Ministry of Long-Term Care

Long-Term Care Homes: Delivery of Resident-Centred Care

1.0 Summary

Long-term care homes provide accommodation, nursing and personal support services to adults who need 24-hour care, seven days a week (24/7). All long-term care homes are publicly funded and are licensed and regulated by the Ministry of Long-Term Care (Ministry) to operate in Ontario. Most residents in long-term care homes are seniors; over half are 85 years or older. However, homes are also open to anyone over the age of 18 who has comprehensive care needs that cannot be met in other settings.

Our Office has conducted several audits of long-term care in recent years, covering the areas of quality inspection (2015), food and nutrition (2019), and pandemic readiness and response (2021). For this audit, we focused on the ability of long-term care homes to provide residents with both high quality of care and high quality of life. While it is essential to care for the physical well-being of residents, it is equally important that homes offer support and enrichment to meet the mental, social, spiritual and cultural needs of residents. Long-term care homes exist for the benefit of residents; the interests of residents should be at the centre of all decisions. That is the essence of resident-centred care.

Overall, we found that long-term care homes lack the resources and supports to provide their residents with care and a living environment that is centred on their needs. More proactive leadership, guidance and support from the Ministry and its system partners (for example, Ontario Health) are essential to address the systemic issues identified in the audit.

Despite a significant increase in Ministry funding for long-term care staffing (an additional $4.9 billion over four years, 2021/22–24/25), we found that homes are still struggling to maintain sufficient staff to meet the needs of their residents. Many homes we visited have high vacancies and turnover in their nursing and personal support positions, and our analysis of staffing data revealed that a quarter of the homes in the province still provide fewer hours of direct care to residents than the provincial targets. To fill the staffing gap, homes have used agency staff with increasing regularity—a temporary solution that is costly and unsustainable. In addition, we noted from our visits to homes that some homes were missing certain allied health professionals (for example, physiotherapists, social workers and recreational therapists) that are key to residents' quality of life. With the Province set to build 30,000 new long-term care beds by 2028, the staffing issue will only worsen if actions are not taken.

We also found that homes are not always prepared to prevent and manage responsive or aggressive behaviours, which are common among residents with dementia, complex mental illness, substance use and other neurological disorders. These behaviours have sometimes led to physical injuries, creating an unsafe environment for both residents and staff.

In long-term care homes across Ontario, diverse populations must coexist in environments that are geared toward the needs of the majority. Hence, we

found cases where younger adults may not have access to age-appropriate programs and meaningful social connections, and where autistic residents may face a daily barrage of bright lights and loud noises. We also found instances where immigrants may seldom eat foods from their culture or have conversations in a language they understand.

Over the past few years, both the Ministry and long-term care homes have responded to the COVID-19 pandemic with intense efforts to prevent infections and control outbreaks. As the level and risk of infections decline and home operations continue to normalize, the Ministry and the homes should turn their focus toward the quality of life for residents.

The following are some of our significant findings.

Staffing

- **Staffing levels for nurses and personal support workers (PSWs) varied among homes.** We found that at least a quarter of the homes in the province failed to consistently reach the provincial targets in 2021/22–22/23 for hours of direct care. We also noted that the staff-to-resident ratio varied significantly across the homes we visited, especially during the evening and overnight shifts when the coverage of one home could be two or more times worse than another home—with ratios of up to 1:80 for nurses (one nurse for 80 residents) and 1:30 for PSWs. Recruitment and retention continue to be a significant challenge in the long-term care sector due to a shortage of health human resources in Ontario.
- **Increasing reliance on agency staff was costly and reduced continuity and quality of care.** We found that the average direct-care hours provided by contracted nurses and PSWs, including those supplied by agencies, rose from 4% in the first quarter of 2021/22 to 10% in the last quarter of 2022/23. We also noted that the reliance on agency staff varied significantly across homes, with agency staff contributing up to 50% of a home's direct-care hours. By their temporary nature, agency staff were unable to provide residents with the same continuity of care as permanent staff, and some homes we visited noted that mistakes like medication errors tended to happen more frequently among these staff. Agency staff also cost significantly more than permanent staff, since staffing agencies are private for-profit companies and there is currently no legislation capping the amount that these agencies can charge homes. For example, based on our estimates, the average hourly rate for an agency registered nurse (RN) was $97.33/hour, which was 142% higher than the average rate of an RN directly employed by a home ($40.15/hour), with a portion of the difference retained as profit by the agencies.
- **Pay inequity between homes and other health-care settings contributed to higher turnover and staff vacancies.** Besides competition within the long-term care sector, homes also face competition for staffing resources from other health-care settings, such as hospitals. We noted that hospitals offer better pay than long-term care homes. For example, the average hourly rate for registered nurses was 6% higher in hospitals ($40.47) than in long-term care ($38.05); and the average hourly rate for registered practical nurses was 11% higher in hospitals ($29.99) than in long-term care ($27.02). This disparity puts homes at a disadvantage in staff recruitment and retention, resulting in high vacancy rates of 8–12% for PSW and nursing positions in 2022/23.
- **The availability of allied health professionals (AHPs) varied among homes, with many homes lacking support from key professions.** AHPs include a broad range of professions—such as nurse practitioners, physiotherapists, occupational therapists and social workers—whose services contribute to residents' quality of life. We found that about half of the homes fell below the provincial target for direct-care hours in the fourth quarter of 2022/23. Our analysis of 2022/23 staffing data revealed that many homes were severely lacking services from certain

AHPs. For example, 74% of homes provided zero hours of direct care from nurse practitioners. Our visits to homes also confirmed that the utilization of AHPs varied across homes, with some positions missing from some homes.

- **Personal support workers (PSWs) continue to be unregulated.** While PSWs constitute the largest workforce in long-term care homes (approximately 60% of direct-care staff), they are unregulated. The profession is not governed by a code of conduct or standards of practice, and there is no regulatory body to report PSWs with serious misconduct or competency issues in order to discipline or keep them out of long-term care homes. An oversight authority was established in 2021. However, the authority is not functioning as yet and it is not mandatory for PSWs to register with the authority.

Resident-Centred Care

- **Homes had limited access to behavioural support resources.** Responsive or aggressive behaviours are common among people living with dementia, complex mental illness and substance abuse. We noted that over 40% of long-term care residents were assessed with aggressive behaviours in 2022/23. We identified examples from homes we visited where residents' aggressive behaviours led to physical harm or harassment of other residents and/or staff. Homes often do not have sufficient resources to effectively manage these behaviours. For instance, we found the following:
  - Over one-third of the homes we visited were denied funding to hire dedicated behavioural support staff.
  - Although the Ministry has established 307 beds in behavioural specialized units to provide a tailored environment for residents with behaviours that cannot be managed in the regular long-term care setting, the supply is limited and the admission to these units is generally restricted only to residents with a dementia diagnosis.
  - External behavioural resources for younger residents with mental illness or addiction problems were limited, as many of these resources would not accept residents under the age of 65.
- **There was not enough culturally specific care to meet the demand.** There are currently 57 out of 626 long-term care homes focused on serving specific ethnocultural or religious groups. We found that the median wait time in 2022/23 for an ethnocultural or religious home could be up to 1,843 days (approximately five years), compared to 50–223 days for all homes, depending on the region. Our regional analysis noted that while certain regions have a high concentration of particular ethnic groups (for example, the population in Peel Region is approximately 14% South Asian), there are no designated ethnocultural homes in those areas to serve that need. In our visits to mainstream homes (that is, homes that do not provide culturally specific care), we noted that the level of cultural accommodation varied across homes—for example, not all homes have staff who can communicate with residents in their native language, either directly or using language tools or technologies. Providing care in the residents' own language is important, especially for those with dementia (about 63% of all residents), who are more likely to revert to their mother tongue as their condition intensifies.
- **Younger residents were underserved in homes that cater to an elderly population.** Homes had about 6,200 (6.3%) younger residents under the age of 65 as of 2022/23, with some in their early 20s, who stay in long-term care homes because of their high care needs. It is difficult for younger residents to develop social connections that bridge the generation gap between them and the predominantly senior population. In addition, younger residents often do not have access to age-appropriate recreation programs, as programs at long-term care homes primarily cater to the senior residents (for

example, bingo, 60s-themed movies and music activities). In our visits to homes, we also noted that community resources for age-appropriate activities were limited, with some younger residents not getting access to any resources in the community.

