Standing Committee on the Legislative Assembly
c/o Valerie Quioc Lim, Clerk
99 Wellesley Street West
Room 1405, Whitney Block
Queen's Park
Toronto, ON M7A 1A2

[sent via email]

November 25, 2021

**Re: OAA Submission on Bill 37**

Dear Chair and members of the Standing Committee,

The Ontario Association of Architects (OAA) commends government for introducing comprehensive legislation on long-term care, and welcomes the opportunity to comment on Bill 37, *Fixing Long-Term Care Act, 2021*. This legislation touches on important aspects related to fixing long-term care in the province; however, it fails to address the design of long-term care homes as a key part of addressing the problem. While a commitment to maintaining the building in a safe condition is included, this also needs to be present in a more consistent manner throughout the legislation.

As the OAA and its membership watched the tragedy of long-term care in Ontario unfold throughout the COVID-19 pandemic, we have all taken the opportunity to begin exploring the design interventions that can help mitigate the effects of this crisis and prevent it from ever happening again.

As the regulator for the profession responsible for the design of built environments where Ontarians live, work, and play, and entrusted to serve and protect the public interest, the OAA is keen to continue working alongside government to fix long-term care in our province.

The Association has taken the opportunity to review the proposed Bill 37, and the following is a series of recommendations based on this legislative review:

**Continuous Quality Improvement:**

The OAA is encouraged to learn that "continuous quality improvement" is contemplated in the proposed legislation. While a focus on patient satisfaction and outcomes is a significant measure of quality improvement, the opportunity to explore innovative and evidence-based design of long-term care homes should also be integrated into government's approach to "continuous quality improvement".

Section 44 of the proposed legislation states that, "The Minister may establish a Long-Term Care Quality Centre" that will support mission-focused organizations and advance and share research on innovative and evidence informed person-centred models of care. **The OAA recommends that the advancement and**

**sharing of research on innovative and evidence informed design of long-term care homes be included as an additional function of the Long-Term Care Quality Centre.**

This recommendation is one that the OAA has heard loud and clear from members who design long-term care. In April 2021, the OAA hosted a member roundtable about the design of long-term care homes attended by 15 members with a combined 300 years' experience designing long-term care in Ontario. There was a resounding call for government support of design innovation. Moreover, the OAA has invested in this cause by supporting a research study with the University of Toronto and Jacobs Consultancy Canada Inc. This study explores design best practices that maximize infection control and patient quality of life outcomes. The final recommendations from this study will be submitted to government and can inform innovative and evidence-based approaches to the design of new long-term care homes in the province, as well as renovations to existing homes.

The addition of long-term care beds in the province is not enough; these beds must be better suited to infection control and patient quality of life outcomes. By supporting research on innovative and evidence informed design of long-term care homes, government can uniquely position itself to deliver the highest return on its investment to the betterment of everyone in Ontario.

**Licensing:**

Government has positioned Bill 37 as a tool to enhance transparency and improve enforcement. To be effective at doing this, measures need to be put in place that require licensees to bring their facilities up to the current Design Manual standards, and to update them as these standards are updated. As noted in the Auditor General's report on long-term care that was published in April 2021, over 40% of long-term care homes in Ontario are not currently compliant with 1999 design standards and many residents continue to share rooms with three additional people.

One major contributing factor to the 3800 deaths that have occurred in Ontario long-term care homes is the widespread reality of double- and multi-occupant bedrooms throughout the province. These bedroom configurations make physical distancing very difficult and increase the risk of infection spread. At the time of publication of the Auditor General's report, neither the Ministry nor the LHINs had record of how many residents were living in rooms designed to accommodate four beds (C and D classified rooms). However, it is known that in for-profit homes where more than half of the residents contracted COVID-19, bedroom configurations were primarily (more than 70%) multi-occupant suites.

In order to be eligible for licensure, the **OAA recommends that government require licensees to demonstrate how their homes are designed to meet the current design guidelines, including the accommodation single occupancy bedrooms.** In the case of existing homes, inspectors should be required to enforce this single occupancy requirement within a shorter, defined period.

**Ontario Building Code:**

Upon review of the proposed legislation, it is notable that there is no mention of updates to the Ontario Building Code as it pertains to long-term care (and other congregate living environments). The following recommendations for Code changes are straightforward and could have a significant impact on quality improvement in long-term care.

The first recommended change is to section 3.7.1.3. Sleeping Areas in Group B and Child Care Facilities, which currently states that:

> (2) Sleeping rooms for residents in long-term care homes shall have, exclusive of space provided for washrooms and for built-in or portable clothes closets, a floor space not less than,
>
> (a) 10.22 $m^2$ in a single-bed unit,
>
> (b) 16.72 $m^2$ in a two-bed unit,
>
> (c) 25.08 $m^2$ in a three-bed unit, and
>
> (d) 29.73 $m^2$ in a four-bed unit.

