Bill 21 – An Act to Regulate Retirement Homes

Presentation to *Standing Committee on Social Policy*

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Alzheimer Society
ONTARIO

Attendee Information

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Speaking Notes

On behalf of the *Alzheimer Society of Ontario,* thank you for this opportunity today to speak to you about *Bill 21 – An Act to Regulate Retirement Homes.*

I want to begin by commending the government for its efforts to strengthen the quality of care and safety for residents in retirement home in Ontario, however, having said this, our organization and a number of other stakeholder partners I have had discussions with have serious concerns about whether these efforts and the resulting Bill 21 have in fact accomplished the desired strengthening.

While Bill 21 has gone to some length to identify the rights of residents, as well as to put form around their safety and care, it is our belief that the *Act* has been crafted in such a manner, in particular, how *authority* is assigned, that there is significant risk of these intended improvements materializing.

The Act has not focused adequately on the specific, ever-changing healthcare needs of an aging population, nor has there been adequate response/sensitivity to the unique risks to this aging client group, frequently presenting with impairment issues. Indeed, it is the changing needs of an older person that present the greatest challenges.

We are dismayed at the seeming internal contradiction in the Act where s.65 (5) specifically calls for staff to be trained in :**"mental health issues, including caring for persons with dementia and behaviour management"**. Yet in the definitions, there is no provision for care in these 2 areas. There is no mention either in section 62. If these two health issues warrant particular concern re: staff skills, surely provision should be made for how those skills will be applied to care.

We know of the growing prevalence of dementia and of the psycho-social needs of aging adults and we urge you to amend the Act to include cognitive health and mental health in the definitions section and in section 62.

We commend the provision for establishing different classes of retirement homes, although we would have preferred that the classes be defined in the Act. We will expect that operators who represent themselves as serving people with dementia and offering a secure unit, will be subject to the most stringent standards.

Our concerns and proposals are set out in a supplementary document . In the few minutes I have left, I want to draw your attention to two of these areas of concern:

Part 1, section 1: Fundamental Principle

- **the *fundamental principle* does not adequately include the concept that the residents are a group *aging in place*, with *diminishing capacities*, and the associated importance of appropriate, accessible quality healthcare and what constitutes this, specific additions to the *principle* should include**

  - when referring to *care choices*: "*from a full range of appropriate, accessible quality healthcare services as required in intensity by a person "aging in place"* and *diminishing capacities" "* should be added
  - As well a definition for *"aging in place"* should be included (something to the effect): *the ability to live in one's own home, wherever and whatever that may be, confidently and comfortably, for as long as is possible*
  - As well a definition for *"diminishing capacities"*, particularly as related to cognitive impairment

2. Residents' Rights, Care and Safety

- ***Care Services*** **- While a menu of care services is identified in the *Definition* section (administration of a drug; assistance with feeding, bathing, dressing, personal hygiene and abulation; provision of a meal, other prescribed service, and continence care), and the importance of a resident-determined *care-plan, ASO* has a number of concerns:**

  - lack of detail/explanation in what constitutes scope/quality of such services

- no mention health of the of care encompassing the psycho-social and cognitive health of the resident (even though s.65 identifies these as 2 specific areas where staff need training)
- there is a lack of indication of the importance of maintaining up-to-date *health records,* including the process and content requirements for such
- there are no policies, practices regarding *Missing Persons*
- *to feeding* consider *meal provision* rather than well-conceived *nutritional plan*
- inadequate policies and procedures concerning *incontinence*

Restraints and Secure Units

We are concerned that provision should be made to allow restraint and detention at all. If it is allowed, it should be restricted to the highest classification contemplated and require an order of a regulated health professional. The designation of a regulated profession gives added protection to the resident.

Our other concerns continue on the following pages but I will stop here to allow time for questions.

Submission

Introduction

Thank you for the opportunity to submit a written submission on *Bill 21 – An Act to Regulate Retirement Homes.*

We want to begin by commending the government for its efforts to strengthen the quality of care and safety for residents in retirement home in Ontario.

As an organization working to improve the quality of life of people affected by dementia, Alzheimer Society of Ontario (ASO) is very interested in care-related initiatives. We know that a significant percentage of residents in retirement homes have a cognitive impairment, including Alzheimer's disease or a related dementia.

