Cutting Ontario's red tape in long-term care:

Immediate solutions to unleash capacity now and for the future

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How does red tape affect Ontario's long-term care homes?

Ontario is experiencing an unprecedented surge in seniors who require care with all levels of daily activity, and who need to be cared for somewhere more suitable than a hospital bed and more safely than at home. The system is struggling to cope, as evidenced by the current **hallway health care crisis**. Long-term care homes have been identified as a key solution to ending hallway health care now and to meet growing demand as the seniors' population increases. The redevelopment of 300 older long-term care homes and the addition of 30,000 new beds will help meet future demand, but this is still not enough. There are many challenges facing long-term care homes that stifle their capacity and ability to care for some of the most vulnerable in Ontario.

As an essential service, long-term care operators and staff want to play their role in the system and want to be the solution to ending hallway health care. However, they are struggling to do so as the system, as it is designed, does not allow them to work at their full capability.

The significant challenge facing long-term care homes is the current **human resource (HR) emergency**. A shortage of staff, particularly Personal Support Workers (PSWs) and Registered Nurses (RNs), is increasing the burden on existing care staff and is limiting the sector's capacity to care for the 78,000 seniors living in long-term care. There are many factors contributing to the HR emergency, including supply challenges and geographic disparities which exist across the health system, and these are further amplified by inflexible funding policies. However, the greatest challenges relate to attracting and retaining staff in long-term care because of the high administrative workload and the stifling and punitive culture created by the heavy regulatory and inspection systems.

Frontline care workers are diverted from providing direct care to fulfill the documentation requirements created through regulation and duplicate reporting. This process eats into direct care hours and creates a culture that perversely encourages a focus on compliance and process rather than resident care and improving health outcomes. Recently, one long-term care home was cited for non-compliance with their medication management policies because a Registered Practical Nurse (RPN) did not administer insulin to a resident who had stable blood sugar levels. It is unreasonable that a clinician be penalized for using their clinical judgement to deliver care according to the resident's care needs. Care and health outcomes must come first.

"I make no findings of misconduct because the Offences were the result of systemic vulnerabilities, at the failures of any individual or organization within it. [....] Moreover, given the need for those throughout the long-term care system to work collaboratively in resolving the systemic issues, assigning blame to individuals or organizations is counterproductive. Systemic issues are 'best dealt with by encouraging people to go down a path where they can change the things that went wrong. In the Report of the Arbour Inquiry into the Events at the Prison for Women in Kingston, Justice Louise Arbour explained: 'Attribution of personal blame would suggest personal rather than systemic shortcomings and justifiably demoralize the staff, while offering neither redress nor hope for a better system.'"

Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, Report by the Honourable Eileen E. Gillese, Commissioner

The stress on staff is further compounded by the punitive nature of the inspection process, which creates a culture of fear among staff and operators. Staff often feel personally responsible and demoralized through the inspection process. As a result, staff and operators tend to overcorrect to avoid future non-compliance, which has the unintended consequence of adding to the workload and administrative burden.

This challenge was recognized by the Honourable Eileen E. Gillese, Commissioner for the Long-Term Care Homes Public Inquiry. The Commissioner called on long-term care operators to "cultivate a **'just culture'** – one in which human error is dealt with openly rather than punitively." However, operators cannot change the culture without government support to eliminate the counterproductive and perverse impacts of the current regulatory requirements and inspection process. Recognizing that a change in the relationship between the ministry and operators is required, the Commissioner also called on the ministry to support long-term care homes struggling with compliance. She stated that, "collaboration, co-operation, and communication must become the watchwords for the system."

Legislation and regulations are important to safeguard residents and staff, and are effective in enforcing minimum standards. However, they are not sufficient for creating a culture of innovation and learning that is required to deliver the best care and outcomes for residents, to end hallway health care, and to continue to serve a growing seniors' population with higher health needs. It is well-documented in management literature that a culture of fear and rigidity is an impediment to creating learning organizations.[1] Operators and staff must have the permission to test new models of care. They must also have the freedom to problem-solve based on their clinical judgement and understanding of resident needs without fear of being penalized through the inspection process for putting patient outcomes ahead of paperwork and administrative processes. This requires changes to the inspection process and regulatory requirements.

The Ontario Long Term Care Association proposes to work with the government to implement these changes in a phased approach. This work will safeguard residents' care and build public confidence in a long-term care system that is outcome-focused and high performing rather than compliance-focused based on minimum standards. Ultimately, a comprehensive review of the *Long-Term Care Home Act, 2010*, its regulation, and the inspection system is required.