**The OAA recommends that this section should be amended to remove consideration of three- and four-bed units and should include the requirement for a vestibule between the sleeping room and any corridor.** The vestibule could support hand hygiene through the inclusion of a washbasin, and could function as storage space for personal protective equipment and linens. This amended section should read as follows:

> 3.7.1.3. Sleeping Areas in Group B and Child Care Facilities
>
> (2) Sleeping rooms for residents in long-term care homes shall have, exclusive of space provided for washrooms and for built-in or portable clothes closets, a floor space not less than,
>
> (a) 10.22 $m^2$ in a single-bed unit, and
>
> (b) 16.72 $m^2$ in a two-bed unit shared by consenting residents.
>
> **(3) [new inserted article] Sleeping rooms for residents in long-term care homes shall have a vestibule, not less than 8 m2 in area, between the sleeping room and any corridor.**

The second recommended change is to section 3.7.4.4. Plumbing Fixtures for Care, Care and Treatment or Detention Occupancies, which currently states that:

> (2) In a Group B, Division 2 or 3 *occupancy*, washrooms shall be provided so that each washroom,
>
> (a) serves not more than four patients or residents,
>
> (b) is accessible from patients' or residents' sleeping rooms,
>
> (c) contains one water closet, and
>
> (d) contains one lavatory.

**The OAA recommends that this section is amended to include single occupancy bathrooms in long-term care and to require a shower in each**

**of these single occupancy bathrooms.** The amended section should read as follows:

3.7.4.4. Plumbing Fixtures for Care, Care and Treatment or Detention Occupancies
(2) In a Group B, Division 2 or 3 *occupancy*, washrooms shall be provided so that each washroom,
(a) serves not more than:
i. four patients, or
**ii. one resident in long-term care, or**
**iii. two consenting residents in long-term care;** and
(b) is accessible from patients' or residents' sleeping rooms,
(c) contains one water closet,
(d) contains one lavatory, and
**(e) in the case of a long-term care facility includes one shower.**

These simple Code changes can lead to significant quality improvements for long-term care residents and the time to implement them is now. Ontarians living in long-term care have been through enough tragedy in the last two years and these changes can help to mitigate further tragedy from unfolding.

**Long-term Care Design Manual:**

The OAA is keenly aware of the importance of the Long-term Care Design Manual's role in regulating the design of these homes; however, this manual appears to be updated at irregular intervals (the last update was 2015, and prior to that was 1999). **In order to strengthen Bill 37 and to improve long-term care for all Ontarians, the OAA recommends that the legislation mandate:**

- **Regular intervals for updates to the Design Manual;**
- **Shortened, defined timeframes for existing long-term care homes to come up the current standard; and,**
- **The inclusion of Design Manual compliance inspections along with the other quality improvement inspections that the legislation currently proposes.**

**"Safe Condition and in Good State of Repair":**

Inspections to ensure compliance with the current Design Manual, the Ontario Building Code, and provisions within this Act or related regulations, are of particular importance. In the Auditor General's report, it was noted that licenses for approximately 26,500 beds are set to expire in 2025, but it is not clear how many of these meet 2015 (or even 1999) Design Manual standards. Similar to condominium reserve fund inspections which are mandated by the Condominium Authority of Ontario to occur within the first year of the condominium incorporation and every three years following that, the **OAA recommends that similar inspections are done within the first year of licensing and every three years following that. Furthermore, inspection reports should be made publicly available to enhance transparency about long-term care quality.**

Further amendments to the legislation should be considered. While this legislation begins to address recommendations in the COVID-19 Commission Final Report to prescribe the staffing mix under the Act, the maintenance and upkeep of the

facility remains largely undefined putting residents at potential risk. S19(2)(c) does clarify that every licensee is responsible to ensure that the home is “maintained in a safe condition and in a good state of repair” but how this gets operationalized within homes should be better defined.

*Good state of repair* should be further assigned as a responsibility to one of the designated staff in s76, most likely to the Administrator unless legislators determine that a new person should be defined within this section. Training (s82) should require that staff be trained on how to report building-related deficiencies to this designated individual. S84 and 85 should be amended to make it clear to residents or substitute decision-makers how they communicate building-related complaints. This amendment could occur in s84(2)(e) or be added as a standalone subsection.