In March 2007, the ASO provided input into the *Retirement Home Consultation* process. A number of recommendations were provided, and while many of these have been considered in the drafting of Bill 21, there were other recommendations we believe have not received adequate inclusion:

Bill 21 has gone to significant lengths to identify the rights of residents, their general personal treatment, and their safety. To what extent they are ensured is in question given, how *authority* is assigned under the Act and the fact that healthcare is being virtually privatized under the *Act*. It also has not focused adequately on the specific healthcare needs of an aging population, nor has there been adequate response/sensitivity to the unique risks that attribute to this aging client group, frequently presenting with cognitive impairment issues.

In the *Analysis* section below, items recommended by ASO in the *2007 Consultation* that have not been adequately incorporated into the *Act,* are revisited with a specific recommendation pertaining to both

content/wording and where such additions could appropriately appear in the *Act*. The concrete nature of the feedback, rather than simply providing general opinions, is intended to assist the document crafters with making substantive changes. We recognize that providing, where the crafters accept a suggestions as important for inclusion in the Bill, they may in fact feel it has a more appropriate place to reside within the *Act.*

Recommended Items identified in the 2007 consultation that were satisfactorily included in the *Act,* are not discussed further in this analysis.

DISCLAIMER:

It is also needs noting, that while the analysis and recommendations contained in this submission are those believed not to be regulated elsewhere and therefore recommended here due to their absence in *Bill 21*, it is acknowledged that in fact some of what is recommended may in fact be regulated elsewhere

Analysis (by Section): (includes: COMMENTARY and SECTION WORDING CHANGES/ ADDITIONS/DELETIONS)

PART ONE: INTERPRETATION

Section 1: *Fundamental Principle*

COMMENTARY

While appropriately addressing the residents ***rights*** (dignity, respect, privacy, autonomy, security, safety, comfort and informed choice), the *fundamental principle* does not adequately include the concept that the residents are fundamentally a group ***aging in place*** (see *Definitions* below), and the associated importance of **appropriate, accessible quality healthcare** and what constitutes this.

WORDING ADDITION

At the end of the current wording for *Fundamental Principle*, add: … *from a full range of appropriate, accessible quality healthcare services as required in intensity by a person "aging in place"*

Section 2(1): *Definitions*

DEFINITION ADDITIONS

1. ***Aging in Place*** - (something to the effect): *the ability to live in one's own home, wherever and whatever that may be, confidently and comfortably, for as long as is possible*

2. ***Dementia Care Facilities*** - *two characteristics distinguish a dementia care facility: 1) that it locks, secures, segregates, or provides a special program or a special unit for residents with a diagnosis of probable Alzheimer's or a related disorder; and 2) that it incorporates measures preventing or limiting the access of a resident outside designated areas*

COMMENTARY

Some number of *Dementia Care Facilities* should be part of any Retirement Home. These are also distinct from *Secure Units* (section 68)

Analysis (continued)

PART TWO: RETIRMENT HOMES REGULATORY AUTHORITY

Sections under Corporation and under Objects, Powers and Duties

COMMENTARY

The *Act* has been conceived in such a way as to make the industry self regulating, by virtue of its vested *authority (*where the majority of board members can be retirement home operators and their nominees*),* and the power vested in this *authority* including, administering the statute, setting its own by-laws, etc. This power is further augmented by Section 24, where the *Risk Officer* (the person responsible for the reviewing and assessing the *authority's* effectiveness in administering the *Act,* including its ability to meet care and safety standards and residents' rights) is appointed by the *Authority,* as well as the *Complaints Review Officer* and *Registrar.*

This effectively privatizes healthcare, and sets up a two-tier situation when lined up against a highly regulated LTC home system and allows the authority to **negate the integrity and efficacy of the *rights, care services*** and ***complaints and appeal*** **processes identified under the *Act.***

In the 2007 consultation, when asked about:

1. *Third-party Regulatory Agency*, the ASO recommended that if this regulatory function did not fall to the Ministry of Health and Long-Term Care, than it should fall to an independent third-party regulator,bt where the majority of members are appointed by government.