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>
> **The Honourable Eileen E. Gillese, Commissioner for the Long-Term Care Homes Public Inquiry**

In the meantime, **immediate changes** are required to alleviate the HR emergency and unleash long-term care home capacity to better care for residents and help solve hallway health care. This report outlines short-term, easily implementable recommendations to reduce red tape within the long-term care sector, all while ensuring that caring for residents comes first. Implementing these recommendations will signal a more outcome-focused and collaborative approach that supports frontline staff in providing best care to residents and will begin to cultivate a "just culture" in long-term care homes across Ontario.

What can the government do on a short-term basis?

There are a number of short-term and easy-to-implement changes that can improve the use of staff resources, improve the inspection process and streamline administration processes. The improvements would unleash the existing capacity in the sector to be a successful solution to hallway health care.

1. Respond to the **HR emergency** through increased flexibility and reduced administrative burden.

1.1 Allow operators to staff their homes according to resident needs and human resources.

The legislation prescribes staffing complements that limit the home's ability to best meet residents' needs. For example, homes are required to ensure that at least one RN, employed by the home, is always on duty and present in the home. The government should expand continuous nursing coverage to include both RNs and RPNs based on the care needs of residents assessed by the nursing and medical staff in the home. This will enable homes more flexibility to staff according to resident needs and achieve a higher level of direct care staffing based on staff competencies and availability.

The Canadian Institute for Health Information has found that more RNs are leaving the long-term care sector than entering it, and the trend is likely to get worse as RNs working in long-term care are older and closer to retirement than their peers.[2] Rural long-term care homes are particularly vulnerable and already struggling to recruit RNs, forcing them to rely on agency staff, which then contravenes agency staff limits set out in the regulation. This is a system issue that requires flexibility to address local factors. Rather than continuously citing homes for doing the only thing they can, the regulation should be adjusted. RPNs have the clinical competencies to effectively deliver care in long-term care homes and are in greater supply.[3]

1.2 Allow staffing and funding flexibility so that adjunct care and service staff can provide personal support services.

Legislation restricts qualified PSWs as the only providers who can offer personal support services to residents. While this regulation was intended to increase the quality of care for residents, it is actually having the opposite effect. There is currently a severe shortage of qualified PSWs, and this requirement creates a significant barrier to ensuring appropriate staffing. While a broader PSW strategy is being developed and implemented, an immediate solution is required. An Ontario study found that **50% of PSWs' current work is unrelated to direct resident care**.[4] As recommended in the Long-Term Care Homes Public Inquiry, homes should have the ability to hire a greater spectrum of staff to deliver direct care. Specifically, homes should be allowed to hire adjunct care and services staff to meet residents' care needs and the restrictions in the legislation and funding policy that prevents this should be removed. This type of staff would provide activities of daily living, meal supports, portering, comfort and companionship to promote the wellbeing of each individual resident.

1.3 Shorten hiring and onboarding times for new staff by resolving redundant police record checks and Vulnerable Sector Screening requirements for regulated staff.

A police record check, including a Vulnerable Sector Screening (VSS) that has been conducted at least six months prior to hiring, is required for all new staff. This results in delays, often of several weeks and sometimes months, before the home can onboard newly hired staff at a time of severe staff shortages. In addition, every year, staff working in long-term care homes must sign an attestation to maintain their employment and all registered staff must also complete the same process to maintain their licensure through their respective professional college. These are important safeguards but the current redundancies result in lost care days due to hiring delays.

In cases where regulated staff change jobs, homes are required to ensure the VSS falls within the mandated six-month period and cannot use the annual attestation provided to a previous home operator or to the professional college. The full VSS must be redone. This redundancy delays employment in an already strained sector and could be better managed if the regulation extended the timeline for VSS to 12 months and the recognized sworn attestations to support labour mobility. Additionally, to help alleviate current HR challenges, agency staff should also have the ability to provide a VSS attestation and not be required to redo a new VSS for each home assignment.

1.4 Abandon the implementation of the Personal Support Worker registry.

There is a ministry-led project underway to create an employer-based PSW registry which requires operators to register and unregister their PSWs. As designed, the registry does not have the required features to protect the public interest. Instead, this move would substantially increase the administrative burden as it simply enshrines existing employer obligations under a new registry framework and has the potential to negatively impact recruitment of PSWs.