The OAA hopes that inspections (s144 onwards) explicitly cover the home being “maintained in a safe condition and in a good state of repair” but advises government to make this explicit if not adequately reflected in existing or envisioned inspection processes and/or roles and responsibilities.

The OAA believes that s159 (suspension or revocation) would cover failing to maintain the home in a safe condition and good state of repair, but posits that government may want to explicitly add this failure under subsection (2) as a clearly articulated reason why a license may be suspended.

The OAA believes that s184(2) would allow for the Minister to issue operational or policy directives on homes being “maintained in a safe condition and in a good state of repair” but posits government may want to amend s184(2)(a) to read “the proper management, operation **and maintenance** of long-term care homes in general.”

These clauses will help to operationalize s19(2)(c) and to ensure that homes remain in the “safe condition and in a good state of repair” that residents deserve and that the legislation intends. In this spirit, the OAA hopes that once the legislation is passed, the Lieutenant Governor in Council will also take full advantage of S193(2)(17). The OAA welcomes the opportunity to collaborate on establishing those regulations.

It is important to note that earlier in the year, the OAA tabled 27 recommendations to the Minister of Long-Term Care. While many of these recommendations may reside more at a policy level, we do still encourage members of the Standing Committee to consult both this deputation and our earlier submission and to determine if any recommendations could be reconciled within the existing legislation; for instance, requiring long-term care homes to be integrated within existing communities as the default.

On behalf of the OAA, I thank you for the opportunity to share the architecture profession’s recommendations and encourage you to reach out to me further should you wish to discuss clarifications, legislative changes, or how we can work with government to help ensure Ontario’s long-term-care homes can better serve the public.

Sincerely,

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President

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The Honourable Rod Phillips
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July 8, 2021

Sent via email: rod.phillips@pc.ola.org

**Re: Long-Term Care Submission**

In March 2020, we collectively began to witness the unimaginable: a hundred-year pandemic sweeping across the globe, infecting thousands across Canada, but particularly vulnerable residents and loved ones in long-term care (LTC) homes.

Deeply moved by the unfolding tragedy, the architectural profession began to explore what it could do to help mitigate the effects of the crisis. As the regulator of a profession responsible for the design of Ontario's built environment, and entrusted to serve and protect the public interest, the OAA is keen to play an important role in assisting the Government as it moves forward with this critical task.

In *Ontario's Long-Term Care COVID-19 Commission: Final Report*, the province's Long-Term Care COVID-19 Commission (the Commission) reminds us that, "Ontario's legislative promise to long-term care residents is to provide residences that are 'safe, comfortable, home-like environment[s]' that support 'A high quality of life'." The Ontario ***Residents' Bill of Rights*** requires a safe environment for every resident. Ontario has not met this challenge, and we must collectively strive to do better.

**The OAA submits the following 27 recommendations for consideration, and looks forward to discussing them further as we work together to solve this urgent crisis.** These recommendations are covered in the pages that follow, categorized by broader subject, and can be seen collectively in Appendix B.

**FUNDING**

In April 2021, the OAA hosted a virtual roundtable event that brought together those in the architecture profession with experience in designing long-term care homes. The participants agreed that good policy and adequate funding are required to create a successful space. In the most recent iteration of the *Long-Term Care Home Design Manual* (2015), attempts were made to shift thinking away from institutional settings toward the creation of home-like environments. However, despite many revisions, this desired outcome is often contradicted by the document and the way it is applied. Participants agreed a shift in the guidelines is necessary to focus more on performance and less on prescriptive rules.

At the roundtable, participants discussed the importance of funding to support innovations in design and care to improve the quality of LTC homes across Ontario. They noted that their clients are keen to innovate, but lack the financial



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ability to do so. Trying to secure funding for any measure that goes beyond the guideline is difficult. It is further complicated by the unprecedented realities brought on because of the COVID-19 pandemic, such as the quadrupling of construction material costs (namely lumber and steel) that have resulted from supply shortages. Architects are eager to innovate but, in the absence of appropriate funding, very little innovation is possible.

**Recommendation #1**: Increase capital funding for long-term care homes by indexing the Capital Funding Model to annual construction cost data.

**PROCUREMENT**

In their final report, the Commission cites "credible estimates" indicating the province will require "an additional 96,000 to 115,000 long-term care beds by 2041." As this is a dauntingly high number, the natural response may be to do whatever it takes to get as many shovels in the ground as quickly as possible. However, this approach poses great risk—at best, from failing to realize the full potential of LTC homes Ontarians deserve and, at worst, from repeating the mistakes of the past.

