

Submissions By SEIU Local 1.0n Members

January 16,2007

SERVICE EMPLOYEES
INTERNATIONAL UNION, LOCAL 1.ON

The Vice-Chair: The next presentation will be by the Service Employees International Union, Local 1.0n. I believe we have with us Sharleen Stewart, the president, and, for Hansard --

Mr. John Van Beek: John Van Beek.

The Vice-Chair: Thank you very much. You may start whenever you are ready.

Ms. Sharleen Stewart: First, I'd like to thank the members of the committee for allowing the Service Employees International Union to address our concerns this morning on Bill 140. As indicated, I am Sharleen Stewart. I am president of SEIU Local 1.0n.

The Service Employees International Union has been fighting for better nursing home care standards for years. SEIU Local 10n. represents approximately 12,000 nursing home workers -- registered practical nurses, health care aides, personal support workers, dietary and housekeeping aides, and maintenance staff -- at more than 140 nursing home facilities across Ontario.

I will be jumping around this morning, so please bear with me and hopefully just sit back and listen.

Seniors in Ontario nursing homes are still not receiving the care they deserve, and Bill 140 will entrench the fact that Ontario will continue to have the lowest nursing standard for nursing homes in the western world. The Ontario government, despite promises made by Dalton McGuinty prior to the 2003 provincial election, refuses to establish a standard of quality care that nursing homes must provide each resident.

Since the McGuinty government came into office, there have been no significant increases to nursing home staffing levels, save for an increase in registered nurses. The Ontario government promised a revolution of change to Ontario's nursing home industry. What nursing home residents get is more of the same old regime. The Ontario government's lack of action in developing any standards for a minimum number of care

hours nursing home operators must provide is nothing short of scandalous, and in my view it's immoral.

Prior to the last provincial election, SEIU asked the following questions. I'd like to point out these questions and Dalton McGuinty's responses.

The question was, "Will your government make public the number of care hours nursing home residents receive on a daily basis, for each Ontario nursing home?" The answer: "Ontario Liberals are committed to ensuring that nursing home residents receive more personal care each day. We will invest over \$400 million to increase the level of care in nursing homes and reinstate minimum standards."

Next question: "Will your government establish a minimum number of care hours nursing home residents must receive on a daily basis? If so what should the number of care hours per day be?"

"Yes. Ontario Liberals are committed to reinstating the standards of care for nursing homes that were removed by the Harris government, including a minimum 2.25 hours of nursing care daily and three baths per week," was the answer.

A year after taking government, here is what George Smitherman responded to questions at the standing committee on estimates. Ms. Martel asked, "Are you going to reinstate the 2.25" hours of care?"

"Hon. Mr. Smitherman: I answered the question yesterday, directly, and I'm pleased to answer it again.

"Ms. Martel: Okay, let me just confirm again. Are you going --

"Hon. Mr. Smitherman: No.

"Ms. Martel: So in fact you don't have any intention of keeping the promise you made in your election document, even though you were quite critical of the former government for cancelling the 2.25 hours of nursing care."

Moreover, the Liberal government has failed to deliver on funding by \$3,500 per resident annually to fulfill yet another 2003 election promise to increase nursing home funding to \$6,000 per resident annually.

I'd like to refer to the brief we've handed out, on page 6, where it says the crucial issue for this legislation must be the inclusion of a care standard. Every other jurisdiction in

the western world is adopting minimum care standards. My question is, why not Ontario?

There is wide support in the literature that suggests minimum staffing levels ensure better quality care. Dr. Robyn Stone says, "Front-line workers such as nursing assistants, home care aides, and personal support workers are the centerpiece of a long-term-care system.... They are the 'eyes and ears' of the care system...."

"Inadequate staffing levels diminish quality care...."

"The consequences of inadequate staffing levels and poor training are:

" -- diminished quality of care;

" -- high turnover;

" -- poor job quality;

" -- abuse and neglect;

" -- higher rates of injury to staff and clients."

Nancy-Ann DeParle says, "Our findings to date show a strong association between staffing levels and quality care.... The findings demonstrate that there are significantly more problems in facilities with less than 12 minutes of registered nursing care, less than 45 minutes of total licensed staff care, and less than two hours of nursing aide care per resident per day." This is a total of 2.95 hours of care per day. In no nursing home SEIU surveyed was this standard anywhere near to being met.

DeParle contracted research firms and gathered data from 1,786 nursing homes in three states. Her recommendation for daily care came out as follows: Suggested minimum staffing is 2.95 hours per day; the preferred minimum is 3.45 hours of care per day.

A conference on nursing home staffing in April 1998 at New York University recommended that a proposed minimum total number of direct nursing care staff be 4.13 hours of care per resident per day, and that the total hours of care, including administrative and direct and indirect nursing hours, be 4.55 hours of care per day.

A United States study commissioned by the federal Centers for Medicare and Medicaid Services identified three staffing thresholds below which the quality of care was found to suffer. The threshold is 45 minutes for RNs; one hour, 18 minutes for total licensed services -- RNs plus LPNs; and two hours, 48 minutes for certified nurse assistants. Any

nursing home that meets these standards would provide at least four hours, six minutes of total nursing care per day. Thirty-six US states have adopted minimum standards of care. Some of those standards include: in California, 3.2 hours; Vermont, three hours; Ohio, 2.75 hours; Illinois, 2.5 hours; Florida, 3.6 hours.

I'd like to refer you to page 8 of the brief. You are already familiar with the PricewaterhouseCoopers study so eloquently cited by Liberal MPPs when they were in opposition. Again, the study points out that Ontario has the lowest standard in the western world. SEIU data shows most nursing homes are still below the 2.25 standard eliminated by the last government.

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Page 9 of the brief: According to Online Survey Certification and Reporting, a data network maintained by the Centers for Medicare and Medicaid Services in the United States, total staff hours per resident per day in 2004 averaged 3.6. Nova Scotia's Department of Health has set targets when establishing approved facility staffing budgets: 3.25 hours of care for level II nursing homes.

William F. Benson, president of the National Citizens' Coalition for Nursing Home Reform, at a White House Conference on Aging in 2004 said, "Staffing is the primary issue that determines the quality of all of long-term care ... a minimum staffing level is absolutely essential to ensuring that basic care is provided to residents."

The Toronto Star, in an editorial in October 2006, had this to say about the new Long-Term Care Homes Act: "Without such a [minimum] standard, other efforts to improve care and curb problems will almost certainly fall short. How can neglect be stopped if nursing homes are not required to hire enough workers to ensure adequate care? How can abuse be ended if harried workers are too busy to notice?... Smitherman said this week he has not set a minimum level of care because it would encourage staff to `treat people like widgets.'"

Smitherman's view has done exactly that. He has treated people as commodities rather than real people with real needs.

A coroner's jury report in May 2005, in the inquest into the death of two nursing home residents in June 2001, made 85 recommendations to improve nursing home standards. The Ministry of Health and Long-Term Care responses to these recommendations in July 2006 indicated that the Ontario government will not make the changes to the care nursing home residents receive. Liberal promises for better standards remain broken.

For example, the coroner's jury recommendation 29 calls on the MOHLTC, pending an evidence-based study, to fund and set standards requiring long-term-care facilities to increase levels to, on average, no less than 0.59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case mix measure. The funding formula must be immediately adjusted to reflect this minimum staffing standard.

The ministry's response to the coroner's jury recommendation that at a minimum the care hours in Ontario nursing homes are comparable to similar jurisdictions is, as the international data shows, simply not true.

In a response to a petition presented to the Legislative Assembly of Ontario in the fall of 2006, the McGuinty government now says it believes that every resident's needs have to be assessed and that a legislated care level would not be responsive to a resident's changing needs. Does this government really believe that private nursing home operators will allow their front-line workers to make a decision on the level of care a resident will receive?

In the middle of page 6, understaffing equals poor resident care: In a membership survey conducted by SEIU last fall, 69% of nursing home workers indicated their workloads had increased over the past three years. Overall, they estimated their workload had increased by 36%. That's a result of the workload and the levels of care that these people are providing in the nursing homes as they exist today.

This government has lauded the fact that it has introduced patient lifts in every nursing home. While this is true, SEIU nursing home members report that it takes at least 10 minutes to find another staff member to help lift that patient because those lifts require two people to operate.

This government prides itself on the fact that it increased resident baths from one to two per week, ignoring its election pledge that it would institute three baths per week. Even now, our members report that residents always or sometimes -- at least 30% -- miss their second weekly bath.

Smaller nursing homes laid off other caregivers so they could accommodate the new 24-hour-RN regulation.

The typical situations nursing home workers experience daily show --

The Vice-Chair: You have one minute left.

Ms. Stewart: -- thank you -- show the urgent need for increased staffing. Local 1 members responded to a survey about patient care and staffing.

I want to touch on a couple of our many amendments for nursing homes in the remaining minute that I have.

Section 72: Amend to read, "That in order to provide a stable and consistent workforce and to improve the continuity of care to residents, every licensee of a long-term-care home shall ensure there is a staffing ratio of not less than 75% full-time and 25% part-time. No nursing home licensee shall allow the nursing staff or resident ratio to fall below 3.5 hours of care per resident per day."

Accountability: The Minister of Health and Long-Term Care has indeed established a public reporting on long-term-care homes; however, the information is dated. The data includes only information from the current reporting period, which means it will be at least six months old and could be as old as eight or nine months.

The Vice-Chair: Thank you very much for the presentation. There's no time left.

**JANET HOLTRUST
DAPHEN STANTON**

The Acting Chair: Janet Holtrust, please. Good afternoon. Welcome. I see two of you, so please begin by introducing yourselves for Hansard. You'll have 15 minutes to do your deputation this afternoon, and if you leave any time, it'll be divided among the parties for questions. Please proceed.

Ms. Janet Holtrust: Thank you, Mr. Chair and members of this committee, for allowing us to make a presentation to you today. My name is Janet Holtrust. With me is one of my co-workers, Daphen Stainton. We are both personal support workers, with many years of experience between us. We work in a for-profit nursing home owned and operated by Central Care Corp.

We are here today to make a request for a minimum standard of care hours for long-term-care facilities. We were told by Mr. Smitherman that there would be a "revolution in long-term care." He stated that he would fix the problems that were facing troubled nursing homes. It is with great disappointment and regret that we inform you today that in fact there have been no real changes or improvements to the amount of care or the quality of care seniors receive today.

The hours of care in our facility is 2.23 hours per resident per day. This is at an optimal level. We often don't get to 2.23 hours. Yesterday we worked two short, the day before that we worked one short, and the same for the day prior to that. This is just for the day shift. It needs to be made clear that the expectations from the employer are the same regardless of what our staffing levels are. Only yesterday the administrator called all the PSWs together to inform us of our obligation to complete our baths regardless of staffing. "Other homes get it done," she said. "We should be able to too."

On a regular basis we work with a complement of staff less than required and scheduled. This reduces the time we are able to spend with each individual resident. When staffing levels are met, the average PSW is responsible for the care of approximately 11 people. When we work short, each PSW becomes responsible for up to 13 or 14 residents.

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The ministry has also imposed a two-baths-per-week mandate. This is great for the residents, but again it's more work with no additional staff. When we work short, the time spent bathing a resident takes away from the care we need to provide for other residents. It also leaves us unavailable to assist our partner with transfers and to monitor high-risk residents.

There are many reasons we work short, including illness, WSIB injuries and stress leave. We also struggle to maintain staff, including administrators and managers. Quite often new employees quit because they are unable to keep up with the workload. It becomes so overwhelming that they leave and never come back. We are unable, much of the time, to recruit new staff due to our rural location. In fact, at this time we are laying off nursing staff. So much overtime has been paid in the nursing department that we in fact exceeded our budget. We now fear more layoffs will come. It's cheaper to pay straight time; it's less stress on the staff, much more cost-effective and ultimately better for the residents. Nursing staff often work 16-hour shifts, then return again in eight hours to work another full shift. There have been situations where staff have had to work a 24-hour shift. Weekends have been a nightmare for the staff and residents alike. Employees just don't want to work every weekend and should not be expected to do so. Vacation time poses the same ongoing problem. Staff are even called while on vacation to work.