Ontario has instituted the strongest protections for residents in Canada through the *Long-Term Care Homes Act*. Ontario's legislative scheme provides greater protection than the current provincial registries in British Columbia, Nova Scotia, and most recently introduced in Alberta. These registries serve as repositories for the outcome of the usual labour-management processes. Neither the public nor an employer can easily access performance information as access is strictly limited to either authorized government or registry staff. Any other access requires the consent of the registered PSW. Investigations of alleged incidents of abuse and/or neglect remain the purview of employers based on existing collective agreements and labour arbitration rules because there is no registry process for investigations. Ontario's proposed PSW registry will face similar limitations.

For these reasons, the Association recommends abandoning the proposed registry and would be pleased to work with government to develop alternate solutions to protect the public interest and, more importantly, recognize the contribution of PSWs to the province's health system.

2. Start to cultivate a more "just culture" in long-term care through a focus on resident outcomes and more predictable approach to compliance.

2.1 Apply inspection protocols consistently across the province.

Inspection protocols are interpreted differently by inspectors, creating variability and uncertainty in regard to how legislation should be understood. As a result, long-term care homes are compelled to amend policies and practices to non-compliance findings, rather than the actual regulatory requirements, to avoid being found non-compliant in the future. For example, in previous inspections, some long-term care homes have been cited for not completing mandated manual checks on water temperature. In response, some operators have introduced unnecessary daily manual checklists for all environmental systems – even where this is not mandated and there are available controlling and monitoring technologies. Checks are required three times a day of the controls, and at the source throughout the home. Since only regulated staff have continuity across shifts, they take on this burden. It is estimated that these checks could take up to more than two hours to complete and document. As noted earlier, this type of activity has the unintended consequence of adding low-value and administratively burdensome activity to already struggling care staff.

In numerous other examples, inspectors are not consistent in applying a timeframe to the home's previous inspection history when they assess non-compliance in a particular area. Some inspectors refer up to 10 years prior and identify new areas of non-compliance based on documentation and records that are long out of date. This creates an unpredictability and inconsistency in the inspection process, which results in long-term care homes overbuilding their administrative system to avoid non-compliance findings. A more consistent approach to inspections would eliminate burdensome practices developed in response to variation in interpretation of the regulation by inspectors, and would free up regulated staff time to care for residents.

2.2 Adopt a balanced and risk-based approach to inspections.

The culture of the inspection program needs to change. We need to return to a quality-based approach and, as recommended by the Long-Term Care Homes Public Inquiry's Commissioner, support struggling homes by connecting them with sector peers to assist in improving performance instead of taking an inspection-driven punitive approach. As a first step, since inspectors are usually examining incidence or complaints from weeks or months past, they should look for and acknowledge quality improvement. This will reward staff for being proactive in addressing issues and reduce the punitive nature of the current process. In addition, inspections should be refocused on high-risk incidents rather than low-risk non-compliances or complaints. It is estimated that **1.7 staff days**, primarily of nursing and personal care staff, are required to support each inspector day spent in a home. Inspectors are often in the homes for several days or weeks at a time.[5] One simple example of wasted time spent on a low-risk issue relates to discrepancies between dessert options. During a recent inspection, staff were required to spend time examining why pineapple and green jelly were offered for dessert instead of rhubarb and banana loaf as stated on the daily menu. In this example, an overall total of 6.8 staff days were required to gather information, answer questions and respond to the inspectors' queries. Staff were ultimately taken away from supporting resident care to be involved in reviewing a low-risk issue.

3. Streamline low-value or redundant requirements to reduce the **administrative burden** and redirect staff effort and hours to resident care.

3.1 Reduce the administrative burden by clarifying, streamlining and consistently inspecting reporting of complaints and critical incidents.

Another area of inconsistency in inspections is related to complaints and critical incidents. Several homes have been cited non-compliant for not submitting resident complaints as critical incidents. These complaints can range from a lost sweater to issues relating to resident care. As a precaution to this inconsistency and unpredictability in inspections, operators have implemented measures and policies to protect themselves from future non-compliance orders. For example, staff submit every written and verbal complaint to the ministry. There is no clear definition of what a written complaint is, hence both service inquiries and actual complaints are reported. This results in more work for staff within homes and within the ministry. The number of critical incidents has increased over **780% from 20.3 per 100 beds in 2013 to 159 per 100 beds in 2017**.[6] Among these are many low-risk complaints that divert inspection efforts from high risk areas and staff time from care.