2. *Compliance Advisors,* the ASO recommended that the inspection role should be furnished with adequate enforcement capacity to generate rapid compliance. An assessment framework should be devised that locates sanctions along a continuum with their consequent penalty. This framework should be clear, measurable, enforceable and resident-focused. Aberrations should include public notification and reporting. Additionally, the inspections themselves should also be subject to standards, not merely left to the inspector's discretion. This inspection role should be housed centrally in the Ministry of Health and Long-term Care or in the proposed Regulatory Agency.

In the 2007 consultation when asked, given that a third-party regulatory agency was appropriate, who should be represented on the agency's board or directors? Who should appoint the board members? And, Should the government specify a certain number of consumer and industry representatives to ensure a balance of perspectives? – The ASO responded with:

It is worth reiterating that the preferred regulatory enforcer is the Ministry of Health and Long-Term Care. As the consumer protection model is inappropriate for healthcare services, our suggestion is a formal regulatory body comprised of industry, government and consumer representatives in equal parts, with the consumer representatives elected from established senior's organizations.

Analysis (continued)

COMMENTARY

We have previously suggested the initial care contract between Retirement Home operators and residents must be revised in line with the evolving healthcare needs of residents. Such efforts must also account for dementia residents without the means to live in a privately-owned retirement facilities.

PART THREE: LICENSE TO OPERATE A RETIREMENT HOME

Section 44: *Reduction in Care Services*

COMMENTARY

Reduction in Care Services
While, the *Act,* does stipulate both the form of *notice* and the required *notice period* for reducing care services, and requires the licensee to make reasonable efforts in providing the resident with alternative service/residence, it appears that the reduction in service can be applied to one resident (rather than having any reduction in care services be a home-wide change). ASO has concerns that what constitutes reasonable efforts, may not be sufficient to protect a resident from discrimination as a result of dementia-caused behaviour that the licensee finds problematic.

Analysis (continued)

WORDING ADDITION

In Section 44, in addition to subsections (1) (a-d), another subsection should be added stipulating: *that the licensee must provide the resident for the reasons behind any reduction of service, as well as to indicate how widely the reduction in service is being applied across the home to other residents. Further, if the reasons, to the resident seem prejudicial in any way, the resident has the right to challenge any such reduction.*

Section 51(1): *Residents' Bill of Right*

WORDING ADDITION

The same wording additions applied to Section 44, above, should also be added under *Residents' Bill of Rights* (section 51(1) 1.ii.

PART FOUR: RESIDENTS' RIGHTS, CARE AND SAFETY

COMMENTARY

Care Services

While a menu of care services is identified in the *Definition* section (administration of a drug; assistance with feeding, bathing, dressing, personal hygiene and abulation; provision of a meal, other prescribed service, and continence care), and the importance of a resident-determined *care-plan* **there is a lack of detail/explanation in what constitutes scope and quality of such services.**

As well, we argue that the definitions should include care in respect to the psycho-social and cognitive health of the resident, consistent with the staffing skills identified in s. 65.

Staff Coverage

Care services should embrace a resident-focused care model that is attentive to residents' physical, psychological, social and spiritual needs. Ensuring the satisfactory care of Retirement Home residents **recognizes the importance of sufficient staff numbers and specialized training at professional staffing levels.**

It is recommended that standards be established for specialty units or facilities for cognitively-impaired individuals who have been diagnosed as potentially aggressive. **Units should be staff with sufficient numbers satisfactorily trained workers (with and aim to minimal staff turnover)**.

Retirement Homes should be required to have a specified number of registered nurses on duty at all hours.

Analysis (continued)

Section 51(1): *Residents' Bill of Right*

WORDING ADDITION

At the end of the current wording for ***Right #4***, add: *included in this right is the choice to interview staff that will be providing the care, the right to know of the qualification, skills and experience such staff.*

WORDING ADDITION

At the end of the current wording for ***Right #1 (i)***, add: *and the staff to resident coverage rates for specific services, and staff turnover rates*

Section 62: *Plan of Care*

COMMENTARY

While the *Plan of Care* is primarily developed based on assessment, given the growing importance of patient engagement in client-centred healthcare, it is critical that a main undertone of the assessment is to reflect resident wants and needs.

