



News Release

For Immediate Release

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Long-Term-Care Homes Don't Consistently Follow Residents' Plan of Care: Auditor General

(TORONTO) Plans of care define the level of care residents require for various aspects of their living activities, including eating. Not following these plans can pose significant and unnecessary risks to the people living in Ontario's long-term-care homes, Auditor General Bonnie Lysyk says in her *2019 Annual Report*, tabled today.

"The 77,000 people living in these homes are among the most vulnerable in Ontario," Lysyk said after the Report was tabled in the Legislative Assembly. "Many of them require assistance eating and drinking and rely on long-term-care home staff's help to maintain their health."

While the average age of residents in Ontario's long-term-care homes is 83 years (same as a decade ago), 64% of residents (compared to 56% a decade ago) have a form of dementia and require more assistance with eating and drinking.

The Report found that the Ministry of Long-Term Care (Ministry) and the long-term-care homes do not have sufficient procedures in place to confirm that residents are receiving sufficient mealtime assistance and that they receive food and nutrition services in accordance with their individual plan of care.

Ontario's 626 long-term-care homes provide 24/7 nursing care and support to residents whose needs cannot be met in retirement homes or supportive housing. Funding for the homes comes from the Ministry and from the residents themselves.

Other findings of the Report include:

- Between January 2017 and May 2019, the Ministry noted 56 homes that failed to follow a resident's plan of care related to food and nutrition, with 29% of these homes having repeated non-compliance issues in the same area.
- Menus at the homes offered sufficient protein and energy, but contained as much as 93% more sugar than recommended by regulatory requirements in current Dietary Reference Intakes, 59% more sodium, and 34% less fibre.
- The high sugar content of menus can contribute to heart disease, stroke, obesity, diabetes, high blood cholesterol and cancer. The 2019 Canada's Food Guide recommends water as the drink of choice, but juice was the most purchased item in three of the five homes where auditors obtained detailed food-purchase information.
- In three of the five long-term-care homes where auditors conducted detailed work, some food used to make meals was past its best-before date. Two of these homes served such food to residents, with one serving liquid whole eggs three months beyond the best-before date. Such food may still be safe but can lose some of its freshness, flavour and nutritional value.

- Auditors observed that residents typically wait longer during breakfast to receive their food, an average of 43 minutes, compared to 29 minutes during lunch and 24 minutes during dinner. Mealtime service is affected when personal support workers tend to other responsibilities or do not report to work.
- Dietitians do not spend sufficient time proactively monitoring residents; most time is spent completing clinical assessments or updating plans of care.
- Although incidents involving food and nutrition issues were low relative to the number of meals served (1.3 incidents per day), between January 2018 and May 2019, the homes reported over 660 such incidents, including 27 deaths from causes such as choking or aspiration.
- Ministry of Health statistics for 2018 found long-term-care-home residents made 1,121 food-related emergency-room visits that might have been avoided, including 454 visits due to dehydration.
- According to the Ministry of Health, long-term-care homes could prevent 20% of gastroenteritis infections simply by requiring residents to wash their hands. Of the five homes at which auditors conducted detailed work, only 19% of residents and 76% of staff were observed practising proper hand hygiene directly before or after a meal. Four of these homes had experienced gastroenteritis outbreaks between January 2018 and May 2019, and one of them experienced an outbreak in spring of 2019 that affected over 20 staff and more than 100 residents—five of whom died as a result. Auditors observed that the fifth home, which did not have an outbreak in that period, had the highest hand-washing rate, at 69%, compared with between 0% and 35% at the other four.

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Read the report at www.auditor.on.ca

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