So you see, without a standard of hours that employers are required to meet, things simply are not going to improve. The government provided funding for new equipment and new builds, but until there are more staff provided to operate that equipment and work in the new builds, we are really just wasting taxpayers' money. We have sufficient mechanical lifts in our facility, but we often wait up to 10 minutes to get help in using them.

Truly, this gives a false sense of security to the public. This bill is not going to make lives better for the seniors who currently live in long-term-care facilities in this province. What they really need the most is more staff.

Ms. Daphen Stainton: Just throwing numbers out there doesn't give a clear picture of the truly sad situation in nursing homes. For this reason, I would like to share with you a typical day for us and for the residents.

At 6:30 a.m. we start our shift and receive report. Shortly thereafter we do a quick check of our residents to make sure they are safe and accounted for. We then stock up on linen and other nursing supplies. Quite often we are searching in vain, as there are insufficient supplies available.

Now it is almost 7 a.m. We start morning care for our assigned residents. On a day when we are fully staffed, we have approximately 11 people to care for. Each resident should be provided about 15 minutes for care.

At 8:15 we are to stop care and take residents to breakfast. So 15 minutes per resident times 11 residents is 165 minutes. There are only 80 minutes available to meet the needs of these individual patients prior to breakfast.

Please consider also that during this time we have a partner that will require assistance to transfer his or her residents. The buzzers will ring and we must stop what we are doing to answer them immediately for safety reasons. Oftentimes we have to stop everything to address medical emergencies, residents who become aggressive and/or agitated. If this happens, we are likely going to be late for meal service. Not all residents have to come to breakfast dressed for the day. We are allowed to send them in in nightclothes, but they still need time spent with them to prepare them for leaving their room, regardless of if they are dressed or not. So simple math will show that 15 minutes per resident is not possible.

At 8:30 we start serving breakfast. Increasingly, there are more residents to feed and to assist than there is staff. We cannot rely on other departments, as often there is no one to assist. We struggle though a very busy meal and then porter all residents to another area of the home.

It is now about 9:15. We have documentation to complete, breaks to take, bathroom requests from residents to meet and residents who require being put back to bed.

At 10:30 all staff converge to do the nourishment cart. This takes about 30 minutes, and then we move on. The beds need to be changed, laundry needs to be taken down and documentation needs to be done. During this time, we continue to answer buzzers and assist any residents with other needs.

Usually by now it is 11:30. We start getting the residents up from their nap and porter all residents to the dining room for lunch. This does take up to about 30 minutes to complete. We go through another busy meal and then follow the same routine again. By now there are many more residents who go to bed for a nap and others who again need a trip to the bathroom.

It is now 1:30 p.m. We take our lunch break, complete documentation and do our report for the next shift. We take down more laundry and check our residents again. The shift is now over. It's 2:30 p.m.

Ms. Holtrust: This day has been laid out to you with no exceptions. Further to basic care needs, we feel there has been an increase in resident falls in our home. We would not be surprised to find that we are above the provincial average. Many of our residents require constant monitoring to reduce the risk of falling. New alarms have been made available, but again, you can have the equipment, but if there is no staff to respond quickly enough to those alarms, then they are ineffective. We also have to assist residents with all appointments they may have to attend that day.

Twenty years ago, when I started nursing in this facility, we had the same amount of staff for the same amount of residents. At that time, almost all our residents were ambulatory; now almost all are in wheelchairs. Then, most people were continent, and now most are incontinent or require assistance with toileting. Back then, they were able to feed themselves, and now almost half require feeding or some level of assistance with feeding. You could also leave a resident alone in their room to eat a meal; now you must stay with them. The level of care has tripled, but I can say our staffing has not increased to meet the demands. The ministry standards were much different 20 years ago. Now they are quite strict and require three times the amount of documentation. The time spent on charting takes away from hands-on care.

This inability to provide the level of care we should be giving to our elders is emotionally trying and frustrating to health care workers. We are trained to provide holistic care, yet always we are looking for ways to cut corners to keep up with the workload. Their needs far exceed the basic activities of daily living that we struggle to meet each day. These people have the right to not be rushed and treated like a number. They should also have the right to have staff be able to make time for them when they need to cry on our shoulder or if they just need to talk.

A typical day for a senior is much different from ours. They will wait until someone has time to provide them with their morning care. They will see us for a few minutes only. We will come back to get them for breakfast and spend another minute or so talking to them on the way to breakfast. If they are classified as a total assist or a feeding resident, then a nurse will sit with them during that meal; otherwise, they will be served their meal and left to eat with their tablemates. After breakfast, we will porter them to another area of the home. If they require assistance with any nursing needs, we will provide it at this time. This may take up to 10 minutes, depending on the needs of the resident.

Now they will sit and wait for any activities that may be scheduled. The ministry mandates 1.5 activity aides per 100 residents. It is impossible for all residents to attend an activity program on a daily basis. If there are no programs, they will now sit, likely in front of a TV, sleeping, and wait for us to come and get them for lunch. They wait and

they wait and they wait. We will come at some point and get them for their meal and they will go through the same process again. After lunch, they will have their nap and wait for dinner.

You can quickly add up the amount of time residents have had contact with staff. These people are dying of loneliness and boredom. For this reason, they become more dependent on their PSW to be available for all aspects of their needs. These needs, many times, cannot be met.

These people are human beings with the right to be treated as such. We are not factory workers and they are not machines, but this is how both parties feel. These people are the individuals who built this country. They are my parents and grandparents and your parents and grandparents. They are also our war vets that we owe so much to. These people have already endured enough hardship in their lifetime. They have the right to live out their golden years in a safe and comfortable environment. They have the right to dignity and respect. Their needs are few, and yet we continue to fail to meet them. We all know this is not what we want for our seniors, and we all know that what is happening in long-term-care facilities can be changed. It is time that Ontario got with the rest of the world in setting minimum standards of care.

So in conclusion, we plead with you to consider a minimum care hour of 3.5 in Bill 140. It's time to move forward in the direction that will evoke the revolution that Mr. Smitherman promised all of us. Thank you.

The Vice-Chair: Thank you very much for your presentation. There is no time left.

January 22, 2007

JEAN BERTRAND

The Vice-Chair: We'll move to our next presentation, by Caressant Care Nursing Home. You can start whenever you are ready.

Ms. Jean Bertrand: Good morning. My name is Jean Bertrand. I am a member of Service Employees International Union. I welcome this opportunity of appearing before Mr. Chair and the standing committee on social policy to discuss the Long-Term Care Homes Act, 2006, Bill 140.

I have been employed for 20 years at Caressant Care Nursing Home, Marmora, Ontario. Caressant Care Nursing Home has a total of 84 long-term-care residents.

Staffing hours for a 24-hour period:

-- Day shift: one RN, seven hours; one RPN, seven hours; eight PSWs or health care aides at seven hours, equalling 56 hours;

-- Bath shift: one PSW, seven hours;

-- Evening shift: one RPN, seven hours; one RN, seven hours; seven PSWs at seven hours, meaning 49 hours;

-- Night shift: one RN, seven hours; three PSWs at seven hours, equalling 21 hours.

Total care hours are 168. We have 84 residents, so 168/84 equals two hours of care per resident.

The long-term-care homes in Ontario are understaffed and under pressure. This is why we need a minimum standard of 3.5 hours per day of nursing and personal care for residents. These people are human beings, with the

right to be treated as such. We are not factory workers and they are not machines, but this is how both nurses and residents feel. These residents in long-term care built this country. They are our parents or our grandparents. They have had enough hardship in their lifetimes already. Residents have the right to be respected and have dignity. They have the right to live out their golden years in a safe and comfortable environment. Their needs are few, and yet we continue to fail to meet them. Some residents without families need more care time. We are their loved ones or family.

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Understaffing is a chronic problem in Ontario nursing homes. Understaffing translates into poor resident care. Most of the time, if some employees call in sick or are absent, we work short. Overtime to remaining staff, some RNs, is for one hour. The home claims that it is not in the nursing budget. One personal support worker takes care of 12 residents at a time. If you are short, then you pick up the other short-staffed residents. In a seven-hour day, a personal support worker helps to feed morning nutrition, to deliver laundry to residents' rooms, full periodontal care, toileting, bathing, grooming, suppository days, shaving etc., making beds, tidying dressers and closets, and making sure that everything is marked with names. The nursing home demands that a resident's diaper be 80% wet before we change one diaper in a seven-hour period. Staff need to cope with ringing call bells, wandering residents, doctors' days, blood days and lab days, and sick residents take even more attention.

To get CMI, you have to chart. Who has the time? We work understaffed with full-time staff, and when we work short, then there's stress, sickness, WSIB, loss of time. That is why we have to put the staffing standard at 3.5 hours per day of nursing and personal care per resident. I have been employed in this sector for 20 years, and these residents need these hours for living in dignity and with respect, safely and comfortably.

Bill 140 is a flawed piece of legislation reflecting the betrayal by this government of the people of Ontario, betrayal of the wishes and needs of our seniors and the people who provide quality care in facilities across this province. The sad state of long-term care in our province is that the provincial Liberal government has an obligation to show leadership in dealing with this situation. You cannot have quality care without people. To this end, a staffing standard is a necessary first step. A necessary second step is for the Liberal government to commit itself to the non-profit model, then to the state of long-term care. Taken together, these will ensure that people living in this province will have access in their communities to the kinds of services they need now and in the future, services provided for them by dedicated, qualified staff who themselves are members of the same communities.

If Bill 140 is not amended by this government to deal with a staffing standard of 3.5 hours per resident per day and a non-profit model, then the state of long-term care in our province will not improve. We urge the Dalton McGuinty government to address the issues I have raised in my presentation. We further urge them to listen to the concerns of the people in Ontario and act upon them.

Thank you for the opportunity of appearing before the standing committee on social policy to share my thoughts regarding the Long-Term Care Homes Act, Bill 140.

The Vice-Chair: Thank you very much. We have six minutes left, which we can divide equally among the three parties. We'll start with Mrs Witmer.

Mrs. Witmer: It's always very refreshing to hear from someone who's personally working with the residents on a day-to-day basis. Certainly when I visit homes I do see the tremendous pressure and stress on the health care providers such as yourself, with the lack of resources.

The Liberals did promise an additional \$6,000 for each resident to provide for personal care. That hasn't been delivered. Now we see a bill that introduces more paperwork and that really, again, is going to lead to a decline.

We've been hearing today that the residents in the long-term-care homes today have much more complex needs than in the past, and I suspect that this is only going to increase. You've said that, for example, a minimum level of 3.5 hours of personal care needs to be provided, as opposed to the current two hours. What is it that you could do for residents with the additional care that you really feel is impacting them negatively today?

Ms. Bertrand: My feeling and the feeling, I'm sure, of all nursing staff, PSWs, health care aides and hands-on care people is that we really need to have a little bit more time so the residents don't feel that they're being treated like a machine. You go in there, you say, "Good morning," and that's about it. You have so little time, because you start at 6 a.m. and you have to be in the dining room for 8 o'clock. That's unfeasible. You have 14 residents to wash or bathe and care for before breakfast.

The Vice-Chair: Thank you. Ms. Martel.

Ms. Martel: Thank you for your presentation and for your work in this sector over many years caring for the frail and elderly. Tell me, in those 20 years, what has been the change in the health of those residents who are coming into your home now?

Ms. Bertrand: I find that the thing with CMI is you get more points, you get more hours, for your hands-on care, but if you don't have time to document -- which we don't, because we're so overworked. We don't have time to document to improve our hours.

Ms. Martel: If someone calls in sick, if someone gets ill or gets hurt and has to go home, is the home replacing the staff? Or is the first line, essentially, to just ask others to do more?