Alternate Level of Care (ALC) Patients

- **Implementation of new legislation has not been transparent to the public.** A patient who requires an alternate level of care is someone occupying a hospital bed who no longer requires acute care in the hospital setting. The *More Beds, Better Care Act, 2022,* which came into full effect on September 21, 2022, authorizes Home and Community Care Support Services to determine the ALC patient's eligibility for long-term care and to select homes for the patient without the patient's consent. There were 7,357 ALC patients placed into long-term care homes between September 21, 2022 (effective date of the *More Beds, Better Care Act, 2022*) and March 31, 2023; of that total, 99 ALC patients were placed in homes that were not selected by patients but by placement co-ordinators without the patient's consent, as allowed by the new legislation. Among the remaining 7,258 placements, approximately 60% were not placed in their first-choice home, which was comparable to the 58% observed in the six-month period prior to the implementation of the *More Beds, Better Care Act, 2022*. Despite the public's concerns over the new legislation, none of this information has been disclosed to the public to show when and how the new provisions were used.
- **Outcomes of ALC patients in long-term care homes were not monitored to assess whether their needs were met.** Aside from freeing up hospital beds, one intent of the new legislation is to provide ALC patients with the care they need and a better quality of life in a more appropriate setting. However, the Ministry has not monitored the outcomes of ALC patients after their admission to long-term care to determine whether the transitions were smooth and whether these patients were actually doing well after discharge from the hospital.

Funding and Oversight

- **Funding method lacked up-to-date information to meet residents' current care needs.** The Ministry adjusts the funding to homes every year based on the health condition of each home's residents. However, the index used for adjustment is driven by resident acuity data collected from homes two years prior. Given that the residents' average length of stay in homes is about two to three years, and that health conditions can change significantly over that period, this data does not reflect residents' current care needs. In comparing the data for 2021/22 and 2023/24, we noted that the index can fluctuate significantly for some homes over the two-year gap, with one home reporting an increase of up to 18% (reflecting higher resident needs) and over 40 homes reporting an increase of 5% or more.
- **Long-term care homes faced barriers in navigating through and accessing funding initiatives.** The Ministry currently has over 40 funding initiatives to provide homes with additional funds to address specific issues. The funding system is complex and administratively burdensome, with different requirements for each initiative. Smaller homes are particularly challenged by the process as they have fewer administrative resources than larger homes. We also found that the Ministry has not consistently analyzed the uptake of these funding initiatives to determine whether the initiatives met their intended purposes, and to identify barriers that impede homes from effectively accessing funds.
- **Not all performance indicators had targets to drive and measure improvements, including indicators for residents' safety and care.** The service accountability agreements between Ontario Health and long-term care homes have nine indicators for the homes. However, aside

from two indicators that measure home financial health, most indicators have no targets—including those measuring home performance in relation to quality of care and resident safety. This limits Ontario Health's ability to effectively monitor and hold homes accountable for their performance.

This report contains 12 recommendations, with 29 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry, in conjunction with Ontario Health and long-term care homes, does not have fully effective systems and procedures to ensure that residents receive quality care and services. We found that the ability of long-term care homes to provide competent and appropriate care that meets resident care needs is constrained by staffing issues in the health-care sector. Despite increases in funding, long-term care homes still have high vacancy rates for nurses and personal support workers (PSWs)—about 8,000 open positions in 2022/23. To manage the staffing gap, some homes have paid a high price to hire temporary staff from agencies. The high vacancy rates and the increased use of temporary agency staff are disruptive to resident care. We also noted from our visits to homes that some homes have significantly poorer staff-to-resident ratios, which impedes their ability to care for the increasingly complex needs of residents. From 2018/19 to 2022/23, about 41% to 44% of residents exhibited some form of aggressive behaviours and required more care time from staff. We found that homes are not always prepared to manage these behaviours, which puts the safety of both residents and staff at risk on occasions.

We found that long-term care homes lack some of the resources and programs that are critical to residents' quality of life. For example, many homes have not employed certain allied health professionals (for example, social workers, physiotherapists and recreational therapists) who provide a broad range of services that address the physical, emotional, social and spiritual needs of residents. Moreover, home resources and programs primarily catered to the interests and needs of the majority of residents aged 85 and above, resulting in the unique needs of certain groups of residents, such as younger residents, not being met. The supply of culturally sensitive homes is also limited and wait times are long.

Lastly, neither the Ministry nor Ontario Health has developed targets to effectively measure the performance of long-term care homes in relation to quality of care and resident safety. The Ministry also has not consistently measured the uptake of its various funding initiatives to determine if the initiatives (totalling $1.8 billion in 2022/23) have met their intended purposes.

OVERALL MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the recommendations from the Auditor General and will use them to further inform key Ministry priorities, which aim to increase the confidence of residents and prospective residents, as well as their families, in the quality of long-term care in Ontario. While there are many effective systems and procedures in place to ensure that residents receive quality care and services, there is always more that can be done to improve resident experience.

As the long-term care sector continues to recover from the ongoing impacts of the COVID-19 pandemic, the Ministry remains committed to supporting a system where every resident experiences the best possible quality of life, supported by safe, high-quality care. The Ministry works closely with our partners, including Ontario Health, and has a multi-year plan to fix long-term care through strategic priority areas, including staffing, sustainability and capital development. These priorities and enablers align with the pillars of Your Health: A Plan for Connected and Convenient Care, and are supported by the quality framework and provisions of the *Fixing Long-Term Care Act, 2021*.

Recent initiatives and investments have built a solid foundation on which to grow, including:

- strengthening staffing and care through investment of up to $4.9 billion over four years towards training, hiring and retention of sector staff;
- doubling the number of home inspectors and enhancing accountability through a $72.3 million investment;
- creating modern, safe, comfortable homes with a commitment to create 30,000 new beds by 2028; and
- enacting the *Fixing Long-Term Care Act, 2021,* and Ontario Regulation 246/22, which more closely align the language in the Residents' Bill of Rights with the grounds of discrimination in the Ontario Human Rights Code and established direct hours of care targets, new compliance and enforcement tools, and strengthened emergency planning and quality improvement requirements.

2.0 Background

2.1 Overview

Long-term care homes provide 24/7 nursing and personal care, as well as assistance with activities of daily living to those whose needs cannot be safely met in the community through, for example, care at home and supportive living programs. In addition to nursing and personal support services, long-term care homes provide residents with a wide range of services—from therapies to recreational programs—to improve physical and mental health, enrich daily life, and promote well-being. The *Fixing Long-Term Care Act, 2021* (Act) describes a long-term care home as "the home of its residents" and a place where its residents "may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

2.1.1 Ontario's Long-Term Care Landscape

There are currently 626 long-term care homes in the province, with close to 80,000 licensed beds. These homes can be publicly or privately owned, operating either for profit or not for profit (see **Figure 1**). Homes are spread throughout the province and vary in size, ranging from fewer than 20 beds to over 400 beds. Regardless of ownership and size, all long-term care homes are publicly funded and must be licensed by the Ministry of Long-Term Care (Ministry) to operate in Ontario. They are regulated and subject to requirements prescribed by the Act.

Ontario's senior population (age 65 or older) has grown significantly, from about 2 million in 2013 to almost 2.8 million in 2022, an increase of almost 40% over a 10-year period. Based on the latest population projections published by the Ministry of Finance, this trend is expected to continue, with the senior population projected to increase to 4.4 million by 2045. Among the senior population, the number of seniors aged 85 and older is expected to grow the fastest (see **Appendix 1**).

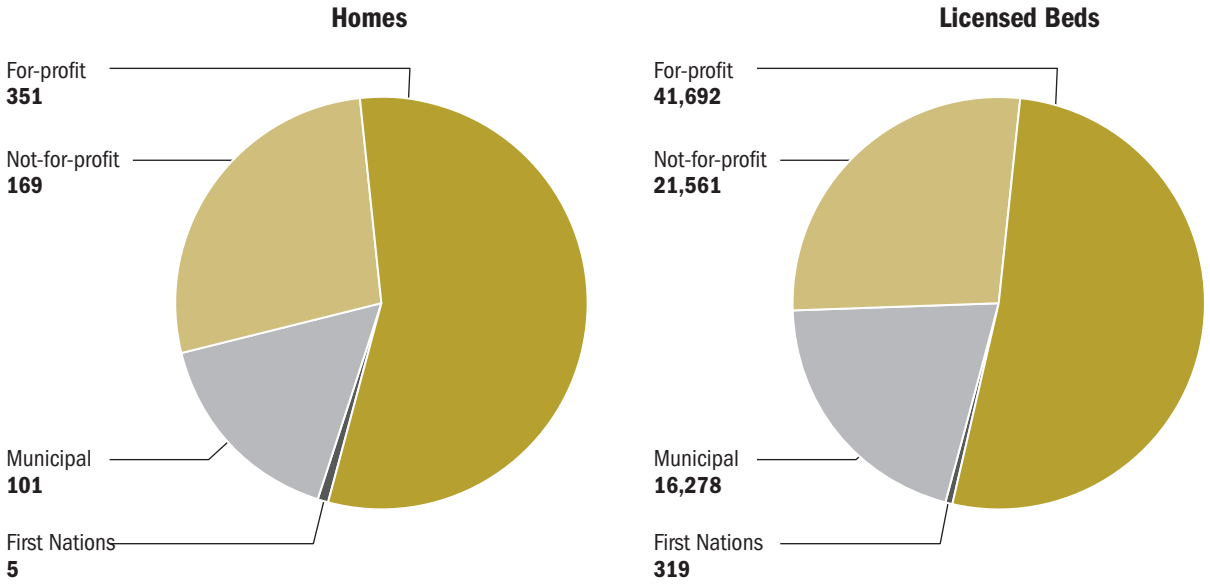
While the senior population increased by almost 40% over the last 10 years, the province's long-term care capacity has remained stagnant, with the number of licensed beds increasing by less than 2% since 2015. The median wait time for long-term care homes has remained long, sitting at about 130 days in 2021/22 (see **Figure 2**). To increase long-term care capacity, the Province has committed to invest $6.4 billion to build 30,000 new long-term care beds by 2028 and to redevelop over 28,000 older beds to modern design standards through the Long-Term Care Development Program. Some projects include beds dedicated for specific cultural and linguistic needs.