We should not stop construction underway, but we must recalibrate in real time how we procure, design, construct, and maintain long-term care homes. Extraordinary costs may drive procurement officials and legislators to the lowest bid, but the focus is, and has always been, on best value. We must use our investment wisely to get the best and most innovative long-term care homes to protect and enrich the lives of our residents.

The Commission recommends separating the delivery of services from the construction of long-term care homes. It is questionable whether a profit incentive will actually decrease the costs of construction, particularly when considered over the lifecycle of the building. Short-term decisions geared toward the handover may result in significant post-occupancy costs in terms of both operations and maintenance.

It is understandable for investors and developers to focus only on the part of the equation that concerns them. However, a sustainable, long-term approach will be paramount in warding off the problems that are almost otherwise guaranteed to manifest.

More broadly, on the subject of private versus public procurement, the OAA has members with opinions across the spectrum. Some diametrically oppose P3s, while others support the model. Throughout these concerns, it has become apparent that P3 procurement can contribute toward a solution, or actively work against one. The procurement model must be carefully considered before it is employed. Simply put, a P3 is not the only way to design and construct these facilities—this delivery method simply forms a part of the solution at best.

While procurement may seem innocuous, it has reared its head in subtle but unmistakably significant ways throughout the course of the crisis. Indeed, the Commission flags that while 90% of the existing stockpile of personal protective equipment was destroyed, "successive governments spent three years deliberating procurement policy options" instead of replenishing the stockpile. We must focus some of our attention on getting our procurement processes right.



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| **Recommendation #2**: Focus on the long-term cost, not the lowest cost. |
| **Recommendation #3**: Find the right mix between traditional and P3 procurement. |

**INVESTING IN DESIGN**

Regardless of whether these facilities are procured through a public or private model, the selection process—particularly for architecture and engineering services—must change. For well over a decade, the industry collectively has advocated for a change from lowest bid procurement to qualifications-based selection (QBS).

While this may sound self-serving, there is an irrefutable body of evidence that shows lowest-bid value cannot be effectively used in the procurement of consulting services. Repeatedly, governments at the municipal, provincial, and federal levels have used low-bid procurement to disastrous effect. Setting aside the detrimental effects to taxpayers and the institutions themselves, lives have even been tragically lost in the process. These realizations have been accepted long-ago by our counterparts in other jurisdictions.

Qualifications-based selection has been federally required for the procurement of architectural and engineering services in the United States since 1972 (via the passage of the *Brooks Act*). "Mini *Brooks Acts"* have been passed by almost every state legislature, and further mirrored down within many municipalities. While Ontario may have pride in our procurement process and like to view ourselves as leaders, that pride is largely misplaced. In this particular regard, we are more than a half-century behind our closest neighbour.

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| **Recommendation #4:** Adopt QBS as the procurement method for architecture and engineering services. |

**STRIKING THE RIGHT BALANCE**

Symptomatic or asymptomatic spread. Existing threats and future unknowns. Architects must plan for these challenges, incorporating necessary separation, barriers, and safety measures while delivering meaningful homes for our citizens. At the OAA's roundtable, architects spoke at length about this balance. We must not move too far toward a hospital or institutional setting, or else we break out legislative (and moral) commitment to provide meaningful living spaces. However, we must design spaces that can reduce or even eliminate threats from outbreaks, something the Commission notes are "common in long-term care homes."

All the while, we must also change our very way of thinking, recognizing that the needs of long-term care residents have significantly changed, and likely will continue to change. As the Commission notes, "[w]hen compared to long-term care residents a decade ago, today's residents experience higher percentages of cognitive impairment, physical disability, medical instability and incontinence."

The architecture profession requires a supportive government to be able to move us all out of that paradox of providing adequate medical care and infectious



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disease control while maintaining a home-like environment, and recognizing significantly higher and evolving resident needs. Architects need every possible tool at their discretion given the Herculean task before them.

**Recommendation #5:** Provincial policy and funding must empower architects to design spaces that rise to the challenge of infection control and increasingly complex medical needs, while maintaining a home-like environment.

**INNOVATION**

The Commission celebrates "innovative programs to strengthen quality of life and care in long-term care homes," including "better home design to meet the evolving needs and acuity of long-term care residents." While we have many exemplary architecture practices who have delivered exemplary designs, we must provide broader guidance and leadership to the industry.

The OAA is supporting a research study with the University of Toronto that will conduct a literature review and perform post-occupancy assessments on well-regarded homes in Ontario to identify best practices that maximize infection control, occupant satisfaction, and well-being. While we will not know the findings until the study is completed, we would encourage the government to review these recommendations once available and to work with our industry to set improved standards across the board for all long-term care homes.