Ms. Bertrand: Because the workload is so heavy in the nursing home, it is very hard to keep new staff. They just can't cope with the hours and what you have to do in a short period of time.

The Vice-Chair: Thank you very much. Parliamentary assistant.

Ms. Smith: Thanks for being here today. In my tour of a variety of homes a couple of years ago, I didn't get to Cobden, but I did get to Marianhill and Bonnechere Manor and Deep River -- so a few in your neck of the woods. I appreciate the great care that you're giving to the residents in your area.

I wanted to ask you a bit about the staffing standard that you've been talking about and the 3.5. There's a lot of discussion around that issue and a lot of discussion about what is included in that 3.5. Would you include in the number the hands-on caregivers, would you include dietary and restorative care, and would you include people who are doing activities with the residents?

Ms. Bertrand: No, just hands-on care.

Ms. Smith: How do you define hands-on care?

Ms. Bertrand: Hands-on care is somebody who really takes care of you completely -- total nursing care.

Ms. Smith: So the nursing aides, the personal support workers, the RNs and RPNs?

Ms. Bertrand: Yes.

Ms. Smith: What about people who come in to provide physiotherapy or occupational therapy? Would those be included?

Ms. Bertrand: Definitely not. I'm just speaking about the hands-on care, because these people really do need it -- and not to be washed in a matter of seven seconds.

The Vice-Chair: Thank you very much for your presentation.

WENDY HAWTHORNE AND ETIE JAMES

The Vice-Chair: The next presentation will be by Wendy Hawthorne. Is Wendy around? Welcome. You can start when you're ready.

Ms. Wendy Hawthorne: Good morning, ladies and gentlemen. I would like to start by saying thank you for giving me the opportunity to be here today. My name is Wendy Hawthorne, and with me is Etie James. We are both from Ottawa.

I am a personal support worker and I have been working in long-term care for nine years. The home I work for is a for-profit organization.

I feel that the seniors in long-term care are suffering, not at the hands of the staff, who are hard-working and dedicated, but from the provincial government, which refuses to set a standard for the number of nursing and personal care hours and increase the funding to long-term care in Ontario.

At the home where I work, there are 252 scheduled nursing hours in a 24-hour period. When you divide that by 114, the number of residents residing in the home, you get 2.21 hours a day of nursing care per resident, which is lower than when the Harris government abolished the standard of 2.25 in 1996. If you look at the handout I gave you, I have broken the hours down. Not all the time is hands-on nursing care or, at best, personal care. It shows that our nursing care hours actually calculate in the paid breaks which we are, by law, entitled to take. So when you take away 16.5 hours, you're now down to 235.5 scheduled hours. When you divide that by the number of occupied beds, now we're down to 2.06 hours that the residents get in a 24-hour period, not to mention that there are three meals a day served, there's laundry to put away, a snack to pass, and other miscellaneous little items that are not personal care. So at the end of the day you're down to 1.79 hours of nursing care, or 107 minutes. This is why we need to standardize the number of nursing hours across the board, and increase it to 3.5.

When we are confronted with increased nursing care for residents, i.e., end of life, complex dressing, severe behaviours, we are not given additional staff, and therefore the time needed to tend to these situations is stolen from the other residents. Is this fair?

A few years ago it was introduced that all residents of long-term care were to get a second bath every week. With this announcement came extra funding to help with the increased workload, sequentially creating new full-time positions at the home where I work. A year later it was time for us to be classified, which led our CMI to decrease, which had a direct effect on our funding to be less, causing those positions to be terminated. But we're still continuing to do the extra bath.

When we work short, we try our very best to do the all the work, but it is not possible. Our director of care and executive director have told us that they expect us to do all baths and regular duties regardless of the number of staff on the floor. We have a difficult time doing our job when we are fully staffed; how it can be expected when we are short?

I have the pleasure to work side by side with some of the most compassionate, exceptional and devoted individuals, who feel they need to work through if not part of their break then the whole thing, just so the residents don't suffer.

I could continue with quotes, numbers and facts that you've already been given or will be given at some point through these hearings. Instead I now want to share with you my reality of the day-to-day life in long-term care and why it is so important that the government set a standard of 3.5 hours for personal and nursing care for our seniors in long-term care.

The home area unit in which I work is home to 32 residents, all of whom have varying degrees of dependence. During the day shift there are two PSWs and one registered staff for 7.5 hours and one PSW for four hours. We, the PSWs, are required to assist these 32 residents to the dining room for 9 a.m. This includes washing, dressing, going to the bathroom, brushing hair and teeth, shaving and makeup. It is a very hard and strenuous task when you consider that some of these people require two or three staff due to behaviours or that they use some type of mechanical transferring device. On a rare day, we can be in the dining room by 9:15, but on most days it tends to be 9:30. Once we do get into the dining room, there are still residents to assist with their meal and help out of the dining room.

There are baths and showers to give, four to five on a day shift, laundry to put away, collation to distribute, repositioning of residents who cannot move themselves and aid to all of those who are in need of assistance with going to the bathroom or anything else they might require. Staff coffee breaks need to be taken at this time as well. It is essential for us to try our best to accomplish all of these tasks in an hour and 30 minutes because staff have to start taking their lunch break at 10:45 in order to be ready for the residents' lunch. During the next hour, the floor has only one PSW, which makes it difficult to accomplish next to anything due to the level of care and assistance the residents need.

At 11:45 we start to help the residents back into the dining room for their lunch. There are now only two PSWs to serve and assist 32 residents during this meal. We can usually have everything done by about 1:10. At this point in the day, we are returning people to their rooms and helping them to the bathroom or back to bed, whatever they may require. We are supposed to take a break around 2, but don't always have time as we still have to dispose of soiled laundry and do another collation pass and our paperwork, which usually takes 25 minutes alone to do. All these things are taking us away from what I am really there to do, and that is to look after the residents. This government needs to set a standard for the number of nursing hours and it needs to be 3.5.

Do you have any idea how hard it is to tell a family member or a resident that I can't take them to the bathroom because I don't have someone to help me? It's horrible. It makes me sick every day. It's not right, but it occurs, sometimes more than once. But it shouldn't happen at all.

The people who are working in long-term care are burning out due to the overwhelming physical and mental demand this type of work puts on you. The Ontario government needs to step up to the plate to fix this situation and set the standard number of hours.

The population that is coming into long-term care is older, frailer and sicker, with more complex medical problems than individuals 10 to 15 years ago.

I didn't come here today to tell you I'm overworked or complain about the conditions I work under. I came here today to try and make you see what it is really like, and to show you that our mothers, fathers, grandparents, aunts, uncles and spouses living in long-term care deserve more and deserve better.

Ms. Etie James: I'm an RPN, in long-term care as well, in a for-profit corporation.

I want you to refer to the PSW assignments that we had to do last year when the two-bath mandate came in. I'm not going to belabour that one; I will just let you look through that. That is one thing in our day that took us quite a lot of time to actually get together.

Briefly, I will attempt to outline life in a long-term-care facility from a registered staff perspective and the difficulties we encounter on a daily basis. The time that the CMI does not account for becomes part of the job. You have a copy of that and I just told you about that. It speaks for itself. There are many time-consuming tasks that eat up our days.

Time spent on doctors' rounds, care conferences, answering phones and making appointments for residents is not accounted for in the CMI.

There is time spent on residents who are: (1) dump-and-runs; (2) psychiatric cases; (3) street people with no families; (4) difficult POAs, often related to number (1); (5) palliative residents; (6) family members associated with number (5); (7) mentally ill family members; (8) quasi-residents who are family members but are there on a daily basis from 8 o'clock to bedtime; (9) immigrant dependants who speak no English; (10) families who don't think they need to do anything and that the home will do it all -- including finding clothes for them -- are very demanding and require extensive explanations before doing anything requested, usually with language barriers, or who disappear after leaving extensive requests and leaving said resident with no means of communication; (11) family members with restraining orders against them who have to be monitored to ensure they don't get into the home; (12) heavy-care residents with tube-feeds, IVs, fractures, bedsores -- often admitted from hospitals -- oxygen therapy etc.

None of the above are covered completely, if at all, under the current CMI formula or the one now being implemented. Care for palliative, psychiatric and high-needs residents is done at the expense of the rest.

There is excessive documentation, the latest being that the registered staff review and sign all the PSWs' documentation, in addition to our own charting and medication documentation.

There are increased falls from the no-restraint policies, with time spent sending residents to hospital for assessment.

There is time spent documenting unusual occurrences -- aggression resident to resident, resident to staff, visitor/family aggression to staff and residents.

Cohort nursing: Time is spent in setting up all the isolation and then trying to keep wandering isolation residents in rooms, and extra time spent managing and reassigning aides' assignments to do cohort nursing, often with no extra staff -- especially true for the evening and night shift.

There is time spent with family members with very sick and dying residents; also mentally ill family members.

There is time spent assisting PSWs when there's not enough help, keeping in mind that we can help them with their work but they can't help us.

Each admission takes four hours of paperwork to complete: care plans, assessments, drug orders, setting up the tick sheets, consulting with families, setting up referrals where needed.

1130

Documentation to comply with CMI/MDS: The conservative estimate is that it will take four to five hours to switch from CMI to MDS for each resident. Half of our registered staff have still not had the training. The extra time needed is not funded.

Time spent trying to accommodate the latest directive from the MOH, the most controversial, being that residents could not have their medications with their meals, resulted in very angry comments from the residents who were

aware and demanded them anyway, resulting in the doctors having to write orders to this effect -- more useless paperwork. The chaos this caused, especially in the mornings -- it was tried, with less than encouraging results.

Three point five hours of care legislated as the minimum level for each resident would at least accommodate some of the heavier-care residents and ensure something is left for the rest. As it stands now, the rest get very little.

Thank you for allowing me to share with you a day in our life in LTC.

The Vice-Chair: Thank you very much. We have just 30 seconds left, so my apology. Thank you very much for coming.

January 23, 2007

JOANNE GRAHAM

The Vice-Chair: We'll move to the next presentation, by Joanne Graham. Is Joanne Graham here? Welcome. You can start whenever you're ready. I believe you know the procedure. You have 15 minutes. You can speak for all of the 15 minutes or you can divide them between speaking and questions.

Ms. Joanne Graham: During my presentation I'm going to mention time frames. These time frames, implemented by the Ministry of Health, are from your last meal of the day to your first meal in the morning, and from your first meal in the morning to your nourishment, to the middle meal; time frames as in positioning of residents, whether it's every hour or every two hours, depending on the resident, depending on the location and everything.

Who am I? What do I know about long-term care? Well, I'm Joanne Graham. I am from a small town up north called Kirkland Lake -- population 10,000. I've worked in this field as a caregiver most of my life. I have seen long-term care come from next to nothing to where it is now. Let's not stop till it is what it should be: great.

I am sure you will hear many reasons during these hearings why we need more funding. We are only a few voices for many who can see that 3.5 hours are needed. I hope that I will give you a different look into the needs of long-term-care residents. Who are these seniors? They are people I have known all my life. They are someone's hairdresser, teacher, doctor, someone's mother or father; people who have been sent from hospitals that have downsized, from the psychiatric hospitals that are closing. We have group home people who don't fit into the group home setting because of age or behaviour. These elderly ones are confused, with different illnesses from Alzheimer's, frontal lobe damage, depression, schizophrenia, Korsakoff's and more, illnesses that we are only learning about how to live with now -- all these residents in the same place with all these mixed feelings, mostly fear. And with fear comes lashing out.

Most seniors have been through hard times -- the war, hunger, moving to this great country of ours, doing without so we can do with. All these hardships don't just disappear because times have changed, as the caregiver knows only too well. The caregiver tries to meet the needs of all her residents. She calls to the registered staff -- the doctors, the gerontology doctor -- for guidance. She is faced with time frames, and the ever-so-kind words from the doctor: "Approach in a calm manner. Take your time. Let the resident be aware of their surroundings." The chemical restraint is not popular. Don't get me wrong, the caregiver is not for restraint of any kind for it only makes their job harder. Safety of others is high on the caregiver's list -- so many residents, so many different needs, so few staff.