2.1.2 Resident Demographics

The average age of long-term care residents in Ontario is about 83 years old and the average length of stay

Figure 1: Number of Long-Term Care Homes and Beds in Ontario by Home Type, January 2023

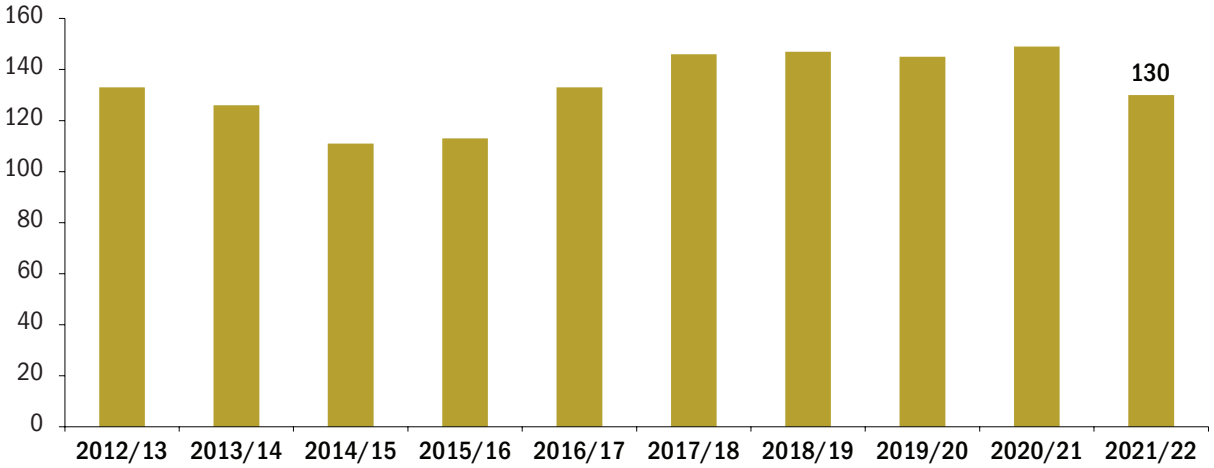
Source of data: Ministry of Long-Term Care



Note: Out of a total of almost 80,000 licensed beds, approximately 4,600 were not in operation, largely due to a directive issued during the COVID-19 pandemic, which eliminated three- or four-bed ward rooms. The directive requires homes to place residents (new admissions and re-admissions) in a room with no more than one other resident.

Figure 2: Median Wait Time for Long-Term Care Bed in Ontario, 2012/13–2021/22 (days)

Source of data: Ontario Health



in a long-term care home is about two to three years. While the majority of residents are seniors aged 65 or older, homes also include a younger population of residents who have experienced brain injury, stroke or other conditions that require the 24/7 care provided by long-term care homes. Today's home residents have more complex needs than in the past, with higher acuity (more severe conditions) and specialized care needs. The majority of residents have cognitive impairments and 63% of residents have a dementia diagnosis. **Figure 3** shows the profile of long-term care home residents in Ontario. The profile of long-term care

Figure 3: Profile of Long-Term Care Residents in Ontario, 2022/23

Source of data: Canadian Institute for Health Information

Selected Characteristics	%
Physical health	
Occasional bladder incontinence	83.8
Occasional bowel incontinence	69.0
Diagnosis of hypertension	64.5
Some indication of health instability[1]	62.0
Diagnosis of diabetes	28.4
Total dependence in activities of daily living	13.4
Diagnosis of cancer	10.6
Daily pain[2]	5.2
Mental and cognitive health	
Moderate to very severe cognitive impairment[3]	72.1
Diagnosis of dementia	63.4
Limited or no social engagement[4]	41.7
Some aggressive behaviour[5]	40.7
Signs of possible depression[6]	24.3

1. Residents with a score of 1 or greater on the Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) Scale. Score ranges from 0 to 5, with 5 being the "highest instability."
2. Residents with a score of 2 or greater on the Pain Scale, which considers the frequency and intensity of pain. Score ranges from 0 to 3, with 3 being "severe or excruciating daily pain."
3. Residents with a score of 3 or greater on the Cognitive Performance Scale (CPS). Score ranges from 0 to 6, with 6 being "very severe impairment."
4. Residents with a score of 2 or lower on the Index of Social Engagement (ISE). Score ranges from 0 to 6, with 0 being the "lowest social engagement."
5. Residents with mild to more severe aggressive behaviour.
6. Residents with a score of 3 or greater on the Depression Rating Scale (DRS). Score ranges from 0 to 14, with "3 or greater" indicating the "potential presence of a depression disorder."

residents in Ontario is consistent with or slightly more severe than the Canada-wide profile on most measures.

2.2 Key Roles in Long-Term Care

2.2.1 Ministry of Long-Term Care

In June 2019, the Province separated the Ministry of Health and Long-Term Care into two ministries: Ministry of Health and Ministry of Long-Term Care. **Figure 4** summarizes the key roles of the Ministry of Long-Term Care, which include developing policies, implementing initiatives, facilitating sector-wide discussions, regulating through licensing and inspections, funding, and collaborating with other ministries in matters related to long-term care.

2.2.2 Ministry of Health

Despite becoming a standalone ministry, the Ministry of Long-Term Care still collaborates with the Ministry of Health in a number of ways. For example, the two ministries must work collaboratively to address broader health-sector issues, such as health human resources, seniors' access to care services at home and in the community, as well as transitional care following hospitalization.

The Ministry of Health also oversees two Crown agencies—Home and Community Care Support Services (HCCSS) and Ontario Health—both of which play a key role in long-term care, as follow:

- HCCSS provides assessment and placement coordination services for the long-term care sector.

Figure 4: Key Roles of the Ministry of Long-Term Care

Prepared by the Office of the Auditor General of Ontario

Key Role	Description
Policy maker	• Develop legislation, regulations and policies for long-term care homes.
Facilitator	• Build and maintain relationships with key stakeholders representing the sector, families and residents. • Engage with long-term care homes to identify and address systemic operational challenges.
Regulator	• License long-term care operators. • Inspect homes to enforce the requirements of the *Fixing Long-Term Care Act, 2021*.
Funder	• Approve, oversee and fund the development and redevelopment of long-term care homes. • Provide operational funding to long-term care homes—through Ontario Health and directly to homes.
Implementer	• Assess and manage service and financial needs. • Implement strategies and initiatives across the sector.
Collaborator	• Work with other ministries, such as Ministry of Health and Ministry of Seniors and Accessibility, on cross-sector strategic priorities to enhance the continuum of care for seniors.

- Ontario Health, through its accountability agreement with the Ministry of Long-Term Care, manages the performance of individual long-term care homes and the province's long-term care system, working with stakeholders to implement provincial priorities and providing advice and support to the Ministry of Long-Term Care. Ontario Health also maintains service accountability agreements with long-term care homes to hold homes accountable for meeting performance expectations.

2.2.3 Long-Term Care Homes

Long-term care homes are governed by the *Fixing Long-Term Care Act, 2021* and its regulation, O. Reg. 246/22, which set out requirements relating to: residents' rights, care and services; quality; admissions; councils for residents and families; operation of the home, including staffing; funding; licensing; and compliance and enforcement. Homes are also required to comply with the terms and conditions outlined in their respective service accountability agreements with Ontario Health.

Every long-term care home must have staff in the following key management positions:

- The **administrator** is in charge of the home and responsible for its management.
- The **medical director** advises the home on matters relating to medical care and must be a physician.
- The **director of nursing and personal care** supervises and directs the nursing and personal care staff of the home and must be a registered nurse.

Besides the management roles described above, long-term care homes hire staff to provide direct care and support services to their residents. Specifically:

- **Direct-care staff** typically include registered nurses, registered practical nurses, personal support workers, and allied health professionals (for example, nurse practitioners, physiotherapists, occupational therapists, dieticians and social workers).
- **Support staff** include those who provide other essential services unrelated to care, such as janitorial and meal preparation staff.