WORDING ADDITION

In section 62(1), following, *"developed based on the assessment"*, add: *which should ostensibly be an accurate reflection of the care wants and needs of the resident…*

Section 62: *Plan of Care*

COMMENTARY

Section 62 needs to be dramatically expanded to identify the full possible scope and bread of specific care services, and again, in the context of a resident in-group that is *aging in place,* faced with on-going diminishment of cognitive and physical capacity.

In this regard, in the 2007 consultation, ASO recommended the following: *For those incoming residents who agree to medical disclosure, a comprehensive assessment of the resident should be conducted on admission an assessment that must include an appraisal of the client's quality of life. Reassessments should be conducted at least biannually and even more frequently if physical, mental or behavioural changes suggest that the resident's care plan may need revising. There must also be regular assessments of residents to ensure that their state of health is commensurate with the standard of care available.*

Analysis (continued)

WORDING CHANGES

Specific wording changes are not provided as they are both extensive and contingent on a shift in to a care construct, based on an *aging in place* ideal. This issue replays itself with other specific care areas discussed below.

COMMENTARY

Health Records

Maintaining up-to-date health records when a resident's capacity declines is essential to ensuring coordinated and conscientious resident care. Health records should offer a detailed account of all encounters between the resident and all healthcare providers. Necessary content includes – but is not limited to – current diagnoses; physician drug and treatment orders; signed and dated progress notes; signed and dated nursing notes on care and treatment; and thorough and meaningful notes on resident's condition. The resident's medical record can and must be referred to on a regular basis, not least to ensure that the practices in place at the Retirement Home reflect proper resident care.

PART SEVEN – GENERAL

WORDING ADDITION

To be included in a separate/unique section: ***Health Records****- the licensee is required to maintain an up-to-date health record detailing changes in a resident's mental and physical capacity.*

Section 51(1): *Residents' Bill of Right*

WORDING ADDITION

To be included as a *Resident Right*: *The resident is entitled to having the licensee maintain up-to-date health records, that are informative as to all "aging in place" issues and is entitled to access these records as desired.*

Analysis (continued)

COMMENTARY

Nutritional Care

Standards should include:

1. Menus for meals served being kept on file and readily accessible for inspection for a period of no less than three months from the date on which the meals were served.
2. Residents having access to three meals and at least one snack daily.
3. Meals being well-balanced and in accordance with Canada's Food Guide.
4. A provision of snacks and fluids between meals for residents who are unable to readily access snacks and fluids independently.
5. Serving staff aware of special diets as applicable.
6. Certification for those involved with food preparation from an approved Food Handlers Training Course.

Section 2(1): *Definitions*
"Care Service" (i)

DEFINITION CHANGE

"Provision of a Meal" should be changed to *Development and administration of a daily nutritional care plan.*

Section 2(1): *Definitions*

DEFINITION ADDITIONS

Added to the list of definitions should be the following definition:

"Nutritional Care Plan" means a regimen of meals, snacks and fluids that satisfies, as a minimum, the following criteria:

- ✓ *Residents having access to three meals and at least one snack daily*
- ✓ *Meals being well-balanced and in accordance with Canada's Food Guide*
- ✓ *A provision of snacks and fluids between meals for residents who are unable to readily access snacks and fluids independently*

Section 62: *Plan of Care*

WORDING CHANGES

Refer to the COMMENTARY and WORDING CHANGES discussion respecting this section on page 5. A *Nutritional Care Plan* within the *Plan of Care* would be one of the care services requiring expanded scope and a shift in construct.

Analysis (continued)

COMMENTARY

Incontinence

Effective treatment of ***incontinence demands*** a systematic approach that establishes and addresses the concern. The systemic response to incontinence should ensure that:

- ✓ Homes are equipped with trained staff capable of identifying and treating residents with incontinence or have access to CCACs for these purposes;
- ✓ Direct access to the toilet is made a priority for incontinent residents;
- ✓ An initial assessment conducted by a trained staff member;
- ✓ The introduction of such treatments as: bladder training initiatives; managing fecal impaction; providing continence supplies; and, using indwelling catheters;
- ✓ Resident records note: the presence and severity of symptoms; whether there has been an annual evaluation; whether a management plan is in place; the treatment and management provided; and the therapeutic outcome;
- ✓ Specialized geriatric services are accessed for remediation

Section 2(1): *Definitions*
"Care Service" (i)

DEFINITION CHANGE

Added to *"Continence Care"* should be "*including a systemic approach to effectively respond/treat incontinence demands.*

Section 62: *Plan of Care*

WORDING CHANGES

Refer to the COMMENTARY and WORDING CHANGES discussion respecting this section on page 5. A *Continence Care including a systemic approach to effectively respond/treat incontinence demands* would be another of the care services requiring expanded scope and a shift in construct.