The night shift, with only a few staff: positioning of residents who are unable to; making sure the resident is dry and comfortable; doing night-shift cleaning; looking for the elderly woman's lost child -- she is in the past, but we are in the present; the war hero who relives every night the terror of war; the 60-pound man yelling, "There's a woman in my room"; holding the hands of the dying. Yes, we are peacekeepers, pastors, cleaning staff. A lot of the time we are the last face they see. We go without breaks to stay with the residents to keep them safe from themselves, or just to be with the resident whose needs are greater than ours.

The evening shift -- a shift that very few want to work: Sundowners and other behaviours increase greatly. Gentle reminders, a light touch -- slow and easy is how to go. But there are these time frames again. The noise from one resident will start angry outbursts from another. If you had the time, you could see the behaviours multiply. On the evening shift families come to see their loved ones. They want to know how they can help to bring their loved ones back in time so they could be as they once were. Families' needs are great as well. We give comfort. They cry; they get angry; they demand results. I often hear, "My father never did hit out before." But he does now.

0950

Day shift: Only one hour to get the residents up, washed, looking good, transported to meals, fed -- toilet activities, bathing, nourishment and appointments. Let's not forget charting: intake, output, skin assessment, circulation, good colour/poor colour, meals, supplements, walking -- did they walk, did they not walk -- anger/no anger. So many difficult residents in one place.

We haven't even spoken about the residents in our home going back to their original language -- Polish, Russian, Finnish, German -- on and on it goes. Communication takes time, and there is no time because we have time frames to meet.

As you are aware, we the caregivers have a hard job. Who doesn't, nowadays? A caregiver can be spit at, hit, sworn at, tossed around like a playtoy several times in a day, depending on the day. What worked yesterday may not work today. We all know it is the illness, not the person, but it takes time to find out what will work. We all know that different diseases have different stages and different behaviours, from early stage/middle stage/late stage. These diseases are different challenges. And there's no time. We have worked without relief for staff for years. The staff can't even get time off when they need it. The staff don't stay. The work is too hard with not enough staff. The people would like the type of work in long-term care if they had the time to do their job. We were at 2.25 hours years ago, and that wasn't enough. We've never seen that since.

Please understand: Staff go without breaks. They get degraded at times. They do things that are unsafe, like rushing. This rushing is not so they can sit; they rush so they can spend time with the ones who need it the most.

I ask you: At 3.5, give our elderly dignity during the last part of their life. That's it.

The Vice-Chair: Thank you very much for your presentation. We have six minutes left. We can divide them equally among the three parties. We'll start with Mr. Ouellette.

Mr. Ouellette: Thank you very much for your presentation. At the start of your presentation, you mentioned about the group home settings aspect. Are you sensing that there should be specific homes for specific illnesses or needs for long-term-care individuals?

Ms. Graham: I'm only a health care worker and I don't know, but I do know that you need the time to approach these people. You cannot approach them in a hurry. We need doctors to come in and assess and give us some guidance on how to deal with these people. We don't have the doctors. We don't have the time.

Mr. Ouellette: To continue on, then, on that train regarding the amount of time, do you believe, as I stated to the last presenter, that an RN is required? It's established, but it doesn't state the level of care, so an RN could be for a

small group or a large group. Do you think that there needs to be an assessment based on the number of individuals who are being taken care of?

Ms. Graham: I think the assessment should be on the care the resident needs at the time. In our home, and that's only what I can deal with, what comes out of the nursing budget is certainly not all hands-on care. The dietitian who comes up and charts -- that portion comes out of the nursing budget. The office girl who comes up and makes appointments and does scheduling -- that comes out of the nursing budget. We also have the DOC who comes up; the RN who does a lot of paperwork. We have the RPN who does the medication. All of this comes out of the nursing budget, but the actual hands-on care is limited. Certainly I'm not saying that they are not needed or are not a big asset, but the actual hands-on care is very much limited. It seems to me and my coworkers that we are taken last as far as looking into what the needs of the residents are, when we should be looked at first and foremost.

The Vice-Chair: Thank you very much. Ms. Martel?

Ms. Martel: Thank you, Joanne, first for coming from Kirkland Lake, because that was a long way to come to make your presentation, but secondly and more importantly, for the presentation that came right from the heart. Thank you very much for doing that.

You focused on the fact that you don't have enough time. In response to my colleague, you pointed out some of the things that are included in the nursing envelope that strictly really aren't hands-on care. I've been advocating for some time that the legislation clearly state and have a provision for 3.5 hours of hands-on care. Right now there isn't any rule about how much care can be provided. There used to be, when the NDP was the government; it was cancelled by the Conservatives. The Liberals promised to put a standard of care back in, but they haven't. What could your coworkers do if there was actually a rule or a law that said that a minimum of 3.5 hours of hands-on care had to be provided to your residents every day?

Ms. Graham: Certainly I think the home would benefit by this. The residents would be more comfortable. They would have more of a bond with their caregiver. We do have primary care where a staff person has the same residents every day, so we try to deal with that. But to pass somebody and say, "I will be back in a minute," and know that you are unable to -- I think that would solve the problem of dignity for the people at their last stage of life, which is a must. I think that certainly would help.

The Vice-Chair: Thank you very much. Parliamentary assistant?

Ms. Smith: Thanks, Joanne, for coming, because Kirkland Lake is a bit of a trek. What home are you at in Kirkland?

Ms. Graham: Extencare of Kirkland Lake.

Ms. Smith: Great. I just want to touch on two things that you brought up. You talked about the fact that the health care aide/personal support worker spends a lot of hands-on time with the resident and you talked about their role in resident care. I just wanted to point out that in our plan of care in the bill, we are setting out that all those involved in the care of the resident have to be involved in the assessment and developing of the plan of care. So it's definitely creating a role -- in some homes, it did exist; in some homes, it didn't -- so that the personal support workers or the health care aides are involved in the assessment and then in the drafting of the plan of care.

But I did want to focus in on the 3.5-hour question and what you would include in 3.5, because I was interested in your discussion with Mr. Ouellette about what is included in the nursing envelope. You noted that the RPN does medication and that there are others who are included in that nursing and personal care envelope. In the 3.5 calculation that you're seeking, who would you include?

Ms. Graham: I certainly would include the RPN who hands out the medication and the personal support worker who does the hands-on care, and I think the others should be in administration.

Ms. Smith: Okay. Thanks.

The Vice-Chair: Thank you very much for your presentation.

LYNN GRANATIER

The Vice-Chair: Next would be Lynn Granatier. Welcome, Lynn.

Ms. Lynn Granatier: Thank you. My name is Lynn Granatier. I'm also from Extencicare Kirkland Lake. I've been with Extencicare for probably 10 years. I am a PSW; I'm the front-line staff.

"Dear," came the fragile voice from behind the privacy curtain, "Come here. Hold my hand. I'm scared. I've just been here for a couple of days. Everything is so strange and scary here." The thoughts that are crossing my mind are: "I've got one resident sitting on the toilet; I've got two more residents waiting to get to the bathroom with the mechanical lift; I've got another resident in bed, waiting to get up for lunch -- all this before I can go on my break. This old woman is not my resident. I have to take 10 minutes out of my precious time to comfort this poor old woman." What a sad, but true, story.

1000

When I started working at a nursing home, my grandmother was alive. She was so proud of me. She told me I was going to be able to help the old folks. She has now passed on, and I try to treat my residents the way I wanted people to treat her.

Here's the truth: I am one person. I have eight people to care for. They need me to do total care for them: wash, dress, feed, bathe, toilet, change their briefs, put them down for a nap. Nowhere in my schedule is there time to meet their emotional needs. I work on a floor where there are a lot of residents with cognitive impairments. These people need one-on-one time that we just do not get. With the lack of this time, there are many, many behaviours that are dealt with by restraints, either chemical or physical. I ask all of you: Is this the best we can do for our seniors? Is this the respect we owe them? You and I will be their age in the not-too-distant future. I hope I will never end up in a nursing home. I hope you never end up in a nursing home. But if you do, are you going to be happy with the decisions you are making?

Thank you.

The Vice-Chair: Thank you very much for your presentation. I guess we have lots of time for questions. We have about 10 minutes, and we can divide them equally. We'll start with Ms. Martel.

Ms. Martel: Thank you very much for your presentation and for coming, again, from Kirkland Lake. I assume the two of you came together.

Ms. Granatier: Yes, we did.

Ms. Martel: That's good. A safe journey back.

You've been with Extencicare for 10 years. Can you tell the committee what changes you've seen over that 10-year period in terms of staffing, the level of care that residents require etc?

Ms. Granatier: Where to begin? I know that workloads have increased incredibly. We have been given more chores for less time, and when I say "chores," it's a terrible way to put it, because we're dealing with people.

With the increased two baths a week, it has increased our workload enormously, because when you increase the bath, you're talking about behaviours, you're talking about someone who may not want to have a bath. So you have to approach all of these with kid gloves.

Feeding is another thing. At my particular table, I have a group of eight people. I feed three people at my table, each and every one of them with individual needs.

I could go on and on with the increased needs and the lack of time that we have.

Ms. Martel: When you talk about the two baths per week and what that means, because you could have residents who are fighting that very aggressively --

Ms. Granatier: Oh, definitely.

Ms. Martel: -- was there a staff increase to allow that to happen, and are you actually able to provide baths versus what has been referred to as a "bath in a bag," which is more of a sponge bath?

Ms. Granatier: We at our home really do try to do our baths. I'm sorry; what was the first question?

Ms. Martel: Did you see an increase in staff? You've said this increased your workload. Was there some kind of increase in staff -- another part-time person, another casual person who came in?

Ms. Granatier: When we had the one bath a week, I was a bath girl, and I really enjoyed that job, but with the increase to two baths, the bath positions disappeared and we did have one more full-time staff. But that took the job of two bath girls. So, yes and no; we had a transfer of positions.

Ms. Martel: In terms of the residents you are caring for, you talked a little bit about baths and some of them not being comfortable with that. How many of them are mobile, for example? You talked about the number that you need for feeding. I'm assuming that's not tube feeding.

Ms. Granatier: We have at least 27 feeders on our floor, probably 25% mobile, 75% of whom use a mechanical lift.

Ms. Martel: And in wheelchairs?

Ms. Granatier: Oh, yes. With the wheelchair, we have to use the mechanical lift to put them in the tubs or to put them in the showers. So, yes.

Ms. Martel: Okay. Thank you.

The Vice-Chair: Ms. Smith.

Ms. Smith: I appreciate, Lynn, that you came as well. Thank you for being here and for your presentation.

I just wanted to ask you, because you're a front-line worker and you can tell us a little bit about this: We've had different comments about this "bath in a bag" question. It's my understanding that some of the residents prefer a sponge bath to the discomfort of going into a full bath, so sometimes for those residents a home will choose to do

one sponge bath and one full bath in order to meet the needs of the resident. Is that an accurate description in some cases?

Ms. Granatier: The people who have a hard time with the bath are probably the cognitively impaired people. So it's the people who don't know any better that we have to make decisions for, and that's why they're there. If they are extremely resistant to having a bath, it's not worth putting them through that, but sometimes it's better for them to have a bath than to not have a bath. In our home there are very few cases when there's a bed bath given, as opposed to the two baths.

Ms. Smith: I wanted to ask you the same question that I asked Joanne, and that was about the 3.5 and what you would see included in that number. We talked about the different people who have involvement and interaction with the residents and what they would see as being included in the number of hours of care.

Ms. Granatier: I would be really selfish there and say probably PSWs and maybe RPNs.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Acting Chair: I now call on John Van Beek of the Service Employees International Union, Local 1. Good morning, sir. You have 15 minutes, and any time left over will be reserved for questions.

Mr. John Van Beek: Thank you very much. I'm pinch-hitting for Cathy Carroll, our secretary-treasurer, who couldn't make it today.