To provide 24-hour nursing care, every long-term care home must have either a physician or a registered nurse in the extended class (that is, nurse practitioner) providing after-hours and on-call coverage. Also, each home is required to have at least one registered nurse on duty and present at all times, who must be an employee and a member of the permanent nursing staff of the home, except for circumstances as prescribed in regulation where this requirement may not apply.

As of March 31, 2023, there were over 85,000 direct-care staff in the province's long-term care sector. **Figure 5** shows the total number of direct-care staff by position.

2.3 Funding for Long-Term Care

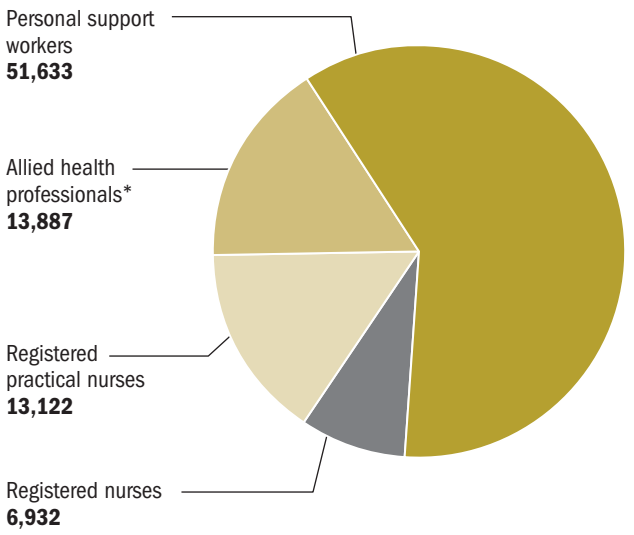
The Province provides funding to long-term care homes to support their ongoing operations. Funding is distributed to homes through the Level-of-Care funding model (see **Section 4.8.1**) and through additional funding streams for specific program objectives (see **Section 4.8.2**). Provincial funding has increased significantly since 2020/21 (see **Figure 6**) to help long-term care homes respond to challenges brought by the COVID-19 pandemic, as well as to implement initiatives to improve the long-term care system (see **Section 2.4**). Residents also contribute a co-payment amount set in regulation. As of July 1, 2023, a resident's co-payment rate ranges from $65.32 per day to $93.32 per day, depending on whether the resident is in basic, semi-private or private accommodation.

2.4 Key Strategic Initiatives

The COVID-19 pandemic has exacerbated and exposed the inadequacies within Ontario's long-term care sector. Various studies and audits have recommended ways to improve the sector (including Ontario's Long-Term Care COVID-19 Commission Report in 2021 and our Office's 2021 audit, *COVID-19 Preparedness and Management: Special Report on Pandemic Readiness and Response in Long-Term Care*). In response, the Ministry of Long-Term Care (Ministry) is implementing various initiatives to fix Ontario's long-term care. These initiatives primarily aim at improving staffing in long-term care, accelerating the development and re-development of long-term care beds, strengthening inspection and enforcement capacity, and broadening the continuum of services to seniors.

Figure 5: Direct-Care Staff in Ontario's Long-Term Care Sector by Position, March 31, 2023

Source of data: Ministry of Long-Term Care



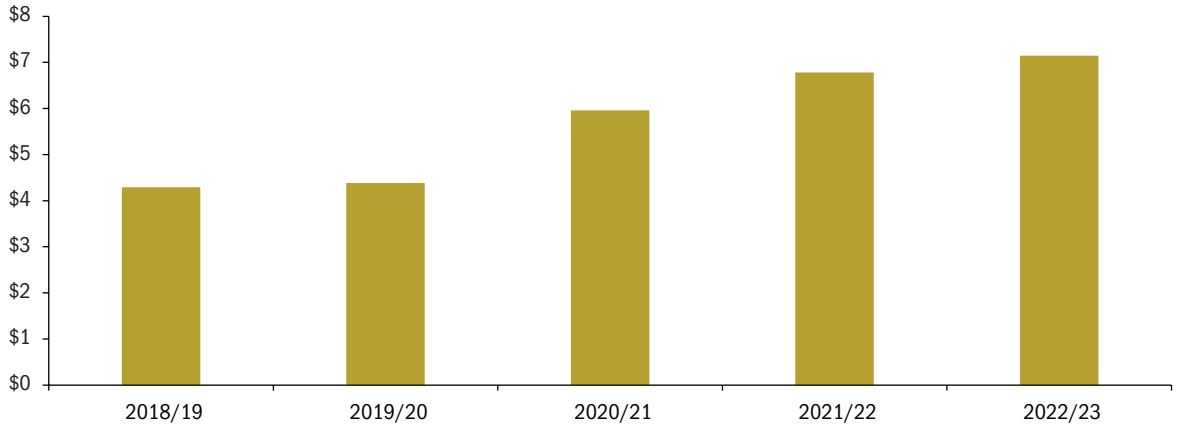
* Examples of allied health professionals include physiotherapists, occupational therapists, nurse practitioners, resident support personnel and activity personnel.

The staffing-related initiatives and impacts are core to the subject matter of this audit. These initiatives, with an estimated investment of up to $4.9 billion by 2024/25, are outlined in the Ministry's 2021-2025 Long-Term Care Staffing Plan, and focus on the following areas:

- increase the hours of direct hands-on care provided by nurses and personal support workers and expand resident access to allied health professionals;
- accelerate and expand education pathways to help increase the supply of new qualified staff;
- build effective and accountable leadership in long-term care homes, support the ongoing development of staff and improve working conditions to help staff retention; and
- continuously monitor and measure the progress of the various staffing plan initiatives.

Figure 6: Provincial Funding Provided for Long-Term Care, 2018/19–2022/23 ($ billion)

Source of data: Ministry of Long-Term Care



3.0 Audit Objective and Scope

Our audit objective was to assess whether long-term care homes, in conjunction with the Ministry of Long-Term Care (Ministry) and Ontario Health, have effective systems and procedures in place to ensure that residents receive quality care and services in a safe environment, by:

- managing, allocating and monitoring staffing resources to provide residents with competent and appropriate care that meets their needs;
- implementing practices and programs to improve services and quality of life for residents; and
- monitoring performance, identifying areas for improvement and implementing action plans on a timely basis.

In planning our work, we identified the audit criteria we would use to address our audit objective (see **Appendix 2**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management of the Ministry and Ontario Health reviewed and agreed with the suitability of our objective and associated criteria.

We conducted our audit from January 2023 to September 2023, and obtained written representation from the Ministry and Ontario Health senior management that, effective November 20, 2023, they have provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

In arriving at the audit conclusion, we have performed procedures including, but not limited to, the following:

- interviewed key personnel at the Ministry, Ontario Health, and Home and Community Care Support Services;
- interviewed representatives from selected industry associations and advocacy groups (for example, Ontario Long-Term Care Association, AdvantAge Ontario, Ontario Association of Residents' Councils and Ontario Personal Support Workers Association);
- interviewed long-term care residents of selected homes;
- conducted site visits of a sample consisting of 18 long-term homes (see **Appendix 3**), which were selected based on a variety of factors, including:
  - location and area of coverage;
  - home type (for-profit, not-for-profit or municipal);
  - home size (based on number of licensed beds);

  - number of recent complaints and critical incidents; and
  - resident population (for example, percentage of residents with cognitive impairment, with aggressive behaviour, or with greater need for assistance in activities of daily living);
- examined legislation and regulations that govern Ontario's long-term care sector;
- examined memorandums of understanding, accountability agreements and mandate or strategic letters between the Ministry and Ontario Health;
- reviewed documentation from the Ministry, Ontario Health, Home and Community Care Support Services and long-term care homes (for example, policies and procedures, decision documents, performance monitoring or assessment reports, complaints, and financial, staffing and other resident records);
- performed sample testing and data analyses on trends across years (for example, staffing level and ratios, staffing mix, direct-care times, wait times, and performance indicators); and
- performed benchmarking or jurisdictional comparisons where applicable.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements, issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standards on Quality Management and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 Homes Lacked Stable and Adequate Staffing to Care for Residents

To provide residents with high-quality care and to keep them safe, it is critical that long-term care homes maintain a stable and adequate level of nursing and personal care staff. However, despite additional funding from the Ministry of Long-Term Care (Ministry) to support staffing increases since 2021/22, we found that long-term care homes are still experiencing difficulty in recruiting and retaining staff to meet residents' needs. Some homes have had to resort to paying hefty prices to hire temporary staff from agencies to fill open shifts.