3.2 Reframe the complaint process to support a "just culture" and better complaint resolution.

Notwithstanding recommendation 3.1, a more effective process is required for management and resolution of complaints. The government should explore shifting the responsibility for complaints management to the Patient Ombudsman who has the expertise in managing patient relations and effective complaint resolution working with the health care provider and complainant. The Patient Ombudsman also has greater objectivity and the mandate to look at systemic issues. Ministry inspectors' efforts can be refocused from triaging and responding to low-risk complaints to higher-risk critical incidents. Based on a ministry testimony as part of the Inquiry, of the estimated **4,800 complaints received in 2017, only one third were triaged for inspection**.[7] In addition, the ACTION line should be reframed as the 'Resident and Family Feedback Line' rather than a complaints line, which perpetuates a negative public perception of long-term care and a punitive approach.

3.3 Streamline reporting requirements to avoid duplicative reporting.

Management fills out reports to several authorities including the ministry, Local Health Integration Networks (LHINs) and Health Quality Ontario (HQO). Most of the information required is identical and therefore creates duplicate work. For example, the Ontario Healthcare Reporting Standards (OHRS) and Management Information Standards (MIS) Trial Balance report duplicates staffing surveys, occupancy reports, financial reporting to the ministry's Annual Reconciliation Report and Behavioural Supports Ontario reporting to the ministry and LHINs. Unlike other providers, such as hospitals, long-term care homes have minimal administrative staff. As such, the Director of Care, with input from care staff, generally supports these reporting functions. Anecdotally, **duplicate reporting generates 100 hours or 13.3 days** that would be refocused on delivery of care in homes. These reporting requirements should be reviewed and streamlined to free up hours for care.

3.4 Remove redundant training requirements to refocus staff hours and funding to resident care.

It is estimated that between **$15 and $18 million dollars** is spent annually on compliance with the annual mandatory training requirements for direct care staff. The legislation requires 31 topic areas be covered in the mandatory training, often duplicating requirements of professional colleges and existing standards of practice and leaving little room for introducing newer, more relevant training to meet rapidly changing resident care needs. Refocusing training on high-risk areas and best practices, and removing redundant mandatory training requirements, would give homes greater flexibility to adapt training to improve resident care outcomes and free up time to care.

3.5 Move to the InterRAI Long-Term Care Facilities Assessment Instrument to provide improved clinical assessment while also reducing administrative burden.

The current system of RAI MDS 2.0 was implemented between 2005 and 2012. The system has built-in Resident Assessment Protocols (RAPs) that require a more in-depth assessment based on the RAI-MDS initial screening. Evidence shows that an assessment typically triggers 13 to 14 RAPs which take an average of 96 minutes to complete. The RAPs were initially developed in the 1980s. In comparison, in the 2000s a new system was developed of Clinical Assessment Protocols (CAPs) that are found to have better predictive value in identifying which residents are likely to improve or decline. This will have critical value as long-term care homes take up transitional care to alleviate hallway health care. Unlike the RAPs, the system only triggers an average of four most appropriate CAPs that require 30 minutes to complete. **The CAPs is supported by the new InterRAI Long-Term Care Facilities Assessment Instrument (LTCF), which is currently being implemented across Canada except in Ontario**. It is estimated that moving from RAPs to CAPs would save more than 400,000 care hours and $18 million annually. Ontario should move to the new LTCF and CAPs.

3.6 Reduce the administrative burden created by the admission process and streamline placement to meet the current and future needs of Ontario seniors.

The introduction of Ontario Health Teams provides an opportunity to revisit the placement process for long-term care homes, making it easier for Ontario seniors to transition and receive timely admission to long-term care.

The admission process to a long-term care bed is currently too complex and includes dozens of hand-offs among family physicians, LHIN placement coordinators, applicants and long-term care home staff. The legislation governing admissions sets a complicated regulatory framework requiring up to five home choices, 10 wait list categories, 14 accommodation classes, two gender categories and 10 or more ranking rules. Homes must also consider roommate matching for compatibility and safety, choice of accommodation, variability in hospital discharge rules and times, and families scrambling to meet legislated admission deadlines.

Homes are required to screen residents twice in the process: first to be placed on the wait list and second at the time of admission. With an average wait time of 144 days, the initial assessment is quickly outdated and staff time is wasted. With **more than 36,000 seniors waiting for long-term care**, the placement process must be made more efficient.

A more efficient and consistent system would improve access and coordination among local providers to support admission to and discharge from long-term care as well as to a range of specialized units in long-term care homes, such as the newly created High Acuity Priority Access Beds (HPABs). New placement rules are needed to support seamless transitions to long-term care beds that are increasingly differentiated by a variety of care needs and required as part of a new vision for Ontario's health system.