**Recommendation #6:** Review findings and work with OAA to integrate best practices into the next iteration of the *Long-Term Care Home Design Manual*.

**FOSTERING A NEW SELF-REGULATED PROFESSION**

As a regulator entrusted to serve and protect the public interest, the OAA noted the Commission's recommendation on making personal support workers (PSWs) a regulated profession. The OAA would support government in this mandate, particularly the recommendation to bridge a new group of regulated professionals under the umbrella of an already-established regulator. This model would appear to parallel the one we have proposed for other professionals in the consulting industry.

**Recommendation #7**: Consider making PSWs a regulated profession under the umbrella of an already-established regulator.

**NEW DESIGN STANDARDS**

The Commission flags concerns around the physical design of older long-term care homes—in particular, three- and four-bedrooms. The OAA expressly shares these concerns, and we are in agreement with our experts that single occupancy rooms are a requirement both from a best practice, Infection Prevention and Control Canada (IPAC) standpoint, human dignity, and from a user preference



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standpoint. Some studies indicate residents prefer their own room by a margin of 20 to 1.

However, things are not quite so simple. As our roundtable participants point out, even if single-occupancy rooms should be the requirement, there must be flexible spaces allowing for deviations from the prevailing standard. Examples include space for specialized medical equipment or the need to accommodate elderly couples entering (or wishing to enter) a facility together. It is inhumane to separate a couple, family member, or possibly even a friend because a policy is too prescriptive and inflexible.

This flexibility could most likely be accomplished by specifying a proportion of couples suites or larger rooms, which could accommodate these and other needs as they arise. (A recent report prepared for the Alberta Department of Health recommended eight couple suites per 100 units) This approach would be consistent with Ontario's *Residents' Bill of Rights* which specifies "[e]very resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available."

On a similar note, in its report, the Commission identifies the 2015 requirement for a washroom in all resident bedrooms. The OAA is not aware of any discussions to change or lessen these requirements, but recommends the single-occupancy washroom requirement be upheld not only in new facilities, but also in the retrofit of older ones. The Commission detailed stories of residents who were denied the right to a shower due, in part, to risks around contagion. The only way to resolve this would be to also require a shower in each of these washrooms.

Throughout the Commission's findings, as well as other various studies, cohorting and isolating were critical to reducing the spread of COVID-19. The OAA's own roundtable echoes these findings, recommending smaller cohorts, improved funding models, and policies supporting small-scale "household" models. Various other targeted design recommendations were also shared, including:

- Increasing dining and lounge space to allow for great social distancing or subdividing space when heightened transmission risks exist;
- Increasing staff space to reduce the risk of transmission between staff members;
- Incorporating a personal protective equipment (PPE) station at the entrance to each room; and
- Creating a unified standard for ventilation of all long-term care homes, incorporating best practices from hospital ventilation.

The importance of clean air is becoming increasingly clear and its relevance is being explored in the context of shared spaces and other congregate living environments. Recent reports from the U.S. Centers for Disease Control (CDC) found that COVID-19 incidence was 39% lower in schools that improved ventilation.

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| **Recommendation #8**: With the exception of a set proportion for couples suites or larger rooms that allow for flexibility, require all long-term care homes to have single-occupancy rooms with individual washrooms containing a shower. |
| **Recommendation #9**: Update and rapidly deploy a new *Long-Term Care Home Design Manual*. |



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| **Recommendation #10:** Update the Ontario Building Code and *Long-Term Care Home Design Manual* to explicitly recognize and address infection control in design, incorporating relevant CSA standards. |
| **Recommendation #11**: Consider developing a national standard on long-term care design to reduce regional variation and bring together national best practices. |
| **Recommendation #12:** Reflect the current literature on airborne (specifically aerosol) transmission of COVID-19 in the design and retrofit of long-term care homes. |
| **Recommendation #13**: Improve ventilation in long-term care to provide clean air, particularly in older facilities. |

**ZONING AND DELAYED PLANNING APPROVALS**

The Commission estimates a cost of $19.8 billion to build enough beds "to replace the expiring licences and to accommodate the current waitlist at the estimated cost of $350,000 per bed." Costs to meet the longer-term demand is significantly higher, at a projected price of $33.6 billion. Innovative architectural solutions can help to deliver those necessary investments. The Commission also identified another critical factor, which they subtitle as "Delayed and Prolonged Licensing Approval Process."

At multiple points, the Commission flags that alongside Ministry approvals, "zoning issues at the provincial and municipal level…are blocking redevelopment." Indeed, the OAA has seen the recent employment of Minister's Zoning Orders (MZOs) for long-term care homes, but these represent site-specific and one-off solutions to a broader problem. Slow and ineffective approval processes are causing perplexing delays not only to long-term care facilities, but also to all development across the province. The OAA has advocated for significant reforms to site plan approval and the planning approval process in general, for nearly a decade, with cautions dating back 15 years.