4.1.1 Direct-Care Time and Staff-to-Resident Ratios for Nursing and Personal Support Staff Varied among Homes

While the quality of care provided to residents could be affected by various factors (for example, the home environment, home management, staff experience), the reliable presence of nursing staff and personal support workers, and a sufficient staff-to-resident ratio, are key elements in maintaining high-quality care.

Hours of Direct Care

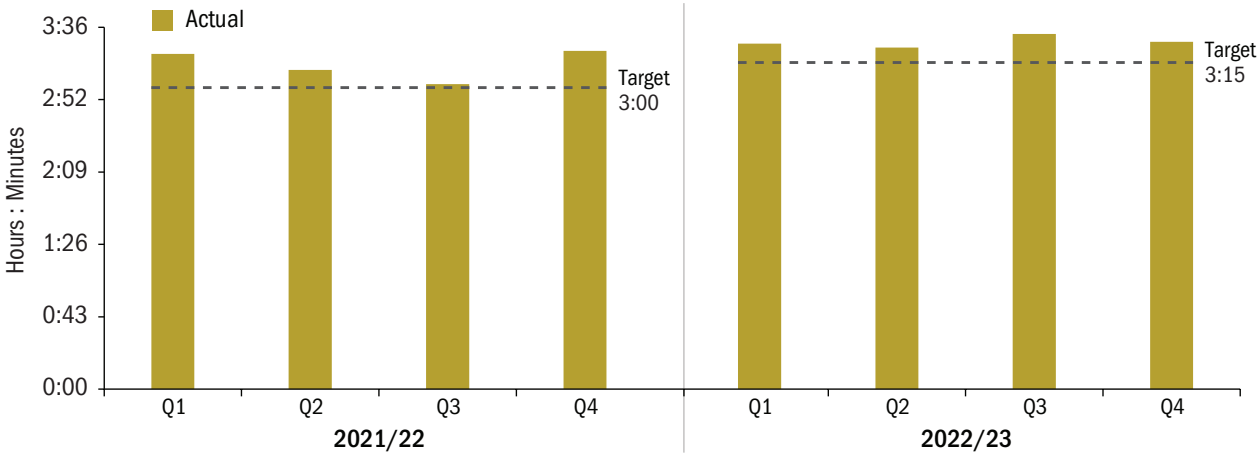
In its 2021-2025 Long-Term Care Staffing Plan, the Ministry recognized the need to have additional staff in homes to provide increased hands-on care to residents. To enable homes to increase their hours of direct care, the Ministry budgeted approximately $3.6 billion to be allocated to homes over four years, from 2021/22 to 2024/25, for the hiring and retention of registered nurses (RNs), registered practical nurses (RPNs) and personal support workers (PSWs). This

is in addition to the base funding allocated to homes (see **Section 4.8.1**). The target, as defined in the *Fixing Long-Term Care Act, 2021* (Act), is for the province to reach a daily average of 4 hours of direct care per resident by 2024/25, with interim targets set for each of the three preceding years (that is, 3 hours by 2021/22; 3 hours 15 minutes by 2022/23; and 3 hours 42 minutes by 2023/24).

In examining staffing data from long-term care homes, we noted that even though homes have collectively achieved the interim provincial targets set for 2021/22 and 2022/23 (see **Figure 7**), direct-care hours varied among homes and at least a quarter of the homes were unable to consistently meet the targets set for the province (see **Figure 8**). However, we found that the Ministry has yet to complete analysis beyond data validation to understand the causes of the

Figure 7: Hours of Direct Care by Nurses and Personal Support Workers (Provincial Average), 2021/22–2022/23

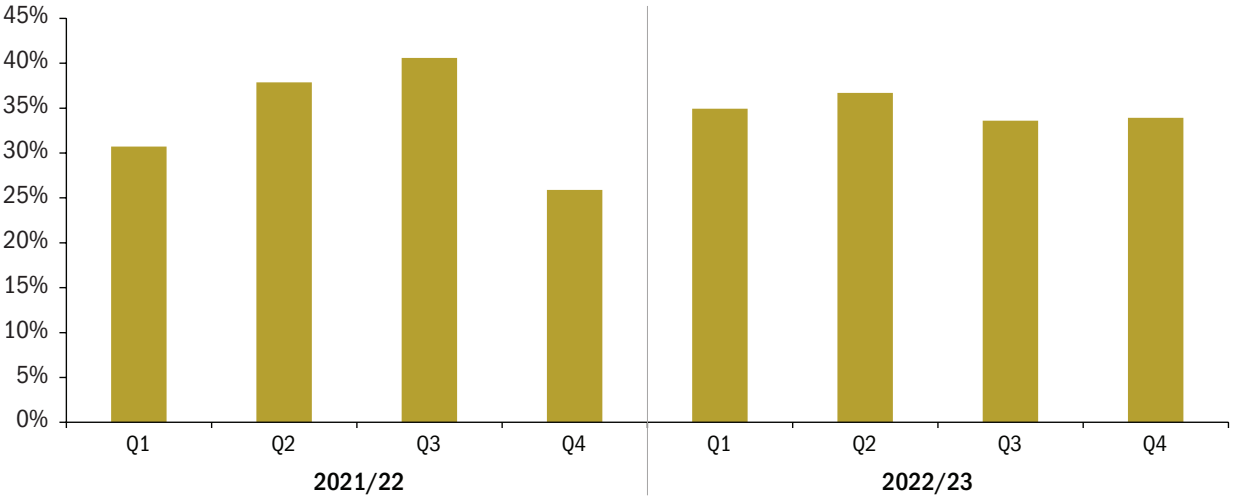
Source of data: Ministry of Long-Term Care



Note: The provincial average is based on the average hours of direct care provided by registered nurses, registered practical nurses and personal support workers, as reported by over 97% of homes that submitted staffing data to the Ministry for the period.

Figure 8: Percentage of Homes Below Target for Direct Care by Nurses and Personal Support Workers, 2021/22–2022/23

Source of data: Ministry of Long-Term Care



Note: The percentage of homes not meeting the provincial target is based on the average hours of direct care provided by registered nurses, registered practical nurses and personal support workers, as reported by over 97% of homes that submitted staffing data to the Ministry for the period.

variations. We also noted that the Ministry does not have insight into how the funds were used to increase direct care (for example, how much was used and by which homes) because the information is unavailable due to delays in reconciling and settling financial information with the homes (refer to **Section 4.8.3**).

The homes and stakeholders we spoke with indicated that recruitment continues to be a challenge in the long-term care sector due to a shortage of health-care workers in Ontario. The strong competition for resources has left many long-term care homes with vacancies. For example, one of the homes we visited indicated that even though the Ministry has provided funding to support the increase in direct care, it had been unable to take full advantage of the additional funding to fill all vacancies due to difficulties in hiring. Homes could have positions vacant for months and receive very few applications to their job postings. Our analysis of staffing data for 2022/23 noted that, despite increases in funding, long-term care homes maintained an average vacancy rate of 11% for RNs (1,047 positions), 12% for RPNs (2,089 positions) and 8% for PSWs (4,870 positions). Also, certain homes have found it harder to attract staff due to factors such as the home's location and compensation (as discussed in **Section 4.1.3**).

The Ministry of Long-Term Care, in collaboration with other ministries (for example, Ministry of Health, Ministry of Colleges and Universities), implemented a number of initiatives in recent years to increase the supply of health human resources. For example, investments have been made to: expand enrolment in nursing and PSW programs at publicly assisted post-secondary education institutions, private career colleges and district school boards; support internationally educated nurses to transition and practise in Ontario; and enhance opportunities for Indigenous learners studying PSW or nursing programs at Indigenous institutes. Some of these initiatives are in an early phase of implementation while staffing shortages remain an issue in long-term care homes. With the commitment to build 30,000 new long-term care beds by 2028, the demand for staffing from the long-term care sector will continue to rise over the next five years.

Staff-to-Resident Ratios

We noted from the homes we visited that the staff-to-resident ratios varied across homes (see **Figure 9**). The variance was particularly noticeable during the evening and overnight shifts, when one home could have one staff person caring for more than twice as many residents, compared to another home. Overnight-shift staff cover a variety of activities, which include performing routine checks, documenting resident condition and care, administering medications, assisting residents with personal care and responding to call bells, among other tasks. Homes with a staff-to-resident ratio as poor as 1:80 for nurses and 1:30 for PSWs could struggle to keep up with the needs of residents during night time, especially in emergencies and where staff need to actively supervise residents who remain awake. For example, one home

Figure 9: Staff-to-Resident Ratios by Shift in Homes We Visited, May–August 2023

Prepared by the Office of the Auditor General of Ontario

	Nurses*		Personal Support Workers	
	Best Ratio	Worst Ratio	Best Ratio	Worst Ratio
Day shift	1:16	1:30	1:6	1:10
Evening shift	1:16	1:40	1:7	1:23
Overnight shift	1:23	1:80	1:13	1:30

Note: Ratios are based on data from the 18 long-term care homes we visited (see **Appendix 3**).