COMMENTARY

Staff Training & Education

Section 64 and 65 of the *Act* specify the need for the staff to meeting prescribed standards respecting skills and qualifications necessary for the work, it **does not specify what those skills and qualifications are**. Respecting training, it identifies a minimum topic set for all employees and another more specific topic set for those staff providing direct care. And while in both cases, these topic sets are reasonable and appropriate (including training for direct care staff on working with people with mental health issues, dementia, and behaviour issues), there is **no indication of the scope and breadth of such training**, nor indication of **how staff are evaluated in terms of having acquired such competencies.**

Analysis (continued)

In the 2007 consultation, the ASO recommended:

- ✓ **All** Retirement Home employees (including administrators) should be **trained to care for the elderly and residents having cognitive and behavioural issues**. Doing so would ensure that employees are able to distinguish between normal and pathological aging and can work with older adults. Staff training should also address issues of abuse, communication skills, elderly psychosocial needs and palliative care.
- ✓ For staff tending to dementia residents, nursing staff should be instructed in the **Alzheimer's PIECES training** while personal support workers should undergo **U-FIRST training**
- ✓ Direct care staff including sensitivity training around equity issues.

There must be a strong commitment on the part of the licensee to finance continuing education for direct care staff including sensitivity training around equity issues and care standards along with a provincial body to supervise training and skills development.

To achieve this end, there are pertinent programs already in existence provided by the Registered Nurses Association of Ontario, the College of Nurses, the Registered Practical Nurses Association, the Ontario Cultural Society of the Deaf and the Alzheimer's Society of Ontario. Additionally, the ASO advises that training courses for all regulated health professionals adopt a mandatory dementia component.

WORDING ADDITION

A separate section entitled *Staff Training and Education* should be added in this Part of the *Act*, reflecting much of the content in the COMMENTARY above.

OTHER

COMMENTARY

Missing Persons - Retirement Home should take precautionary measures that include:

- ✓ Compiling a folder for each resident who may wander. The folder should include a recent photo, a sealed scent article (for search dogs) and a photocopy of the sole of the resident's shoes.
- ✓ Developing a care plan that is firmly rooted in an assessment of the total resident and 'knowing' the individual resident.
- ✓ Employing preventive devices, such as alarms or electronic devices.
- ✓ Monitoring the exits at all times but particularly during shift changes and emergencies, as these are notorious times for residents to slip away unnoticed.
- ✓ Moving an 'at-risk' resident to a room permitting closer observation by staff.
- ✓ Providing a written search manual on missing residents to guide staff in the event of a missing resident.
- ✓ Registering the patient with Safely Home, a program offered by each Alzheimer Society Chapter.

Analysis (continued)

Section 2(1): *Definitions*

DEFINITION ADDITION

A definition should be added for *"Missing Persons"* stating something meaning: *a resident absent from the property and whereabouts unknown.*

WORDING ADDITION:

A separate section should be added in this Part of the *Act*, itemizing the points in the COMMENTARY (re *Missing Persons*) above.

COMMENTARY

In the 2007 consultation, ASO, recommended consideration be given to a Retirement Home Ombudsperson (RHO). The RHO would represent the needs of Retirement Home and long-term care residents, achieved through facility visits, resident complaint resolution and public education. Moreover, the RH/LTCO would deliver messages from residents to a wider audience, including policy-makers. As an advocate, RH/LTCOs represent residents and resident interests in seeking resolution for both individual issues and systemic concerns.

The importance of this recommendation is heighten given the lack any real power afforded to residents in terms of complaints and appeals by the current rendering of the *Act*

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