The province should focus some of its attention on significant reforms to the *Planning Act* to expedite planning approvals. The Commission stresses that "a new model of building homes [is an] urgent necessity," and the OAA agrees with this assessment. Expediting planning approvals for long-term care homes would be laudable. Expediting planning approvals for Ontario would be even more beneficial as it would expedite and lower costs not only for the development and redevelopment of long-term care beds, but also other critical infrastructure including hospitals and affordable housing.

In 2018, the OAA commissioned Altus Group to study the impacts of site plan delay. The resulting report found the total costs of delay each year to stakeholders could amount to as much as $900 million per year in Ontario—a number believed to be a conservative estimate. Institutional building permits account for over 10% of that total, with estimated delays costing nearly $100 million per year. This estimate is not solely for long-term care, but rather for all institutional building permits subjected to site plan approval—however, a rising tide lifts all boats.

At the OAA's roundtable, it was recommended that development charge waivers be enacted, and that long-term care homes become eligible to be built on



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employment lands given that these facilities generate more job opportunities than many other uses that are currently permissible.

**Recommendation #14**: The Province should focus significant attention on planning approval reforms, including greater use of as-of-right zoning and expediting the site plan control process.

**Recommendation #15**: While these reforms could be targeted toward long-term care, the Province should recognize that urgent reforms are required for *all* institutional projects and for building in Ontario more broadly.

**PERSONAL PROTECTIVE EQUIPMENT**

Through the course of the pandemic, the OAA remained silent on the issue of PPE as the profession recognized the urgent need for the medical community and did not want to compound dangerous shortages. The OAA is glad to have taken this position in support of the medical staff and those needing medical or long-term care. Within the profession, there were also many architectural firms supporting the medical community by providing supplies, including 3D printed equipment.

The security of PPE would help the profession to operate more safely in the future. The Commission reported that inspectors stopped on-site inspections in long-term care homes at the start of the pandemic. The OAA witnessed similar measures as municipal building departments suspended on-site building inspections for a number of reasons, including COVID-19 transmission risks, procedural disruptions, and staffing shortages. In some of these instances, municipal building departments attempted to deputize architects to carry out their responsibilities.

Not every architect needed access to a ready supply of PPE, but it is important to recognize some architects were involved in the design and construction of critical health infrastructure (including temporary structures to increase COVID-19 response capacity). It would be prudent to factor in the architectural profession when determining the level of stockpile and provisions required to face future pandemics or crises.

**Recommendation #16**: Include architects in the PPE count to ensure the profession can safely continue its work—particularly on long-term care and medical infrastructure—during a future pandemic.

**MAINTAINING ACCESS TO RESIDENTS**

The Commission speaks extensively about the impacts of visitor restrictions on long-term care residents and on the functioning of these homes in general. Indeed, the provincial *Residents' Bill of Rights* requires that residents can "receive visitors of his or her choice…without interference" and, in particular, "[e]very resident who is dying or who is very ill has the right to have family and friends present 24 hours per day."

The OAA defers to public health and IPAC experts regarding how residents could more safely have maintained access to their loved ones. However, the ability for



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families and caregivers to maintain access to residents is important, and safe solutions could have been factored into the design (and design standards) for long-term care homes. The OAA would have to further explore ways to create transitory spaces that could safely maintain this access to loved ones.

**Recommendation #17**: Consider how transitory spaces can provide continued access to residents during outbreaks and code this into the *Long-Term Care Home Design Manual* if/where appropriate.

**BUILDINGS REFLECTED IN PANDEMIC PLANS**

Not surprisingly, the Commission continuously stresses the need to be prepared, specifically to have a pre-existing pandemic plan. This is a clear necessity and one the OAA obviously supports. However, the OAA has some concern the Commission may not have incorporated building-specific considerations in these plans. While the Commission applauded homes that "[re]purposed space in the home to create isolation rooms in the event of an outbreak, or used facilities outside the home to isolate sick residents," there is more to be done here.

The OAA believes building layout and configuration should be considered and clearly articulated in these plans so staff know how to conduct themselves not only in their interactions with patients, but also when assisting residents within the physical space. There should be clear plans articulating to staff how elements or uses of the building need to be reconfigured, repurposed, or augmented (for example, through changes to ventilation). Failure to adequately account for the building itself may continue to expose residents to future risk.