* Nurses include both registered nurses and registered practical nurses.

indicated that, with fewer staff on the overnight shift, it took longer to complete routine floor checks, which could delay the discovery of resident falls.

Staff-to-resident ratios are unregulated and are determined by homes based on their own assessment of needs. While setting a standard staff-to-resident ratio for all homes is difficult or not feasible, in its 2021–25 Long-Term Care Staffing Plan, the Ministry has committed to developing guidance for long-term care homes on staffing models, with staff-to-resident ratios identified as an area for consideration. To date, however, no guidance on staff-to-resident ratios has been issued.

4.1.2 Reliance on Agency Staff Was Costly and Reduced Continuity and Quality of Care

Historically, long-term care homes have hired nursing and personal support staff through agencies to meet temporary needs. However, in recent years, some homes are increasingly relying on agency staff to fill shifts. Section 80 of the *Fixing Long-Term Care Act, 2021* requires long-term care homes to limit the use of temporary, casual or agency staff, in order to provide a stable and consistent workforce and to improve continuity of care to residents. An over-reliance on agency staff could disrupt resident care and add financial pressure on long-term care homes, given the higher hourly rates for these staff. The homes and stakeholders we spoke with also consistently identified the heavy reliance on agency staff as one of the primary concerns in long-term care.

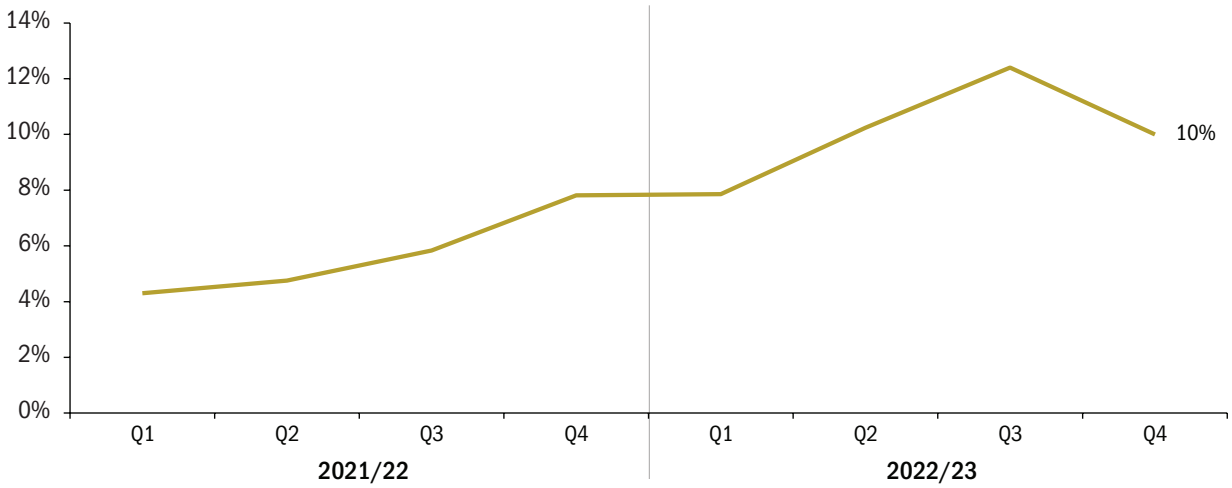
Reliance on Agency Staff Has Been Increasing

As noted in **Section 4.1.1**, homes collectively met the provincial targets for direct-care hours set for 2021/22 and 2022/23 (**Figure 7**). However, our analysis of staffing data revealed that a considerable and increasing percentage of those care hours were provided through contracted staff, including those from agencies, as opposed to regular or permanent staff. As shown in **Figure 10**, these contracted staff accounted for approximately 10% of direct-care hours (over two million hours) provided to residents by nurses and personal support workers (PSWs) in the fourth quarter of 2022/23, an increase from 4% in the first quarter of 2021/22.

We also noted that the reliance on agency staff varied significantly across homes, with agency staff

Figure 10: Percentage of Direct Care Provided by Contracted Staff, 2021/22–2022/23

Source of data: Ministry of Long-Term Care



Note: Percentages are based on staffing data submitted to the Ministry from over 97% of homes. Contracted staff include registered nurses, registered practical nurses and personal support workers supplied by agencies, as well as those who were independently contracted by homes. Presumably the majority of the direct-care hours were contributed by agency staff; however, the actual breakdown of hours between agency staff and staff independently contracted by homes is unavailable from the staffing data.

contributing up to 50% of the direct-care hours of nurses and PSWs at some homes at certain times over the two-year period from 2021/22 to 2022/23. In general, we found that homes in rural or remote areas placed the heaviest reliance on agency staff among all areas, likely because rural and remote areas have traditionally faced greater challenges in attracting health-care workers than urban centres.

Agency Staff Cost More

Staffing agencies are private for-profit companies, and there is currently no legislation capping the amount that these agencies can charge their clients, including long-term care homes. With the entire health-care sector experiencing staffing shortages, agencies can charge long-term care homes significant premiums. Their high profit margins enable agencies to offer higher wages to attract nurses and PSWs to pursue agency opportunities, exacerbating the vacancy issue experienced by long-term care homes. An increased use of agency staff also meant that more public funds were going to these private agencies.

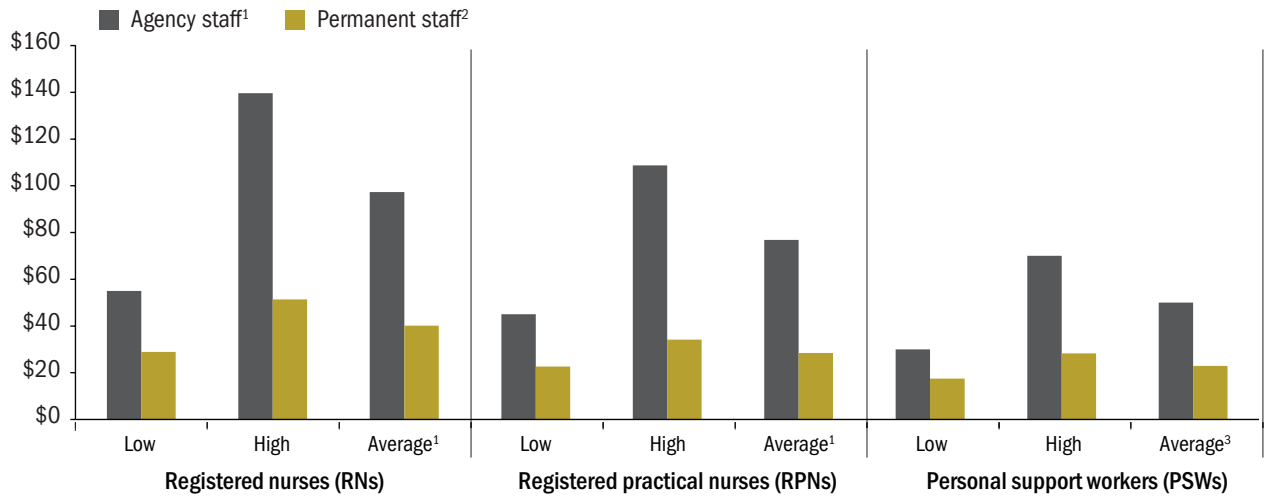
Based on staffing data, homes often pay significantly higher rates for agency staff than for permanent employees. **Figure 11** shows the average hourly rates for agency staff, in comparison to the averages for permanent employees in the same position. Specifically, we noted that:

- The average hourly rate for agency staff is significantly higher than the rate for permanent staff. For instance, the average rate for an RN employed through an agency was $97.33/hour, which was 142% higher than the average wage of an RN directly employed by a home ($40.15/hour).
- The hourly rate for agency staff in the same position also varies significantly. For example, the hourly rate for an RN employed through an agency could range from $55/hour to $139.65/hour.

In addition to the higher hourly rates for agency staff, we were informed by the Ontario Long-Term Care Association that some of its members in remote locations also provided agency staff with accommodation and transportation subsidies. This was confirmed through our visits to homes, with three homes in areas

Figure 11: Average Hourly Wages of Agency and Permanent Staff Providing Direct Care

Sources of data: Ministry of Long-Term Care and Treasury Board Secretariat



1. For agency staff, average wages were calculated from data reported by long-term care homes to the Ministry of Long-Term Care for the third quarter ending September 30, 2022, the latest data available.
2. For permanent staff, average wages were calculated from data submitted to the Treasury Board Secretariat for the Workforce Data Transparency Survey as of December 31, 2021, the latest data available. Wages for PSWs do not include the wage enhancement subsidized by the government. The enhancement was introduced in October 2020 during the COVID-19 pandemic.
3. Average wage is an average of the low and high hourly wages reported for the position. It does not represent the actual average wage earned by staff.

outside urban centres indicating they paid agency staff for travel and/or accommodation in the past. One home informed us that it paid $115 per night on average for agency staff accommodation in early 2023. Another home estimated it paid almost $280,000 in 2021 and 2022 for the travel and accommodation of its agency staff.