I just want to thank the Chair and the members of the committee for allowing us to make a presentation again. Last Tuesday, Sharleen Stewart, our president, made a plea for 3.5 hours of care. In our brief, in the first half of that, you will notice that all of the Western world is setting a standard for care. The only place in the Western world where a care standard doesn't exist now is actually Ontario.

1030

Last Tuesday, the parliamentary assistant put out a number of 2.86 hours of care that the government claims each resident in the province is getting. I can't speak for the non-profit homes, I can't speak for the municipally run homes for the aged, but I can speak for the surveys that we have conducted in the private nursing home industry, of which we are the largest union, and there is absolutely no way, in terms of what the nursing care envelope presents or allows, that the care is 2.86 hours per resident per day.

My question to this committee, if I may -- I think somebody's got to push this government, because the parliamentary assistant has been asking the question, "What do you think should be included in the 3.5 hours of care?" I want to know their methodology in terms of how they came up with the 2.86 hours of care. I think it's somewhat a deflection; it's somewhat spin. She threw out that number when we were in her riding in North Bay last fall, prior to the introduction of the bill. I think somehow the government is running scared in terms of being accountable to the people of Ontario. They made promises in the last campaign and haven't fulfilled any of them.

In any event, what I want to do today is the last part of our presentation, which is some amendments that we think are important that we didn't get to last Tuesday.

Let me start you off at page 26, the issue of residents' rights. There's a clear definition of abuse; in the act, it's defined as "physical, sexual, emotional, verbal or financial...." Nowhere in this bill is there a definition for "neglect of care." I think anywhere that abuse is mentioned, the definition should be extended to be defined also as neglect of care. It's something that staff don't have control over. The claim is that staff can now set up or help establish care

plans and make decisions: No, they can't. They can only make decisions in terms of the financial resources that the home has or under the orders of the administration of that act.

I think one has to take a very serious look at abuse. Abuse clearly is a fist in the mouth, but abuse also is having a resident sit in a wet diaper until it's 80% wet. Abuse also is the fact that you can't help some resident with their toileting because two other bells are being rung. What happens if that resident falls off the toilet while the caregiver is attending to two other care bells? Is that abuse? And where does the abuse fall? It falls on the caregiver, right? A neglect of duty, I would think, because she couldn't attend to the needs of the person that she was toileting. So we suggest taking a serious look at what the definition of "abuse" is.

Also, just moving along in the presentation, one has to appoint an ombudsman. There is absolutely no choice. I think the American experience in terms of some of their ombudsmen spokespeople for residential care has worked tremendously well. It's clear in terms of their experience that the thing an ombudsman is most concerned about and that they get the most complaints about is, in essence, lack of care.

I don't think restraints have been addressed by very many people here. I think the issue of restraints in the act is good. The problem is with the chemical restraints. I have a suspicion that more and more chemical restraints are being used, simply in terms of taking a look at the number of drugs that are now being used in the nursing home sector. If you take a look at 2002-03 to 2005-06, drug costs have increased by about 70% over four years. I can't help but think that a lot of this is because more residents are being forced into a comatose state. I understand drugs have gone up and I understand that the population of nursing homes has gone up, but it doesn't account for the 70% total increase in drugs over that period.

Page 28: care and services. There is a provision for 24-hour RN care in the act -- it's also under regulation now, in subsection 7(3) -- but there's no provision for the number of RPN hours, PSW hours or health care aide hours. Clearly, what we demonstrated last Tuesday in our presentation was that in American jurisdictions there are ratios for an RN provision -- for an LPN position, as they call RPNs in the United States -- and also for personal support workers. The coroner's jury that looked at the Casa Verde deaths recommended 0.59 RN hours of care per day and 3.06 hours per resident per day for overall nursing and personal care. If you can have a standard for RNs, you can have a standard for the rest of the nursing staff.

Complaints procedure: We're not sure how this is going to work. Now you have a 1-800 number; you don't have an ombudsman. But does subsection 21(2), in terms of complaints being reported to the licensee, eliminate the 1-800 number? It may well.

Whistle-blowing protection: Section 24 is an excellent provision; I think the legislation, really, is limiting in terms of enforcement. It's going to be terribly difficult to encourage the reporting of abuse, particularly when abuse may be difficult to ascertain in terms of a legal context and when abuse really is a one-on-one situation, for which it is very difficult to obtain witnesses.

Staffing: section 72. We recommend that you amend that section to read, "That in order to provide a stable and consistent workforce and to improve the continuity of care to residents, every licensee of a long-term-care home shall ensure there is a staffing ratio of not less than 70% full time to 30% part time." That gives some continuity of care to the residents and eliminates, to some degree, the agency staff and that sort of thing. As a matter of fact, we would recommend no agency staff whatsoever. Then, of course, you add to that section that nursing care shall not fall below 3.5 hours of care per resident per day.

Page 31: training. We strongly believe in the issue that staff need to be better trained in terms of the kinds of illnesses and cognitive impairments that exist in nursing homes today.

The least we can do is elevate the certification level of a PSW. Again, the coroner's jury recommended that health care aides and PSWs have a governing body and that training in psychogeriatric aggressive behaviours should be implemented.

Quality management: Here's where it gets sticky, I think, between the for-profits and the non-profits. There is no enhancement in this act in terms of promoting the non-profit sector. Clearly, if they're going to compete with the large corporations that exist in our industry today, I think it behooves the government to provide some kind of training for boards of directors, particularly in terms of what their responsibilities are.

Funding is a major issue. We've heard from all kinds of long-term-care presentations over the course of the last week in terms of how the industry is underfunded, and we would agree. The problem is that all they're calling for is public money to enhance facilities, which will indeed enhance their bottom line in terms of the value of their property. I haven't heard them talk very much about care at all.

1040

When you take a look at Extencicare, which just the day after the federal legislation on income trusts turned itself into an income trust, when you take a look at some of the examples we provide in the brief, when you take a look at Macquarie Power corporation, which runs hydroelectric projects along with nursing homes and is basically an international finance bank, when you look at all of these kinds of people -- residence income trusts, REITs -- in the industry, what they're interested in is making a profit for their shareholders, and they're really interested in not paying tax at all. It's my money, it's your money and the Ontario taxpayers' money that's going to that. I'll give you some examples and, to be fair, not all of their money is made in Ontario. But the fact is that there's severe leakage in terms of Ontario taxpayer money going to for-profit as opposed to direct resident care.

We really do suggest that there must be a provision in this act that encourages the non-profit sector. I think that only in terms of issuing further licences, only where there is not a legitimate non-profit operator in a specific geographic area, should one consider a private operator's ability to bid on the licence in that area.

A number of other issues throughout the act: I think clearly, in terms of penalties, we need a very strong commitment from this committee that we won't, and this government won't, tolerate the kinds of abuses that happened in terms of Royal Crest Lifecare, where the Martino brothers basically ripped off millions and millions of dollars from Ontario taxpayers, didn't provide care, and the ministry never stepped in. We were able to resolve those issues as a union. Nevertheless, it was a big blow to the Ontario taxpayer. Those kinds of people should not exist in our nursing home industry in Ontario. We suggest that the fines must be very heavy in terms of for-profit corporations and their corporate directors. If you'll notice, there have to be criminal checks on the staff and everything else, but I don't notice anything in this legislation where there are criminal background checks on the directors of corporations that run the Extencicare, the Macquarie Power retirement residence REITs and that sort of thing.

Thanks. That's our presentation. I hope you'll have a serious look at our recommendations.

The Vice-Chair: Thank you very much for your presentation. I believe there's no time left for questions.

LINDA EVES

The Vice-Chair: Next will be Linda Eves. Linda, to my knowledge, you're not representing Leisureworld Caregiving Centre, are you?

Ms. Linda Eves: I'm not presenting for Leisureworld, no.

The Vice-Chair: You're representing yourself.

Ms. Eves: Yes. Good morning to the committee and everyone present. Margaret Mather, who was to present with me today, was called away on a family emergency. She sends her apologies to the committee. If I may, I'll begin my presentation. Actually, it's our presentation, so you may hear "we" instead of "I."

We -- Margaret Mather and myself -- are both employed at Leisureworld Caregiving Centre in North Bay. We would like to state that we are not here today to represent Leisureworld, but to present our concerns on Bill 140 as both front-line health care workers and members of Service Employees International Union, Local 1.

Let me begin by saying that, in our humble opinion, Bill 140 does nothing for seniors in long-term-care facilities. Inadequate funding means less care can be given to each individual resident -- care that each resident deserves in their golden years.

My colleague and I have been employed at Leisureworld in North Bay for a combined period of 38 years. Our residents have experienced favourable care, but the lack of sufficient staff on the floor means the level of care deteriorates. It cannot be overstated that certain residents require considerably more care than others. Currently, we have 148 residents in our home. The total amount of nursing and personal care, with HCA/PSW and RPN hours factored in, is approximately 1.89 hours per day. The Ontario Liberals committed to reinstating the 2.25-hour standard of care that was removed by the Harris government in 1996. This has not been done.

As front-line workers, we are the eyes and the ears of the long-term-care system. We see the need for more staffing so our residents can have the quality of care they deserve, as opposed to the rushed atmosphere present funding levels provide. In our home we have 57 residents on one floor, with five health care aides. Our shift begins at 6:30 a.m. From 9 to 11:30 a.m., one health care aide assists the bath person to do 10 baths, leaving four staff to answer bells, attend to personal needs, make beds, do morning nourishments etc.

Often, there are two or more call bells ringing at one time, and it is impossible to meet resident demands immediately. The very ill and palliative care residents require more attention from staff. At meal time, one staff may be required to feed two residents, and after the meal the routine is reversed: helping people to bed, attending to their personal needs and charting, which, for the health care aides and PSWs, takes up to 45 minutes -- time taken away from the resident.

The present funding formula, the case mix measure, CMM, which determines the case mix index, CMI, does not always reflect resident intervention or activities, due to a lack of time to complete a shift's charting.

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Unrecorded incidents will drive the CMI down, regardless of the changes in resident care or population. Now a new formula has emerged and the ministry claims the new RAI will be the basis of future improvements to the funding system. This would be wonderful; however, if the staff cannot complete the increased charting, then both the funding and the care will continue to suffer. Nothing will change.

Service Employees International Union, Local 1, states this will not be enough to maintain the level of care for each individual. Residents deserve a minimum standard of 3.5 hours per day of nursing and personal care. This must be implemented by the government in Bill 140.

For our members, Bill 140 is a seriously flawed piece of legislation, bordering on a tragedy in a province such as ours. It is a betrayal of the wishes and needs of our seniors and families who have members in these facilities.

Bill 140 outlines the residents' bill of rights, numbers 1, 3 and 4, as follows:

"1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity....

"3. Every resident has the right not to be neglected by the licensee or staff.

"4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs."

However, it falls short by not providing a set standard of care that will go a long way to ensuring that these rights, as outlined, can be met. Only the government can rectify the situation. And we respectfully request that this government heed the concerns of dedicated employees of the nursing homes, the residents and their families by incorporating a 3.5 hours per resident per day standard of care in Bill 140.

Thank you for the opportunity of appearing before the committee on social policy to share our concerns.

The Vice-Chair: Thank you very much for your presentation. We have six minutes left. We can divide it among the three parties. We have, first, the parliamentary assistant.

Ms. Smith: Thanks from coming from the Bay.

Ms. Eves: You're welcome.

Ms. Smith: Nice to see you.

Ms. Eves: Nice to see you.

Ms. Smith: I was at Leisureworld not that long ago having a big dinner downstairs; it was great. I know the great work that you do there and what a good home it is.

I wanted to ask you about your calculation. In your presentation, you talk about the hours per day and you talk about your particular -- I think that number, 1.89, is Leisureworld North Bay.

Ms. Eves: Yes, it is.

Ms. Smith: Who calculated that number?

Ms. Eves: I did, and it could very well be wrong.

Ms. Smith: Okay. We've done provincial numbers and our average is about 2.86.

Ms. Eves: My math skills are not great.

