Sanctions** should include use of a requirement for Home to pay to Ministry funds from the **Other Accommodations envelope** when there is non-compliance with the Act.

    1 For the enforcement system of the Ministry to have remedial impact on facilities, to encourage compliance and to serve as an effective deterrent, the expectation of being subject to consequential sanctions for non-compliance must be real.

    2 Ministry data shows however that effective sanctions are rarely imposed. Given the existence of long waiting lists, the Ministry is reluctant to impose barriers to homes accepting new residents or to close homes. For similar reasons the Ministry is reluctant to impose financial penalties on homes that must be paid out of the Nursing and Personal Care envelope, because such action will only reduce the available funds to care for residents.

    3 The one financial sanction that would not have directly affected the delivery of care to residents, would be to reduce funding in the Other Accommodations envelope. This is the envelope from which the home takes its profit/economic return. The Ministry for some time had taken the view that they could not access the funds from the Other Accommodations envelope, since the funding from that envelope is supposed to cover the “Hotel” services provided to residents and residents are supposed to pay these costs themselves through the imposition of the resident co-pay. The legislation governing economic

sanctions limited the power of the Ministry to reduce the flow of funding to the Home. Since the monies for the Other Accommodations envelope were assumed to all come from residents and not from the Government, there would be no money to this envelope to hold back.

4 The Ministry's explanation for its failure to impact funding to the Other Accommodation envelope does not stand up to review. The evidence is that some residents have been unable to afford the full amount of the resident co-pay. In such cases the Ministry pays to the Home the difference between the standard resident co-pay and what the resident could afford. Thus there was in fact funding from the Ministry that has regularly gone into this envelope.

5 Ms Simpson gave evidence that the legislation has now been corrected to empower the Ministry to actually require facilities to transfer money from this envelope to the Ministry even if the funds for that envelope had not originally come from the Ministry.

6 Given the Ministry's earlier incorrect view that it could not re-direct money going to or from the Other Accommodations envelope, the Ministry cannot be relied upon to exercise their discretion appropriately, to impact monies from that envelope. The legislation should therefore be amended to limit this discretion of the Ministry. The legislation should set out clear directions on situations when the sanction, for non-compliance that must be imposed, involves securing monies from the home's Other Accommodations envelope.

9. The frequency of **Coroner's autopsies and inquests** into deaths in long term care homes should be increased.

    1 Dr Huyer gave evidence that the frequency of coroner's reviews of deaths in homes was reduced because of the robust Ministry oversight. Ms Simpson gave evidence that she did not agree with the change in coroner practice. Ms Simpson's evidence was that Ministry inspections were an essential element of the Ministry's oversight. Her evidence also revealed that there are limitations in the Ministry inspection protocol.

    2 While there are recommendations in this submission to improve the comprehensiveness and effectiveness of Ministry inspections, greater frequency of autopsies and inquests should be instituted and maintained until it is shown that they are no longer warranted given the enhanced inspection process.

10. The **Ministry** should issue **annual reports** to **address progress in implementing recommendations** from this Inquiry both on its own part and to assess progress of other parties in implementing recommendations addressed to them.

    1 Too frequently the impact of public inquiries is limited because recommendations are not implemented without just cause. Transparency and accountability are also hampered because government does not always publicly report on implementation of such recommendations. Other Inquiries have addressed these concerns by including similar recommendations in their reports.

11. **The Ministry should convene annual conferences of stakeholders** to review the Ministry annual progress reports and to discuss other systemic changes that are necessary to improve safety and security of residents in long term care homes.

    1 While Ministry progress reports can be debated in the legislature, MPPs do not themselves have the background to be able to assess the quality of the Ministry's responses. In the same way that community groups have contributed to the comprehensiveness of this Commission in the review of the situation and in framing recommendations, similar input can assist the Legislature in fulfilling its responsibility. Other Inquiries have addressed these concerns by including similar recommendations in their reports.

We thank the Commission for enabling us to file with it our final submissions including our recommendations to increase the safety and security of residents in long term care homes and protect them from abuse and neglect. We look forward to Phase 2 of the Inquiry to demonstrate the appropriateness of our recommendations and to help develop a consensus for their adoption and implementation.

On Behalf of the Interfaith Social Assistance Reform Coalition,

Sincerely,

Rabbi Shalom Schachter Ll.B.