Fixing Long-Term Care Act, 2021: Phase 1 Regulations explained

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Background

On April 11, 2022, the *Fixing Long-Term Care Act, 2021* (the Act) was proclaimed into force. We previously published an article highlighting the reforms proposed in the Act, and as well, a more focused article for long-term care home employers in Ontario.

On the same day as the Act was proclaimed into force, the "Phase 1" General Regulations (O. Reg. 79/10) also came into effect.

This article summarizes the many notable changes contained in the general regulations, and key points for long-term care home licensees.

Summary of notable changes

Enhancing emergency planning requirements

Requirements with respect to emergency planning have been enhanced in light of experiences from the early days of the COVID-19 pandemic.

Licensees are now required to ensure that emergency plans are recorded in writing, and updated following documented consultation with emergency services in the area, community agencies, health service providers, partner facilities, and other resources that will be involved in response to an emergency. A number of emergencies have been added to the list of what must be contemplated by the emergency plan, including:

- gas leaks;
- natural disasters and extreme weather events;
- boil water advisory;
- floods; and
- outbreaks of a communicable disease (including epidemics and pandemics).

In relation to outbreaks of communicable diseases, epidemics or pandemics, the emergency plan must also set out an area used for isolation, a process to divide the

home into cohorts, staff policies with respect to exposures as well as establishing an Outbreak Management Team. The home must also ensure that the local medical officer of health or their designate is invited to participate in developing, updating, testing, evaluating, and reviewing any emergency plan related to a matter of public health significance.

The regulations also add a number of details on what an emergency plan must cover, for example, with respect to communications with residents, substituted decision-makers, and staff, and in evacuation situations.

Licensees must provide an attestation to the ministry attesting to the compliance of their emergency plan. The first attestation must be provided three months after the regulations come into force and annually thereafter.

Visitor policy

Licensees are now required to establish and implement a written visitor policy that respects the Resident Bill of Rights and ensures that "essential visitors" continue to have access to long-term care homes even during an outbreak. The policy must include the process for visitor access during both non-outbreak and outbreak situations and must outline a process for documenting the designation of caregivers, who are covered under the definition of "essential visitors."

Licensees will be required to maintain visitor logs for a minimum of 30 days, which must include the name and contact information of the visitor, time and date of the visit, and the name of the resident visited.

Continuous quality improvement

The regulations provide the necessary details for the continuous quality improvement initiatives that are required under section 42 of the Act. Licensees are required to establish a continuous quality improvement committee (the QIC) composed of **at least** the following:

1. The home's administrator;
2. The home's director of nursing and personal care;
3. The home's medical director;
4. Every designated lead of the home;
5. The home's registered dietitian;
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the provider;
7. At least one employee who is a member of the regular nursing staff;
8. At least one employee who has been hired as a personal support worker;
9. One member of the home's Residents' Council; and
10. One member of the home's Family Council, if any.

The QIC will be responsible for monitoring quality issues, identifying and recommending priority areas for quality improvement and to support the implementation of the continuous quality improvement initiative.

Licensees are responsible for preparing a report on the continuous quality improvement initiative for the home for each fiscal year, but no later than three months after the end of the fiscal year outlining:

1. the identity of the designated lead;
2. a description of the priority areas for quality improvements in the next fiscal year and the process used to identify said priority areas;
3. a written description of a process to monitor and measure progress, and communicate outcomes for the home's priority areas in the next fiscal year;
4. a record of the resident and family/caregiver experience survey required under section 43 of the Act; and
5. a record of actions taken to improve the home based on the results of the previous year's survey along with the role of the Residents' Council, Family Council, and the committee's involvement in these improvements, and finally, how and when these improvement actions were communicated to residents, families, Residents' Council, Family Council, and the staff of the home.

The first report shall cover the fiscal year ending March 31, 2023, however, licensees are required to prepare an interim report for the 2022-2023 fiscal year setting out the identity of the designated lead, and provide a written description of the home's priority areas for quality improvement, the process used to identify priority areas, and the process used to monitor and measure progress for the home's priority areas for quality improvement. The licensee is responsible for providing a copy of these reports to the Residents' Council and Family Council, if any, and unless the home is in a location in the province that does not have consistent and reliable internet service, must publish a copy of each report on its website.

Air conditioning

Licensees are required to ensure that all resident bedrooms are served by air conditioning before June 22, 2022. Alternatively, if a long-term care home became licenced between April 2022 and January 1, 2023, the licensee has six months from the date of their licence to comply with this requirement.

Exceptions to this requirement may be given if the director is satisfied that:

a. the building cannot be reasonably modified to support air conditioning;
b. the licensee has attempted to enter into an agreement to procure the equipment and materials to provide air conditioning, but such agreement was not able to be reached; or
c. such agreement was delayed for reasons beyond the reasonable control of the licensee. For rooms not served by air conditioning, the temperature must be measured and documented in writing once a day between 12 p.m. and 5 p.m.

Palliative care philosophy

The regulations require the integration of a palliative care philosophy, which must be based on an interdisciplinary assessment of the resident's palliative care needs, considering the resident's physical, emotional, psychological, social, cultural, and spiritual needs. The licensee is responsible for ensuring that the resident has consented before taking any actions, or providing any form of palliative care.

Licensees must ensure that the resident, resident's substitute decision-maker, or any other person or persons designated by the resident, are given an explanation of the palliative care options that are available based on the assessment of the resident's palliative care needs, which may include, but are not limited to, early palliative care and end-of-life care. Licensees are not required to comply with the provisions surrounding palliative care and palliative care philosophies until October 2022.