Ms. Smith: I was just wondering, how did you come up with that calculation? What did you include in that?

Ms. Eves: All the health care aide hours. We have three floors within our building; we call them cares 1, 2 and 3. The health care aides on each shift; it also included the bath people, which we have; RPNs. We have a float RPN and we also have a treatment RPN. The RN hours were not factored into that. Then I just divided it by the number of residents we have in the building, which is 148.

Ms. Smith: And you didn't include dietary aides or activity people?

Ms. Eves: No, I did not. It was strictly nursing.

Ms. Smith: In calculating the 3.5 that you're advocating for, that you'd like to see implemented, would you include the health care aides, the RPNs and the bath people?

Ms. Eves: Yes.

Ms. Smith: You wouldn't include the RNs or any other people who are involved in the care of the residents?

Ms. Eves: I think the RNs have a very important role within the nursing homes. They give us guidance; they certainly do the care plans.

Ms. Smith: So they are involved in the assessment of the residents.

Ms. Eves: Most definitely.

Ms. Smith: Do you call on your RNs when you have a problem?

Ms. Eves: Yes.

Ms. Smith: So they are involved in the care?

Ms. Eves: They're very supportive.

Ms. Smith: But you still wouldn't include them in the 3.5.

Ms. Eves: Well, I didn't with this.

Ms. Smith: But generally speaking --

Ms. Eves: No, I'm selfish, as I heard earlier. I think we need the direct hands-on care for the residents.

Ms. Smith: Okay. I really appreciate you coming. I'm glad that the weather wasn't too bad this morning.

Ms. Eves: Not too bad. North Bay was a little worse than here.

The Vice-Chair: Mr. Ouellette. Two minutes.

Mr. Ouellette: Thank you for your presentation. To continue on the 3.5, the more we hear about the details, I find that setting a fixed number for individuals will be very complex to do. We have such complex and detailed requirements by individuals. I think some individuals may require more. You stated that some require two to do certain things and some would require less. The end result is that we would end up robbing Peter to pay Paul, so to speak, as took place, as other presenters have said, when the nursing envelope was used for various aspects.

Do you think that an in-depth assessment would be a far better way to determine individual needs, to move forward with ensuring the quality of care? What I think is going to happen is that if it were moved to 3.5, all of a sudden administration would be thrown in there. They would be doing the same thing and they would find ways to justify it, but the individual would be the one who ends up losing.

Ms. Eves: Wouldn't that be accountability on the part of the nursing home?

Mr. Ouellette: I would hope so.

Ms. Eves: If it is 3.5 hours, that they are accountable to the government for staffing 3.5 hours of hands-on care?

Mr. Ouellette: Right.

Ms. Eves: And that additional areas are not sort of hidden and thrown in? Am I understanding properly?

Mr. Ouellette: Exactly what you said about hands-on care: What is the definition of hands-on care and how do you break down the difference? Individual assessment, a far more in-depth assessment to determine the individual's care levels, would probably have a much greater impact.

Ms. Eves: As I mentioned earlier, the RAI has emerged, which is resident assessment instrument. I'm not really totally involved with that other than our initial charting, which we must do per shift, which does take considerable time, up to three quarters of an hour per staff, per shift, which is taken out of the resident time.

The Vice-Chair: Ms. Martel.

Ms. Martel: I apologize for being out of the room, but I've had a chance to look at the brief and I wanted to ask you some questions. First of all, thank you for being here, because you've had to travel as well.

I guess regardless of what assessment you use, what the tool is, if you discover that residents need more care, then you have to fund the staff to provide that care. In the last election, the Liberals said that they would provide \$6,000 more for each resident for direct care, for enhanced care. So far, they've delivered on only \$2,000 of that, or about one third. So they've got a long way to go. My sense is that if they actually funded the \$6,000 per resident, we would be in a position to meet the needs of residents, no matter what tool we're using for assessment.

If you look in your home and describe some of what's going on, what kind of changes could you make directly to the residents you're trying to care for if you actually had more time and if there were actually more staff, to have the hands to meet the needs of those people you're trying to help?

Ms. Eves: I could see applying nail polish, doing hair -- simple things. If residents are unable to afford the hairdresser in the facility, then we would have that extra time. A lot of our residents -- or makeup. They wore lipstick. We don't have the time now to meet those needs that maybe they want.

Do we have time to sit and hug someone if they're crying and having a bad day, like we often have? Sometimes they just need a little extra hug, an assurance that everything will be fine and, "I can stay with you. I don't have to run away right away and answer that bell." Their needs have to be met too and it does become frustrating.

Ms. Martel: For you and for them.

Ms. Eves: For everyone.

The Vice-Chair: Thank you very much for your presentation.

DAVID CHESLOCK
CATHY LABRASH

The Vice-Chair: I believe the District Municipality of Muskoka is not here. Are they here? No. So we are going to move to the following presentation, by David Cheslock. Is he here? Okay. Welcome to the standing committee on

social policy. You can start whenever you're ready. You have 15 minutes. You can divide it between presentation and questions.

Mr. David Cheslock: First of all, thank you to the Chair and the members of the committee for allowing us to make a presentation to you today. My name is David Cheslock. I'm a registered practical nurse with over 13 years in the long-term-care industry. Joining me today is Cathy Labrash, also a registered practical nurse, with over 15 years of service in long-term care. I'm a former employee of Extendicare Falconbridge and Ms. Labrash is currently employed in a full-time position at Extendicare Falconbridge in Sudbury.

We're here today to raise our concerns regarding the new Long-Term Care Homes Act, as it has been proposed, and its effects on resident care. It seems that only a few short years ago Mr. Smitherman promised us a revolution in the long-term-care industry and proposed to fix the problems that plagued this industry for over a decade.

In a response to a Local 204 SEIU questionnaire that was sent out on June 11, 2003, Mr. McGuinty's government promised to reinstate the minimum-hours-of-care standard that was removed by the Harris government. This included 2.25 hours of nursing care daily. Furthermore, they promised they would instate a three-baths-per-week standard. The reality is that we have seen no standard of three baths; instead, we have seen two baths. And we have seen no standard hours of care. My question is, what happened?

The staff who care for our family members every day in long-term-care homes used to pour their hearts into providing this care and they used to be a surrogate family, filling in for us when we were not there due to our work and other obligations. I say they used to, because with the increasing workloads caused by government regulations and more medically complex cases, the staff have simply run out of time.

In regard to the bathing issue, let me say that what I learned in school was that three does not equal two. Giving every resident two baths per week is a great improvement, but it is definitely not three. The only problem with the two baths is that there was no increase in the staffing to accommodate the change in workload. At Extendicare Falconbridge in Sudbury, they put in the two baths without any increase to the number of care hours being provided. This means that the same number of staff must now give approximately 234 additional baths every week. My mother always said that I would never be an accountant and that I'd never be a mathematician, but I know bad math when I see it, and that is bad math.

I think when we discuss hours of care, there is often a misconception of what that actually means to a resident's life. If we look at the hours of care at Extendicare Falconbridge, based on SEIU calculations, there was an average 2.12 hours of care per resident per day. When you take RNs into consideration and realize that they typically do not provide hands-on care and you take them out of that equation, it reduces it to 1.93. It sounds like a lot of hours -- 1.93 hours per resident per day. However, when you look at it in reality, what does the number really mean?

Let me point out a few things that no one takes into consideration when looking at hours of care. Of that 1.93 hours there are tasks that need to be performed that do not provide direct interaction with a resident. For a PSW, this will include 20 to 30 minutes of charting each and every shift that must be done. This used to be much shorter, but over the years government regulations designed to ensure proper resident care increased the amount of charting required. Other tasks include loading linen and supply carts to take to your rooms on your rounds, cleaning every piece of equipment that you need to perform your duties, and for infection-control purposes, frequently cleaning them in between each resident.

It includes putting away personal laundry, cleaning bedside tables, dressers and closets. It includes checking every item in a room to ensure that a resident's name is properly identified on each and every item; serving dinner plates at all meals, including beverages; hauling away dirty laundry; in-servicing to ensure people are properly educated and updated on all aspects of their duties; serving refreshments three times a day; and let's not forget, going room to room to get equipment. Walking actually takes a lot of time in some of these big buildings. All of these things cut into the time of the 1.93 hours.

Let us not forget that the RPN role is critical to care of the client as well, but they surely spend much less time with a resident than the PSW does. Much of their time is spent preparing medication for the resident, as it usually takes more time to prepare than it does to actually administer that medication. An RPN can take on average two and a half to three hours for morning medications, one to two hours for noon medications, one to two hours at dinnertime for medications and another three hours for bedtime medications. This does not include what are called PRN medications -- as-needed medications -- such as analgesics for pain.

An RPN must further chart all PRN medication given. This means that a simple Tylenol can take up to five minutes to prepare and chart, not including the time to actually administer that medication. Charting can take several hours each shift when you include the charting for PRNs, resident quarterly reviews, doctor orders, signing in medication from pharmacies and other tasks.

I could spend an hour just running on about those individual things that cut into that time. We should also consider that RPNs must address family concerns and answer repeated phone calls to the units. None of these tasks provide interaction with a resident, but they all become part of that 1.93 hours.

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Based on this information, I think it is fair to say that hands-on care can actually be measured in minutes, not hours. I am not saying the tasks are not important; I'm not saying they don't have their place. However, they do not provide hands-on, human interaction, the missing component of the formula for quality resident care. I could bore you with a lot of numbers and studies that show that Ontario is at the bottom end of the care hours, but I'm sure you all know these numbers already. I ask the government to reinstate the standard hours of care into the act and increase it to 3.5 hours, thus bringing Ontario in line with the rest of North America. Ontario residents deserve better.

Ms. Cathy Labrash: Thank you for allowing me the opportunity to speak to you today. I would like to address the staffing issues challenging the long-term-care industry.

Almost every day that staff report to work, one of the shifts is working short-staffed. The shortage of staff is a result of the employees leaving the industry to go to hospitals, where the workload is substantially decreased and the wages are much higher. This makes it nearly impossible to recruit and retain staff.

Allow me to provide some examples of recent events at Extencare. Saturday, I was asked to work a double shift. Sunday, I received the same request. No sooner had I arrived at home than I received a phone call asking me to come back to work a night shift as a responsible RPN. "Responsible" means there is no RN available to work the shift, and the RPN assumes the responsibilities in his or her place. This means that there is no RN in the facility on that particular night.

The employer's response to a situation like this is an on-call list. If I need a medical directive for a resident who may be having pain, I must call the manager who is on call. This does not allow for proper coverage during an emergency situation. The employer is increasing the training for RPNs who are willing to work as a responsible person. How does this address the fact that there is still frequently no RN in our facility?

To further the problem, if no one is willing to come into work and the RPNs are already working short that night, they are told that they are responsible for their own floors. This reduces the number of professional staff in a building from the regular four to three. One can only hope that we are not already working short on one of those floors -- RPN or PSWs.

The best-case scenario is that all staff show up on a night shift and we have 10 people in our building to spread over our three floors. What will happen should there be a large-scale emergency in this facility?

The staffing in general in our facility has reached critical proportions. We continually work short, which ultimately impacts our residents. The only way to address the shortage is to address our workloads and the hours of care. No staff member wants to go to work and tell a resident that they don't have time to assist with some task of daily living, but what is the choice? Telling a resident that you do not have time right now is a totally unacceptable response.

There are insufficient people to provide care as mandated by the Ministry of Health and Long-Term Care. The employer regularly reminds staff that work has to get done even if we're working short. The employers have developed staffing plans, frequently called "plan Bs," which is one staff member short on a unit, and sometimes we've been "plan C," which is two staff members short on a unit. When all else fails, they'll tell us to pass it on to the next shift. The question is, where does this overflow ever get picked up? The other shift is already running to capacity and often they are working short as well.

Regardless if it is a PSW, an RPN or an RN, the end result is that we are working short. It seems to be a never-ending circle. The real surprise occurs when staff come to work and find out we are actually working full-staffed.