During discussions around the Ontario Health Plan for an Influenza Pandemic (OHPIP), the Commission notes OHPIP included "limited discussion of several items that could have helped the province better respond to a novel threat" including embracing the use of virtual care, and adopting modern communication tools such as videoconferencing. These two elements are excerpted in particular as their implementation may be tied to the design of a facility.

The OAA encourages the consideration of any requirements that create or require a design intervention, such as the better integration of current telecommunications technology, and that these requirements be communicated to the design team, and factored into the facility design, early on. It is critical to identify these requirements early in this period of renewed building and rebuilding of long-term care homes, as it can be far more difficult and costly to add this infrastructure after the fact.

The OAA also noted the Commission's recommendation for more infectious disease control simulations. While these simulations are understandably geared towards front-line workers, the Ministry should consider whether it may be advantageous for architects to be involved as observers in case there are design-related barriers that need to identified and changed.

While much of the discussion surrounds building and retrofitting long-term care homes, the Commission also stressed the importance of identifying alternative quarantine and isolation sites in the emergency planning. Architectural expertise would likely be useful in helping to identify and assess the appropriateness of different sites, and we would encourage the Ministry to engage the profession in this important work.



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| **Recommendation #18**: Use architectural knowledge and expertise in pandemic preparation planning. |
| **Recommendation #19**: Ensure that design is a required consideration for pandemic preparation planning. |
| **Recommendation #20**: Ensure any pandemic preparation plans that entail design changes are clearly communicated to the architectural profession. |

**INTEGRATED HOMES WITHIN EXISTING COMMUNITIES**

Participants at the OAA roundtable cautioned against building long-term care homes at the fringes (or beyond) of society—a practice that seems to have arisen from lower land costs and more friendly zoning and planning approvals. The integration of a home within a community—namely the resident's own community—is inherently tied to quality of life. As our roundtable participants put it, "the key to a satisfying life is feeling like you can make a meaningful contribution to it."

Participants discussed the benefits of locating homes near libraries, community centres, and social and medical supports. Proximity to schools and other very active sites was also viewed as being highly beneficial to residents. Indeed, the long-term care homes could actually be utilized as community hubs. Looking beyond the effects on residents, a disconnected facility can also have negative effects on staff and loved ones who benefit from transit accessibility, places to walk or visit around the home, etc. Socially disconnected sites should be used only as a last resort. To quote the Commission's excerpt from André Picard's recent book: "homes should be an integral part of the community, not hidden away."

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| **Recommendation #21**: Employ Minister's Zoning Orders for long-term care homes until broader changes can be made to expedite the planning approval process. |
| **Recommendation #22**: Review planning approvals to broaden the permissibility of long-term care homes in existing communities. |
| **Recommendation #23**: Require long-term care homes to be integrated within existing communities as the default. |
| **Recommendation #24**: Encourage long-term care homes to be co-located with complementary services and facilities. |

**LEVERAGING CREATIVITY AND INNOVATION**

The Commission's recommendations, building on the former Gillese Inquiry's recommendations, made it clear that leveraging the existing creativity and innovation is critically important to ensuring residents can live safely and with dignity. This is perhaps the best parting comment the OAA can make.



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Architects have no shortage of ideas how to improve these spaces. Some of these ideas have already been shared, some have yet to be shared, and others may still need to be further developed or explored. However, this is not a passive activity. To use a colloquial expression, the best time to start was yesterday but the next best time is now.

Architects must be actively engaged immediately so that we do not, as the Commission put it, make the same mistake again by, "building more of the same type of homes that currently dominate the sector." As previously mentioned, the OAA is collaborating with the University of Toronto and Jacobs to produce a literature review and best practices white paper as it relates to the design of long-term care homes. While this research is taking place, the OAA would be happy to partner with the government to help facilitate and promote direct discussions with practitioners in the field.

**Recommendation #25**: Create processes that enable the full creativity and innovation of the architectural profession.

**AGING-IN-PLACE**

Aging-in-place cannot be the entire solution to the long-term care crisis, and overuse could potentially exacerbate other social problems related to housing. However, aging-in-place remains a critical part of the broader solution, and our members deliver innovative solutions on a daily basis including accessibility retrofits to housing up to full reconfigurations of single-family homes to allow for co-living. The allowance of laneway and secondary suites in the City of Toronto is a prime example of creating improved opportunities for aging-in-place.

While the concept of co-living has been around for a long time, there has been a renewed interest in this arrangement, with significant media coverage ramping up over the last few years. The Commission briefly discussed a number of different models, all of which should be carefully studied given the correlation between smaller housing and reduced COVID-19 infection and mortality, the benefits for residents living within integrated communities, individual preferences, and the apparent cost savings for home care versus institutional care.