3.7 Realign supplementary funding into base funding for reduced administration and greater flexibility.

In 2018, the ministry began a new funding stream for falls prevention providing homes with $100 per bed to purchase eligible equipment. The funding came with rigid and new requirements for tracking and monitoring improvements in fall rates. The rigid eligibility criteria reflected outdated requirements, preventing homes from purchasing the most appropriate equipment. The reporting requirements were duplicative, as the regulations already require homes to have a falls prevention program and HQO already reports on fall rates. In addition, many homes complete a Quality Improvement Plan (QIP) to reduce falls.

With all of these existing requirements, the new funding unnecessarily constrains operators to expand the funds for highest impact in improving direct patient care and outcomes. This is in addition to adding new administrative requirements to track the use and impact of the funds. The funding should instead be rolled into the home's base funding. There are additional opportunities to streamline funding to reduce the administrative burden and unnecessary constraints, instead of refocusing on care and outcomes. The Association is currently finalizing its recommendations for funding reform and recommends convening a joint working group to address sector supplementary funding.

3.8 Defer non-critical capital improvements for homes requiring redevelopment and instead expedite the redevelopment process.

There are many instances of older long-term care homes being cited for non-critical building issues that will be addressed through redevelopment. For example, lighting levels are often found to be non-compliant, which requires relighting that costs on average $763/bed. It is a waste to expend scarce funding towards non-critical capital improvements for homes that need to be redeveloped. The regulation should be amended to prevent citation of non-compliance for low-risk issues requiring non-critical capital improvement for homes pending redevelopment. Instead, the ministry should focus its efforts to expedite the redevelopment process. The Association is currently finalizing its recommendations for improving the development and redevelopment processes to expedite the process and to ensure long-term care homes are able to meet current and future residents' needs through an economical and sustainable model.

3.9 Refrain from introducing new administrative red tape by repealing the *Pay Transparency Act, 2018*.

The Government of Ontario has proposed implementing pay transparency reporting requirements. While the intention is good, this legislation will increase red tape and the administrative burden. Employers are already prohibited from discriminating against employees based on factors such as gender, among other identifiers, under the Ontario

Human Rights Code. These requirements will result in increased wage costs, not for frontline employees where wages are already public (through collective agreements), but the whipsawing effect that will occur with respect to management.

3.10 Exempt homes from reporting requirements on energy and water consumption.

Homes with a minimum gross floor area of 50,000 square feet are required to annually report their energy consumption, water use and performance metrics to the Ministry of Energy, Northern Development and Mines. The annual report must be verified by an accredited or certified person or body, which is estimated to cost approximately **$2,500 per property**. It is unclear what the purpose of this information is and how it informs future policy decisions. The government should grant an ongoing exemption to homes to conduct these reports.

What's next?

The Ontario Long Term Care Association is committed to working with the Ontario Government to achieve the common goals of eliminating hallway health care, addressing the current HR emergency, and alleviating the administrative burdens that prevent staff from providing seniors with the care they deserve.

The 16 recommendations outlined in this submission are easily implementable and have the potential to directly and positively impact the care residents receive. As a result, the government should consider implementing these changes prior to 2020 to ensure homes and resident needs are being met on a short-term basis.

In the new year, the Association will partner with the government to conduct a more extensive review of the Long-Term Care Homes Act to recommend longer-term system-wide solutions to cut red tape and relieve pressure on our hospitals, community resources and long-term care homes.

About the Ontario Long Term Care Association

The Ontario Long Term Care Association is the largest association of long-term care providers in Canada and the only association that represents the full mix of long-term care operators – private, not-for-profit, charitable, and municipal. We represent nearly 70% of Ontario's 630 long-term care homes, located in communities across the province. Our members provide care and accommodation services to more than 70,000 residents annually.

1 Edmondson, A., Bohmer, R., Pisano, G. (2001). Speeding Up Team Learning. Harvard Business Review.
2 Canadian Institute for Health Information (2019). CIHI's Long Term Care Health Human Resources Data: A Focus on Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Presentation to Board of Directors, Ontario Long Term Care Association, January 2019.
3 Registered Practical Nurses Association of Ontario. (2014). It's All About Synergies: Understanding the Role of the Registered Practical Nurse in Ontario's Health System. Mississauga, Canada.
4 Hirdes, J.P., et al. (2011). CAN-STRIVE [Canadian Staff Time & Resource Intensity Verification] Project Final Report.
5 Affidavit of Karen Simpson: Public Inquiry into the Safety and Security of Residents in the long-Term Care System [Exhibit 129] retrieved from https://longtermcareinquiry.ca/en/exhibits.
6 Ibid.
7 Ibid.