Insufficient staffing puts residents' safety at risk. Even at full staffing levels, there are not enough bodies to monitor the residents. On my unit there are nine PSWs, two RPNs and one RN on a day shift. There are approximately 78 residents with numerous health and care issues. Although it looks good on paper, the truth is that we are constantly pulled away from resident care for many different reasons, such as:

-- in-servicing, which reduces staffing to half. These in-services are usually held for 15 to 30 minutes and occur before a break. This means that half the staff could possibly be off our unit for the better part of an hour. Most of this in-servicing is mandated under the Ministry of Health standards; and

-- professional staff meetings. These meetings take all our professional staff off all units for approximately one hour, give or take 15 minutes.

The level of burnout among long-term-care staff is increasing every day. The staff are emotionally drained by the demands put on them by all parties. Residents are not blind to human emotion and easily detect the tension and fatigue of the staff. This does not lend itself to a therapeutic relationship. Ultimately, staff pays the final price for the stresses by injuring themselves trying to get an unreasonable workload completed. The end result is another short-staff situation that will result in lower resident care.

The most recent demand on staff has come as a result of the MDS program developed by the Ministry of Health and Long-Term Care. This program alone has increased the amount of work required from every RPN in the facility. An annual assessment on a typical resident under the program will take an average of 30 minutes. The follow-up documentation required by this program can increase the charting on every RPN by several hours a week. The staff find it difficult to meet the deadlines in this program due to existing workloads, as evidenced by frequent reminders by RAI co-ordinators that assessments are due.

These are some of the challenges we face in regard to staffing levels.

I would like to thank the committee for allowing us to present to you today.

The Vice-Chair: Thank you very much for your presentation. We have two minutes left, which gives every party a chance for a quick question or comment. Ms. Martel.

Ms. Martel: Thank you, both of you, for being here today. Double shift: Does that become 12 hours?

Ms. Labrash: It's 16.

Ms. Martel: So, Saturday, 16; Sunday, 16. You got home and were called in for Sunday night to come in for a night shift?

Ms. Labrash: Had I accepted the shifts, it would have been a 16-hour shift on Saturday and a 16-hour shift on Sunday as well.

Ms. Martel: How often is there no RN in the home at night?

Ms. Labrash: I'm not really sure of the numbers, but it's quite frequent.

Ms. Martel: How often are you working short-staffed? Is that being monitored by the union at all, for example?

Ms. Labrash: Yes, it's reported to the union when we are working short, and we just keep track of it.

Ms. Martel: Do you have any idea, let's say, in the last six months, what those numbers might be? Sorry to catch you off guard. I'm just curious.

Mr. Cheslock: About 20 times every month, they're running staff-short.

Ms. Martel: And you're also monitoring if that's one short or two short? Should I assume that's usually one?

Mr. Cheslock: We are monitoring it, and we can pull it. You shouldn't assume it's one. Sometimes it's two. Sometimes it's one on every unit. Sometimes it's up to two per unit. So it's not uncommon.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: Thank you for being here. When you don't have a 24/7 RN, has that been reported to the ministry? Because there is a regulatory requirement now for 24/7 RNs in our homes.

Ms. Labrash: I'm not sure if it has been.

Ms. Smith: I wanted to ask you, when you did your calculations about the number of hours -- and then I think you factored out the RN. We had other presenters factor out RPNs for the minimum standard number. We've had a variety of opinions on what should be included in the minimum standard number. I'd be interested to hear which caregivers in the home you think should be included in the minimum standard number.

Mr. Cheslock: I believe it should include anyone who provides actual hands-on care or interaction with a resident. So we would say that would include RPNs, PSWs, and it could potentially include RNs, depending on the job description of that individual. It shouldn't include an RN who is a supervisor rather than an actual hands-on care provider.

Ms. Smith: Would you include in that number any of the activation people, the activities coordinators, the people who deal more in the secure units with those suffering from dementia, who may not have actual physical demands but may need more redirection and help -- sundowning?

Mr. Cheslock: In the facility we were looking at, which is the one we come from, there is no one in that capacity. The activation department doesn't provide that type of care. They provide actual activities. So I would say, in that case, no.

The Vice-Chair: Thank you very much for your presentation.

January 24, 2007

LUCY BUTTERY

The Chair: The next presentation is Lucy Buttery.

I know I've just used your name, but the procedure requires that you state your name for Hansard, please.

Ms. Lucy Buttery: Hi. My name is Lucy Buttery. Thank you for letting me speak. I am an SEIU member. I work in the dietary department of a nursing home with 63 residents.

My concerns about Bill 140 are the lack of hours that we have to care for our residents. We need to put more funding into long-term-care facilities so that we can raise the hours of care to 3.5 per resident per day. At our home, we have a level of 2.03 per resident per day.

In the dietary department at our home, we have lost five hours per day since I started there 18 years ago. We currently have 0.4 hours per resident per day in the kitchen. The ministry has made many changes in our department throughout these years. Whenever inspectors come in, the rules change and more and more duties get added to our job, but our hours never increase.

The meals used to be served from the kitchen, but it was decided that the residents should see the staff serving their meals, so a portable steam table was purchased. For the last few years we've had to take the cart out into the dining room. The cart goes out at 8:30 in the morning. We used to serve breakfast with two staff, but now we do it alone. One person must serve 63 residents in 30 minutes. This is less than 30 seconds per resident. It is very important that we make the residents' meals a relaxed dining experience. In our home, it is anything but.

I have heard that in many homes, the health care aides are doing a lot of dietary's jobs. At our nursing home, they come to our cart to get the food for the tables that have residents who need to be fed, and they do our snack cart. We are expected to serve just one table, four residents, at a time: pour their tea and coffee, smile, visit, wait for them to make up their minds on what they want, and get back to our cart, all in less than two minutes. Although we know all of the residents' diets, we were just given a binder that we have to flip through to make sure that we don't give the diabetics sugar and the "dislikes eggs," etc. When we are done, we are expected to go around and see if anyone wants seconds. All of these tasks take extra time out of our day -- time that we don't have. Just imagine: 63 residents brought into a dining room. Some are walking on their own, some with help. Some are getting up just seconds after they've been seated, and some have to be persuaded to go in, because they don't feel like going in at all. All of these residents are served their food, fed, and taken out of the dining room in less than an hour. Does this sound relaxing? There are bells ringing. There are staff taking residents in and out of the dining room, and running trays to the rooms for the residents who aren't coming out because they aren't feeling well.

We are run off our feet in the kitchen. Every meal is just as rushed. We have 30 minutes to serve lunch and supper. Because we have a lot more food to serve, we have two dietary staff working during these two meals. It is still quite a job because we are still expected to show each resident the main meal and the alternate and we have to be polite as we stand there and wait for them to make up their minds.

Another new thing that has been added in the last while is that we now have to chart the amount of food and fluids that each resident has at every meal. We chart the food we use, and the health care aides do the fluid and food intake that each resident has had.

I understand the importance of all the changes that have been made in the past few years, like food presentation, which uses a lot more dishes; charting food and fluid intake; allowing the residents to have the choice of an alternate; a relaxed dining experience; and more time spent with the residents in the dining room, but each change takes a few extra minutes, and we do not have any extra time.

With the price of food, it is very hard to stay on budget, so a lot more dishes and desserts have to be made from scratch. This also takes up a lot of the dietary staff's time.

The housekeeping staff have limited time to accomplish all of their tasks as well, which leaves us kitchen staff spending a lot of time trying to keep the kitchen's cleanliness up to ministry standards.

1100

When the health care aides are going to be working short on evenings, a staff member is taken off the bath shift to fill the evening shift. Sometimes they are unable to replace the bath shift, which leaves some residents not getting their bath. We had the Norwalk virus. Half of our residents were vomiting or had diarrhoea. The health care aides even had to work short one evening through this. Staff availability is just non-existent. It seems like no one wants to work in nursing homes because of the stress and workload.

The housekeeping department had to disinfect all of the doorknobs, railings and handles while the Norwalk virus was in our home. They were given an extra hour per day, but a five-hour shift was taken away so they could have that hour a day to disinfect.

The three housekeeping staff never get their work done, and a lot of days they even work through their breaks. They practically run all day long, and if a resident leaves or passes away, they are expected to clean up that room in their regularly scheduled shift without any extra time.

In the summer we get nursing students, but they only stay until they're done school and then they go elsewhere, where they can make more money and not have to run on the job.

Ours is a small facility in a small town where we often know the clients and their families. Staff try harder because of this. We want to make them comfortable. In our facility, wanderers are not segregated. When agitated or "sundowning," they will often go from room to room to room, which means that you end up having bell after bell ringing from cognitive residents because they are upset by being bothered. Some do not understand it is a disease; others know but they don't want these people in their space, which is understandable.

We are taught to encourage independence, to let residents do as much as possible so they don't lose their abilities. Often this is impossible. Health care aides are rushed to get them washed, to the table and fed, all around a timetable.

If residents are ill, often the well ones are given limited attention. As an example, a resident has MS and also has a cold. She has almost no movement left in her body -- maybe enough to pull the bell. Her nose is dripping but she has to wait and wait because her caregiver is busy somewhere else. Each time a little more dignity is lost. She has to be a patient woman but gets called "demanding" because she sometimes loses her temper or wants things done in a certain way, which is the only thing she has control of -- all of this because she has to rely on others for total assistance. Extra hours and helpful staff would make a huge difference to help our residents maintain their dignity and quality of life.

I would like to share with you what it's like to be a resident in a nursing home, on behalf of my mother. When my mom became unable to take care of herself at home, we talked her into going into a nursing home. She was not too happy about this, but we told her that it would be better for her: Her medication would be given to her at the right times, they would give her her meals and they would help her bathe and dress. My mom was still walking with a

walker with some help when she went into the home. I encouraged her to keep walking around as much as she could so that she would still be able to get around. It didn't take her very long to realize that the health care aides didn't really have the time to walk her all the way to the dining room, and that if she couldn't walk back to her room on her own she would likely stay in the dining room until it was her turn to be taken back. She realized that if she had a wheelchair she could get back and forth on her own, so we bought her a wheelchair. It wasn't too long before she didn't use her walker at all.

My mom went into the dining room for every meal. After every meal, the girls would take her back to her room, they would help her to the bathroom and put her into her La-Z-Boy chair. She would usually stay there until the next meal. The health care aides would bring her a drink or a snack off the snack cart at 10, at 2:30 and at 7 o'clock at night. She never dared to ask for too much because she knew that the girls were too busy and she didn't want to bother them. The health care aides never told my mom when they were working short, but she always knew because they were always in that extra big hurry to get her done. In the morning they would put my mom on the commode. Sometimes they would have problems in another room with another resident and they wouldn't get back to her for 10 or 15 minutes. She would tell me about it, and to her, it always felt like it was an hour. Imagine how helpless you would feel.

Like most seniors, my mother was very set in her ways and she did not like change at all. She suffered from osteoporosis and needed help getting dressed. Before she went to the home, she always liked to wear a buttoned-up shirt, a straight-cut skirt, a slip, pantyhose and a girdle. After about two days of living in the home, the staff were at her about not wearing her girdle because it took too long for them to put it on her and they didn't have time. She was pretty stubborn about this and would not hear of it, so she started at the family about it. After about two months, they finally just stopped putting it on her. I think that's when my mom finally realized that her independence was really gone. Next came the pantyhose. The girls just didn't have the time to struggle to try to get them on her. My mother was 86 years old and for the first time in 60 years she had to wear socks and jogging pants instead of pantyhose. To anyone else, this might seem like a minor thing, but it was a really big deal to my mom. This was one thing that always really upset her.