Continuity of Care Goes Down as Agency Staffing Goes Up

As discussed in **Section 2.1.2**, today's long-term care residents have more complex needs than residents in the past. It is important for homes to maintain a stable workforce that fosters intimate and trusting relationships between residents and staff, so that staff can better understand the needs and preferences of the residents they care for and provide better continuity of care. Continuity of care improves resident care and experiences, especially for seniors with dementia who rely on familiar faces for reassurance.

Agency staff, by their temporary nature, are unable to provide the same continuity of care to residents that permanent staff can provide. This view is shared among many homes we visited. Homes indicated that agency staff were at times unable to attend to residents' needs in a timely manner due to a lack of familiarity with the residents and with policies. For example, the agency staff would have to spend additional time understanding a resident's ability and dietary preferences, hence slowing down the workflow and upsetting the resident.

The agencies also do not always provide staff that are of high quality or good fit with the home. A couple of homes noted that mistakes like medication errors tended to happen more frequently among agency staff, and there were instances where the home would have to release an agency staff person due to performance or attitude issues. Agency staff who return to the same home on multiple occasions were generally better acquainted with the home's residents and policies and became more accountable to the home. However, while homes could ask for the same staff from the agencies, fulfilling the requests depended on availability.

The Ministry's Long-Term Care Technical Advisory Table is currently examining the agency staff issue within the sector to inform future strategies. No specific planned actions and target completion dates had been decided at the time of our audit.

4.1.3 Pay Inequity Contributed to High Staff Vacancies and Turnovers

On July 30, 2020, the Ministry released a staffing study to help inform a comprehensive staffing strategy for long-term care. The study used compensation data from 2018/19 and found that wages of registered nurses (RNs), registered practical nurses (RPNs) and personal support workers (PSWs) varied across long-term care homes, depending on home type. In general, within the long-term care sector, municipal homes paid the highest wages, followed by not-for-profit homes and then for-profit homes. The same trend showed in the more recent compensation data collected by the Treasury Board Secretariat through its Workforce Data Transparency Survey. Our review of the data found a notable wage disparity among municipal, for-profit and not-for-profit homes as of December 31, 2021 (see **Figure 12**).

Wage disparity could cause unnecessary staff movement, resulting in certain long-term care homes having higher turnover and staff vacancies, which in turn impact the level and continuity of care provided to residents. Our analysis of vacancy data from homes revealed that for-profit homes and not-for-profit homes have consistently higher vacancy rates than municipal homes for all nursing and personal support positions (see **Figure 13**).

Besides competition within the long-term care sector, homes also face competition for staffing resources from other health-care settings, such as hospitals. As identified in the Ministry's 2020 Staffing Study, hospitals on average offer better pay than long-term care homes. For example, the average hourly rate for registered nurses was 6% higher in hospitals ($40.47) than in long-term care ($38.05); and the average hourly rate for registered practical nurses was 11% higher in

Figure 12: Hourly Wages for Permanent Nurses and PSWs by Home Type, December 31, 2021 ($/hour)

Source of data: Treasury Board Secretariat

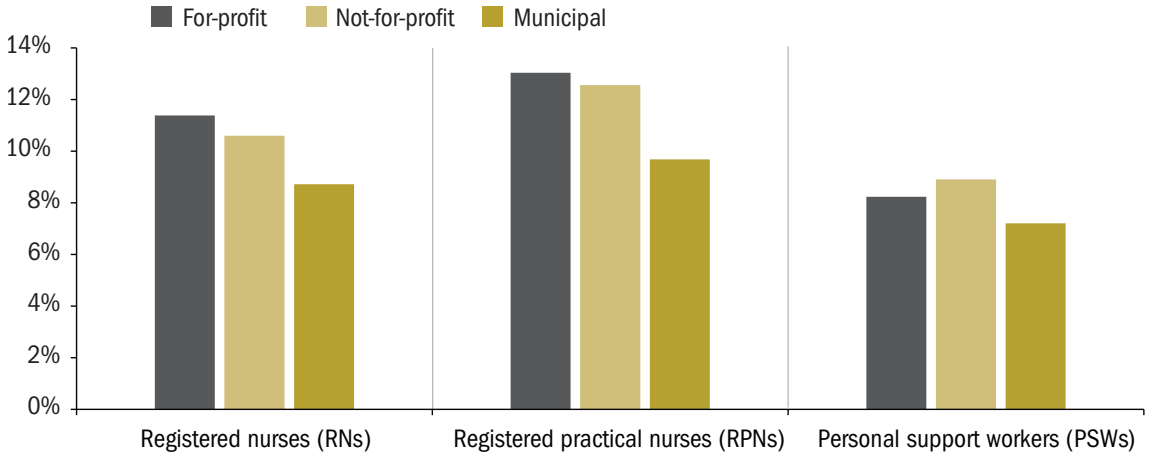
	Registered Nurses (RNs)		Registered Practical Nurses (RPNs)		Personal Support Workers (PSWs)[1]	
Type of Home	**Hourly Range**	**Average[2]**	**Hourly Range**	**Average[2]**	**Hourly Range**	**Average[2]**
All homes	28.94–51.37	40.15	22.70–34.18	28.44	17.54–28.26	22.90
For-profit	28.94–51.13	40.03	22.70–32.88	27.79	17.54–28.26	22.90
Not-for-profit	29.58–51.16	40.37	22.84–32.89	27.87	17.90–27.46	22.68
Municipal	31.14–51.37	41.26	24.94–34.18	29.56	19.50–28.02	23.76

Note: Wages are based on data reported to the Treasury Board Secretariat by long-term care homes in response to the Workforce Data Transparency Survey. The response rate to the survey was approximately 43% among for-profit homes, 34% for not-for-profit homes and 33% for municipal homes.

1. Wages for PSWs do not include the wage enhancement subsidized by the government. The enhancement was introduced in October 2020 during the COVID-19 pandemic. In April 2022, the government made this wage enhancement permanent for PSWs.
2. Average wage is an average of the low and high amounts in the Hourly Range. It does not represent the actual average wage earned by staff.

Figure 13: Vacancy Rates for Nurses and PSWs by Home Type, Fourth Quarter 2022/23 (%)

Source of data: Ministry of Long-Term Care



Note: Vacancy rates show the percentage of jobs that have not been filled for 90 days or more. They do not include short-term vacancies, sick leaves or other forms of temporary absence. The percentages are based on staffing data reported by homes to the Ministry of Long-term Care. Over 97% of homes submitted data for the period.

hospitals ($29.99) than in long-term care ($27.02). This disparity puts homes at a disadvantage in staff recruitment and retention. We noted high turnover and vacancy rates in many homes we visited. For example, one of the large homes had almost 30 vacant positions (excluding temporary positions) in its direct-care staff at the time we visited. In another medium-sized home, 20 nurses and PSWs resigned within the first six months of 2023.

Over the past few years, the Province has not taken a systemic approach to address compensation across health-care settings, considering wage parity to reduce compensation-related labour shortages. The enactment of the *Protecting a Sustainable Public Sector for Future Generations Act, 2019* (Bill 124) on November 8, 2019, did not help to reduce the wage gap across long-term care homes, and may have exacerbated the issue by limiting wage increases at not-for-profit homes to a maximum of 1% annually. However, Bill 124 was overturned by the Ontario Superior Court on November 29, 2022.

The Ministry informed us that compensation harmonization is one of the options that will potentially

be considered in the broader Health Human Resources Strategy that the Ministry of Health is currently developing.

RECOMMENDATION 1

To provide residents with high-quality care and to keep them safe, we recommend that the Ministry of Long-Term Care:

- analyze hours of direct care and staffing mix (that is, permanent staff versus temporary agency staff) at the home level to identify homes with staffing challenges, work with those homes on strategies to address their recruitment and retention challenges, and monitor the outcomes of the strategies;
- monitor staff-to-resident ratios, especially for periods that typically have staffing shortages (such as overnight shifts, weekends and holidays);
- complete the review of the use of agency staff in long-term care and implement strategies to reduce usage and prevent price gouging; and
- collaborate with the Ministry of Health in developing and implementing the long-term Health Human Resources Strategy to address staffing supply and compensation disparity issues across the sector.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to analyze hours of direct care and staffing mix, monitor staff-to-resident ratios, complete the review of the use of agency staff, and collaborate with the Ministry of Health in developing and implementing the Health Human Resources Strategy.

The Ministry is committed to increasing direct hours of care for residents in long-term care in line with the direct-hours-of-care targets under the *Fixing Long-Term Care Act, 2021* (Act), through $4.9 billion in targeted funding dedicated to supporting the achievement of the direct-hours-of-care targets, and other programs aimed at increasing the supply of health human resources.