**Recommendation #26**: Expand the use of age-in-place, particularly co-living, to help deliver the required capacity in a cost-effective manner.

**MANDATORY CHANGES**

As exposed by this pandemic, many long-term-care homes have had decades to complete outstanding and necessary repairs but have failed to do so. It is no longer enough to believe that these facilities will naturally come to upgrade their facilities in the necessary timeline. Both the Commission and Auditor General's report argue the Ministry should reassess its licensing process to require home operators to renovate within a realistic, but shortened defined period to comply with current standards and when LTC home design standards change.



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**Recommendation #27**: Set a shorter, defined timeframe for changes, and tie deadlines to phasing out long-term care homes that fail to meet standards.

**CONCLUSION**

While this submission outlines 27 recommendations, we continue to learn more every day through ongoing discussions with practitioners and partners throughout the industry and academia. We suggest continued discussion and the creation of a working group tasked with quickly identifying and implementing solutions to do justice to the many Ontarians who were so tragically affected by this crisis.

**The OAA also recognizes that these recommendations focus on long-term care, but many of them are applicable to *all* congregate living environments.** The government should consider and adopt a broader suite of reforms that will reduce risks associated with COVID-19 and future pandemics for all congregate living settings including shelters, group homes, and correctional facilities.

Thank you for allowing me the opportunity to share the architecture profession's recommendations on behalf of the OAA. Please do not hesitate to contact me directly should you have questions, need clarification, or wish to discuss further how we can work with the government to help ensure Ontario's long-term-care homes, existing and future, can better serve the public.

Sincerely,

Susan Speigel, Architect

OAA, FRAIC

President

CC: The Honourable Steve Clark, Minister of Municipal Affairs and Housing

CC: The Honourable Christine Elliott, Minister of Health



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**Appendix A: Resources**


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## Appendix B: The 27 Recommendations

#1: Increase capital funding for long-term care homes by indexing the Capital Funding Model to annual construction cost data.

#2: Focus on the long-term cost, not the lowest cost.

#3: Find the right mix between traditional and P3 procurement.

#4: Adopt QBS as the procurement method for architecture and engineering services.

#5: Provincial policy and funding must empower architects to design spaces that rise to the challenge of infection control and increasingly complex medical needs, while maintaining a home-like environment.

#6: Review findings and work with OAA to integrate best practices into the next iteration of the *Long-Term Care Home Design Manual*.

#7: Consider making PSWs a regulated profession under the umbrella of an already-established regulator.

#8: With the exception of a set proportion for couples suites or larger rooms that allow for flexibility, require all long-term care homes to have single-occupancy rooms with individual washrooms containing a shower.

#9: Update and rapidly deploy a new Long-Term Care Home Design Manual.

#10: Update the Ontario Building Code and Long-Term Care Home Design Manual to explicitly recognize and address infection control in design, incorporating relevant CSA standards.

#11: Consider developing a national standard on long-term care design to reduce regional variation and bring together national best practices.

#12: Reflect the current literature on airborne (specifically aerosol) transmission of COVID-19 in the design and retrofit of long-term care homes.

#13: Improve ventilation in long-term care to provide clean air, particularly in older facilities.

#14: The Province should focus significant attention on planning approval reforms, including greater use of as-of-right zoning and expediting the site plan control process.

#15: While these reforms could be targeted toward long-term care, the Province should recognize that urgent reforms are required for all institutional projects and for building in Ontario more broadly.

#16: Include architects in the PPE count to ensure the profession can safely continue its work—particularly on long-term care and medical infrastructure—during a future pandemic.

#17: Consider how transitory spaces can provide continued access to residents during outbreaks and code this into the Long-Term Care Home Design Manual if/where appropriate.

#18: Use architectural knowledge and expertise in pandemic preparation planning.



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#19: Ensure that design is a required consideration for pandemic preparation planning.

#20: Ensure any pandemic preparation plans that entail design changes are clearly communicated to the architectural profession.

#21: Employ Minister's Zoning Orders for long-term care homes until broader changes can be made to expedite the planning approval process.

#22: Review planning approvals to broaden the permissibility of long-term care homes in existing communities.

#23: Require long-term care homes to be integrated within existing communities as the default.

#24: Encourage long-term care homes to be co-located with complementary services and facilities.

#25: Create processes that enable the full creativity and innovation of the architectural profession.

#26: Expand the use of age-in-place, particularly co-living, to help deliver the required capacity in a cost-effective manner.

#27: Set a shorter, defined timeframe for changes, and tie deadlines to phasing out long-term care homes that fail to meet standards.



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