There were a few things that my mother just wouldn't give in on, like wearing her housecoat to the dining room so she would be ready for her bath right after breakfast; going to bed early because the health care aides started at the end of the hall and did one room at a time so they could get them all into bed before 9 o'clock, when one of the shifts would end. That meant that she would have to go to bed shortly after 8. Some staff approached me about buying mom some open-back nightgowns. They said that it would be much faster and much easier for them to change her. The next time the clothing company came to the home, I took mom to look at them. She wouldn't even look at them, but I bought her two, thinking that I would talk her into it later. After my mother passed away, I found the nightgowns in one of her dressers. They had never been worn.

Wandering residents were always a problem. They would just come into her room at all hours of the day and night and get into her belongings. This was very upsetting to her. There was just not enough staff to keep an eye on all of these residents. When any of our family members complained about this, they would tell her to keep her door shut, but my mom was afraid of being locked in a room all by herself. They put a six-inch-wide yellow band across her doorway. This didn't really work, but it was the best they could do for her. She spent many nights being afraid.

My mom was really lucky to have a big family who visited her a lot, and the staff from the activity department did their best to try to talk her into coming out to their activities. I see so many residents who have little or no family. It makes me feel very sad to think of how long their days must be, alone in their rooms with staff rushing in and rushing out to give them care, and push them back and forth to the dining room for their meals in a hurry because they have to get all 63 residents there in 10 minutes. No one has any extra time to just stop by and say to them, "How are you today? Is there anything I can do for you?" or "Would you like to go for a walk?" because we are all so busy trying to do our jobs and stay caught up on all our charting.

Current regulations require documentation and charting. This takes time away from staff being able to provide more hands-on hands. If the government wants more accountability, then they need to provide more money for

staffing to complete documentation for the accountability. As the saying goes, if you don't chart, you haven't done it. By the time you get your work done properly there is no time left to chart. It's always a balancing act. Which is more important -- the resident or the charting?

Because we are a small facility, it is often difficult to obtain staff. Part-time hours are shorter and staff often work two jobs to make a living. Young people do not want to stay working in this environment long-term. After working in this kind of atmosphere, you just get tired, your patience runs thin and it is very hard to stay focused on why you really chose to work in a long-term-care facility.

The Chair: One minute, please.

Ms. Buttery: It is getting harder and harder to find anyone who wants to spend the rest of their career being a health care aide or a dietary aide in a long-term-care facility because the load is just too heavy. This is why so many homes have to work short. There is just no one to hire. It is our job as health care providers to give our residents the best care possible. Please help us help the residents.

The Chair: Thank you. There is no time for questions.

JOHN VAN BEEK

The Chair: The next presentation scheduled is by Margaret McClintock. We've been advised that she's unable to make it today, but John Van Beek has requested that he make a very short statement on her behalf. The Chair has ruled that that's acceptable; if the committee doesn't concur, I will probably storm out in a huff.

Mr. John Van Beek: Thank you very much. I'm going to be very brief, so it will put you back on schedule.

Nursing home workers who have made presentations here have been under the gun. They are very nervous, of course, in terms of presenting in front of this committee. I was informed late last night that a letter had been sent to one of our members who was going to make a presentation, and I just want to read the letter and put it on record. Of course, we will take the appropriate action. This is dated January 23, 2007.

"Ms. Marg McClintock

"c/o Caressant Care on Mary Bucke," which happens to be in St. Thomas.

"Dear Ms. McClintock:

"It has been brought to our attention that you will be speaking at the Bill 140 London public hearings meeting on Wednesday, January 24, 2007 at 11:30 a.m.

"This letter is to notify you that during this meeting you will in no way be representing Caressant Care Nursing and Retirement Homes Ltd. in your opinions and outlooks.

"If Caressant Care determines that you have represented them in any way, this could lead to your termination of employment.

"Sincerely,

"Cheryl MacDonald

"Manager, Human Resources," from their corporate offices in Woodstock.

It's a deplorable situation, of course. The union will attempt to correct this situation in terms of the ability of threatening people's right to speak out. In terms of that, it's just absolutely deplorable. I just want to put that on the record. Thank you.

CINDY RUDDY

The Chair: That brings us to our final presentation, which is Cindy Ruddy.

Welcome.

Ms. Cindy Ruddy: My name is Cindy Ruddy. I am employed at Elgin Abbey Nursing Home in Chesley, and I am also a member of the Service Employees International Union. I'd like to take this opportunity to thank you for allowing me to come and speak today.

I did not prepare a brief ahead of time, as I just decided that I would rather present my concerns with a few notes, kind of wing it and go by the seat of my pants, which I'm known to do, and speak more from the heart. What I'll be discussing today is the current condition of the staffing complements that have been overlooked in Bill 140.

Two patients limp into two different Canadian medical clinics with the same complaint. Both have trouble walking and both need a hip replacement. The first patient is examined within the hour, is X-rayed the same day and is booked for surgery the following week. The second sees the family doctor after waiting a week for an appointment and then waits eight weeks to see a specialist, then gets an X-ray which isn't reviewed for another month, and finally has surgery scheduled for a year from then. Why the different treatment for the two patients? The first is a golden retriever, the second a senior citizen.

I'm not trying to make light of a very serious situation; however, I wanted to point out that we hear many, many jokes about our health care system and how the flaws associated with it make it easy to poke fun at. We rarely, rarely hear jokes about long-term care, and the reason for that is that unless a loved one requires long-term care, there really is no reason to think about it. As a result, people are completely uninformed of how we, the health care providers, the seniors living within the facilities and their families are left to deal with such an underfunded health care component within the Ministry of Health and Long-Term Care system.

The facility that I work in operates on 2.45 hours of nursing care per resident per day. This is simply not acceptable. I'm not going to reiterate what has already been addressed. You are all well aware of the way the CMM works and how the funding is determined. I'm going to use my time today to describe how this system is failing and why our seniors are considered to be the Ontario government's forgotten.

They're at the post. This is where I wing it. Every day, staff members come to work, and that is exactly how their day starts: They feel like they're horses, and the gate is going to flood open and rush in. It is that way almost every single day. It's overwhelming, it's stressful and completely unnecessary. They spread themselves so very thinly that they leave exhausted every day and wonder if it is going to be any better tomorrow, only to find out tomorrow that it isn't. Like I said, we're rushed.

As I look around, I'm assuming that pretty much everybody here has children. What I like to compare it to is when you get up in the morning and your alarm has not gone off; you're rushed, and you get your kids and whip the clothes on them, only to find out that their socks are inside out and they don't want to work with you. They don't want cereal for breakfast; they want a slice of bread. It goes on and on and on. That is a very sad thing; you know yourself how you feel when you leave. You think, "Oh, that was so terrible. Why did I rush them through that? That

was not right." But you had to; in order to get done what you needed to get done, you had to rush. That is exactly what we deal with every day, on a daily basis.

We have families who wish to speak to us, the front-line workers, not the people sitting in their offices. They want the front-line workers. That takes time. You cannot overlook the family members, who need to know that their loved one is being well looked after. They want to speak to us, who deal with them every day. So you stop and you take the time. You are now 10 minutes behind. You were already 15 minutes behind. Now you're 10 minutes more behind.

About eight years ago, a colleague of mine said to me, "You know, Cindy, we do 10 hours of work in eight, and we're expected to do it in seven and a half." She's now retired, and I'm expecting to probably see her in a nursing home some day. I feel sorry for her, because I know how frustrated she will be when she gets in to find out that things have not changed in all those years -- things we don't have time for, like cutting nails, something simple that you would probably take for granted. You jump in a bathtub; you clip your nails; you're done. These people have to wait, and if they don't get done, what happens when they get aggressive? We get scratched. But you have to take priorities and you have to do what is necessary and what is important. There's no time for one on one, to sit, to hold a hand, to talk. That's pathetic. A hug, backrub -- we all like backrubs. That was what we did years ago when I first started. I've been there a lot of years; 27, I think, to be exact. We did that; we used to do backrubs. You very rarely see that any more.

Toileting: This is my pet peeve. We have diaper police. I'm sure you've heard this. You wear your Depends until it is 75% wet. I brought one with me today with water in it. That is a wet diaper. It holds this much water. That's what's in there. If it is not 75% wet, we are expected to take it off, wash them, and put it back on. Would you ever consider doing that to a child? But we're doing it to our seniors. That is disgusting; absolutely disgusting. As a result, staff feel like they've let the residents down, which we have, and we deal with that every day. We have what I call the Florence Nightingale syndrome, and that is, we're all nurturers; that's what's keeping our residents well looked after. It's because that's what we do. We don't care that we've been there eight hours or eight and a half hours. We're there to make sure they're looked after.

I have this feeling -- everybody I talk to says the same thing: They're all very, very stressed and very tired.

We have Alzheimer's residents who constantly repeat themselves during the day, which is interesting, because you hear the same story every day. That's part of the job. But they still want you to stop and listen. Even though I know it verbatim, they still want you to listen. There are elopers and aggressive people. One person could walk out the door 10 times in five minutes, but you have to go out and bring them back in. That's not personal care; that's just caring for them. For stroke patients with paralysis, their comprehension level is down. They don't understand you, so you are repeating yourself over and over again. Sometimes it takes a while for what you're telling them to reach their brain and for them to understand, so you have to sit and wait. You can't just say, "Here," and they take it. You see that their brain is slow, but you must wait. That's all time-consuming; very, very time-consuming.

Mental illness: We have some people who have mental illness. We have one gentleman in there right now who calls me, "Mommy." So I go to work every day and I'm still hearing, "Mommy, I'm wet." These are everyday things that occur within the facility.

1550

What "care" stands for at present: "C" stands for challenges that we meet every day. "A" stands for agnosia, which is lack of recognition of people. "R" stands for resistance from the ministry for additional funding. "E" stands for exertion and exhaustion.

What "care" and "long-term care" should stand for: "C" is for commitment and continuity from everyone, including the Ministry of Health and Long-Term Care. "A" is for accountability from all disciplines which actively participate

in our elderly population, including the ministry, which establishes and sets the standards for all parties to achieve. This should include the allowances of the appropriate and necessary funding requirements for all long-term-care facilities. "R" is for revolutionary. Giving support and allowing the staff and residents the time to interact more will enhance and allow the development of more specific and individualized programming. This would ensure that our residents' needs and desires are enhanced. After all, this should be the ultimate goal of all disciplines. We all know how important it is to us that while at home we can be ourselves. The older we get, the more support we need to reach this desire. Our staff need the time to help our residents. "E" is for enabling choices. They don't have choices. It's very sad.

It is undeniable to say we are faced and confronted with challenges on a regular basis. This is interesting: I have personally -- and you wonder why I cry, but I love my job -- been slapped, kicked, punched, pinched, bitten, spat at, yelled at, sworn at, urinated on, vomited on, defecated on and, in the next breath, hugged, kissed, been confided to. I've cried with, laughed with and grieved with many, many residents over the years. We are fortunate to have so many front-line staff who appreciate our elderly for who they are and what they represent. As you are well aware, it is becoming more challenging to recruit this type of person for our elderly to rely on. It is imperative that we recognize the importance of the commitment required to maintain those we have and make it more appealing for potential employees. Our government needs to realize that our seniors deserve to be given the privilege of the support, the dignity, respect and care they are so rightfully deserving of. It is time to care for those people who have taken care of others for so long, including each and every one of you.

I acknowledge that not every resident requires the same care. That just goes without saying. However, there must be a benchmark that must be established to ensure a minimum amount of care. In the United States, a study commissioned by the Federal Centers for Medicare and Medicaid Services identified three staffing thresholds below which the quality of care was found to suffer. The threshold is 45 minutes for RNs; one hour, 18 minutes for total licensed services -- RNs plus RPNs; and two hours and 48 minutes for PSWs. Any nursing home that meets these standards would provide at least four hours and six minutes of total nursing care per day. I implore you to amend Bill 140 to reflect the 3.5 hours of hands-on care per resident per day. That would be a major, major contribution to help ensure that this standard is met. Thank you.

The Chair: Unfortunately, there is no time for questions, but thank you.

That concludes the public hearings for Bill 140. The committee will meet next Tuesday to commence clause-by-clause deliberations. The committee is now adjourned.

The committee adjourned at 1556.