Infection prevention and control

The regulations contain a new section expanding upon a licensee's infection prevention and control (IPAC) program.

Licensees are required to implement the surveillance protocols issued by the director for particular communicable diseases, as well as any standard or protocol issued by the director with respect to IPAC. In addition, the licensee is responsible for ensuring that there is an interdisciplinary team approach to implement the IPAC program, which includes an infection prevention and control lead, the medical director, director of nursing and personal care, and the administrator. This IPAC control team is required to invite the local medical officer of health to all meetings, which will be held quarterly or more frequently during an infectious disease outbreak.

Three years after the regulation came into effect, the licensee will be responsible for ensuring that the designated IPAC control lead is someone who has education and experience in infection prevention and control practices, such as infectious diseases, reporting protocols, outbreak management, epidemiology, program management, and a current certification in infection control from the Certification Board of Infection Control and Epidemiology. In addition, the regulation sets designated hours of on-site work for the IPAC control lead depending on the size of the home, ranging from 17.5 hours per week in a home with 69 beds or fewer, to 35 hours per week in a home with 200 beds or more. The licensee will ultimately be responsible for considering the vulnerability and complexity of their respective resident population to determine if the IPAC control lead is required to work more than these minimum hours.

The licensee is required to ensure that on every shift, the symptoms indicating the presence of infection in residents is monitored in accordance with the standards or protocols issued by the director, that the symptoms are recorded, and that immediate action is taken to reduce transmission. In terms of residents, the licensee will be required to ensure that each resident is screened for infectious diseases and are offered timely immunization against certain diseases. Staff must also be screened for infectious diseases and there must be a staff immunization program in place that is in accordance with the director's standards. Finally, any pets living in the home or visiting the home must have up-to-date immunizations.

Calculating direct care targets

The new regulation defines the calculation method for direct care targets as part of the commitment of an average of four hours of care, per resident, per day. The calculation period for the targets will begin on April 1 and run to March 31 the following year.

Medical directors

The regulations clarify the roles and responsibilities of medical directors in an attempt to improve oversight of the home. Specifically, licensees will now have to enter into a written agreement with the medical director that provides the term of the agreement, responsibilities of the licensee, the responsibilities or duties of the medical director, the minimum number of on-site hours required, and that the medical director will complete the Ontario Long Term Care Clinicians' Medical Director course within 12 months after becoming the medical director, or if the medical director is already in this position, then within 12 months after the regulation came into force.

Where the medical director is already working in this position, licensees will be required to ensure their agreement includes language surrounding the additional training requirements and the minimum number of hours six months after the regulations come into force.

Staffing

Licensees must now require prospective staff and volunteers to provide a signed declaration in writing that discloses all charges, offences, convictions and orders made under the Act, the *Nursing Homes Act,* the *Charitable Institutions Act,* the *Homes for the Aged and Rest Homes Act,* the *Cannabis Act* (Canada), the *Controlled Drugs and Substances Act* (Canada), the *Food and Drugs Act* (Canada), any other provincial or federal offence involving improper treatment, abuse of, unlawful conduct, or the misuse of a vulnerable person's money. The declaration must also include every commencement of a proceeding, and every finding of guilt for an act of misconduct under the above-mentioned legislation. Ultimately, the declaration must disclose any charge, order, conviction or other outcome, commencement of a proceeding or a finding of guilt that the person has become aware of since this section came into force.

As well, the licensee shall require existing staff members and volunteers to provide a signed declaration within one month after the regulations come into force. If staff or volunteers started during a pandemic and did not submit a police record check, the licensee must ensure that such a police record check is provided within three months after the regulations come into force.

There are similar disclosure requirements for directors and management. The licensee is responsible to ensure a police record check is conducted before permitting any person to be a member of its board of directors, board of management or committee of management or any other governing structure within six months before the start date. For those who started in their roles during a pandemic without providing a police record check, the licensee shall ensure that one is provided within three months after starting in the role. Similarly, all directors or others in management positions must provide a signed declaration outlining any charges, orders, convictions, commencement of a proceeding or a finding of guilt within one month after the regulation comes into force.

As part of the licensees orientation procedures, licensees are required to ensure that staff are trained in infection prevention and control focused on hand hygiene, infection transmission, signs and symptoms of infectious diseases, respiratory etiquette, what to do if experiencing symptoms of an infectious disease, cleaning and disinfection practices, use of personal protective equipment and the handling of biological and clinical waste. The regulations outline the timing by which such training must be completed.

Penalties

The regulations have increased the amount that can be assessed as administrative penalties for non-compliance, which now range from $1,100 to $11,000 on a first offence. This amount doubles for a second failure, triple for a third failure, quadruple for the fourth failure and will be five times the base amount for each subsequent failure thereafter.

Takeaways

While heavily relying on its predecessor, the new regulations under the *Fixing Long-Term Care Act, 2021* stepped up regulatory requirements over a number of areas relating to a long-term care home's operations. The regulations were issued on the eve of the provincial election, so more regulatory reforms may well be forthcoming given the results of the election.

The aforementioned regulatory changes will have significant regulatory and financial implications for licensees. When the regulations were first proposed back in January 2022, the ministry published a note estimating average annual direct compliance costs for all long-term care homes in Ontario as between $20 million to $23.8 million, or approximately $38,000 on average for each long-term care home per year. The cost of non-compliance has also increased, with increased administrative penalties.

BLG's Senior Living & Housing group will continue to monitor the progress of the Act, and any further regulatory changes. If you have any questions or inquiries as to how the expert team at BLG can support your organization through this time of change, please reach out to your BLG lawyer, or any of the key contacts listed below.

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