The Ministry is actively undertaking home and regional-level direct-hours-of-care analysis and will continue with that effort to better understand where there are opportunities to increase direct-hours-of-care performance. To address recruitment and retention, the Ministry will also continue to implement and monitor the uptake of programs that aim at supporting recruitment and retention, such as the personal support workers' permanent wage enhancement, Supporting Professional Growth Fund, Hiring More Nurse Practitioners program, bridging and laddering programs, clinical placements and education/training programs.

As part of work to develop and amend regulations under the Act, the Ministry has made it easier for homes to hire from a broader pool of qualified staff while ensuring safety for residents. Long-term care homes are best positioned to determine the appropriate staffing complement based on their own knowledge of their residents' needs, and the Ministry will continue to monitor staffing mix ratios to inform ongoing supports to the sector.

The Ministry is reviewing the use of agency staff in long-term care to understand regional and home-level trends and is also considering new programs to support human resource capacity, increase full-time work and reduce reliance on agency staff. The Ministry will continue to work in partnership with the Ministry of Health to plan for future staffing needs across the long-term care sector.

4.2 Not All Residents Had Access to Key Allied Health Professionals to Optimize Quality of Life

In addition to 24/7 nursing and personal care, residents at long-term care homes also need access to a

broad range of services from health professionals, such as nurse practitioners, physiotherapists, occupational therapists, social workers, dieticians, activity assistants and others, to help ensure their physical, emotional, social and spiritual well-being. Collectively referred to as allied health professionals (AHPs), these personnel provide care through a variety of programs that are essential in helping residents to maintain and improve their quality of life.

4.2.1 Availability of Allied Health Professionals Varied among Homes

The *Fixing Long-Term Care Act, 2021* establishes a 36-minute target (per resident, per day) for direct care provided by AHPs by March 31, 2023, with an interim target of 33 minutes by March 31, 2022. The 36-minute target was based on a 20% increase to the level of direct-care time identified in 2018. In order to help homes reach the target and sustain care at that level, the Ministry of Long-Term Care (Ministry) budgeted approximately $430 million on top of annual base funding to be allocated to homes over four years, 2021/22–24/25.

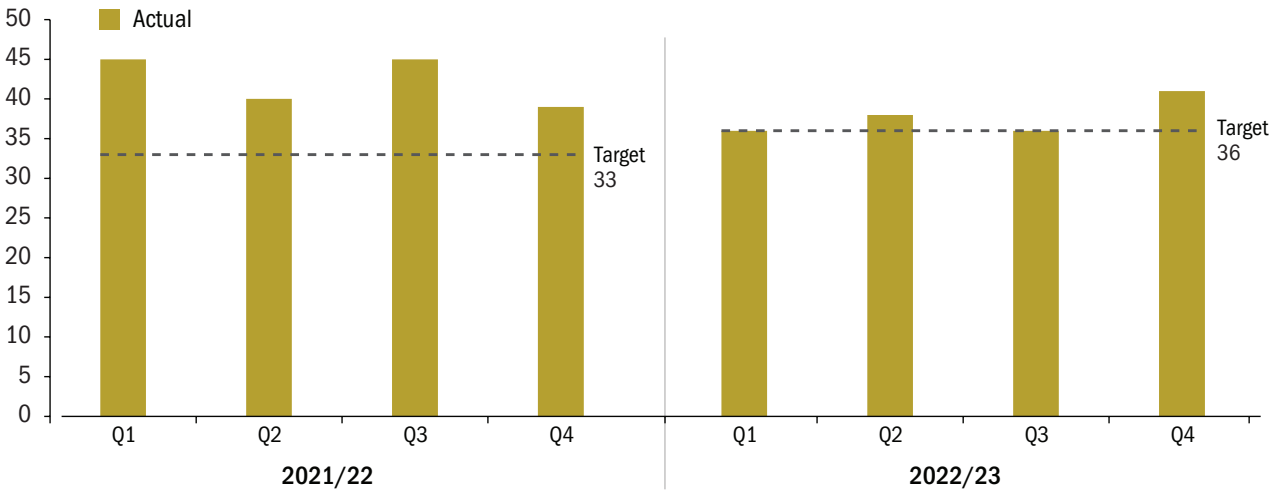
The legislated care target for AHPs is set at the provincial level—that is, it is measured as the average for all homes rather than at the individual home-level. In our analysis of quarterly data on direct-care hours from 2021/22 to 2022/23, we noted that while the annual targets were met at the provincial level (see **Figure 14**), about half of the homes were unable to individually meet this target by the end of 2022/23 (see **Figure 15**). This is similar to what we observed in the direct-care hours for nursing and personal support (refer to **Section 4.1.1**). We found that the Ministry has not investigated direct-care hour variations across long-term care homes to identify under-performing homes with low direct-care time by AHPs, and to understand variations among homes, in order to determine whether residents across the province received equitable services.

4.2.2 Support Was Missing from Key Allied Health Professionals

Our further examination of staffing data also revealed that some homes have consistently failed to provide their residents with services from certain AHPs, as

Figure 14: Minutes of Direct Care by Allied Health Professionals (Provincial Average), 2021/22–2022/23

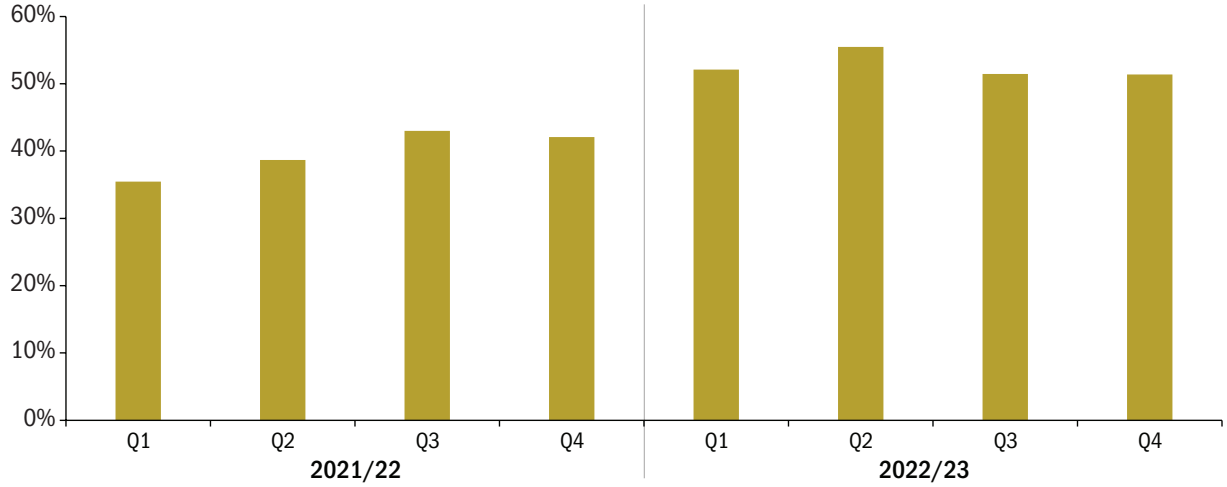
Source of data: Ministry of Long-Term Care



Note: The provincial average is based on staffing data submitted to the Ministry of Long-Term Care from over 97% of homes.

Figure 15: Percentage of Homes Below Target for Direct Care by Allied Health Professionals, 2021/22–2022/23

Source of data: Ministry of Long-Term Care



Note: The percentage of homes not meeting the provincial target is based on staffing data submitted to the Ministry from over 97% of homes.

Figure 16: Homes with No Direct-Care Time Reported for Key Allied Health Professionals, 2022/23

Source of data: Ministry of Long-Term Care

Allied Health Professionals (AHPs)	# of Homes	% of Homes
No nurse practitioner	456	74
No religious or spiritual support staff	447	72
No occupational therapist	418	68
No restorative aide (rehabilitation or therapy aide)	331	54
No social worker or social service worker	239	39
No physiotherapist, physiotherapy aide or physiotherapy assistant	74	12
No activity director or activity assistant	14	2

Note: Results are based on staffing data submitted to the Ministry from over 97% of homes.

indicated by the zero hours of care reported for these professions throughout 2022/23 (see **Figure 16**). Homes have the flexibility to decide the mix of AHPs and their hours, based on the specific and differing needs of residents. However, by having zero or minimal involvement from certain AHPs, homes risk not providing their residents with the comprehensive care they need. This is especially true for residents receiving palliative care. Palliative care in long-term care focuses on improving the quality of life for residents and their families, managing residents' symptoms, and providing psychosocial support and end-of-life care where appropriate. This requires the participation of a multidisciplinary team of care providers—including AHPs—to provide not just the necessary medical interventions, but also psychological, social, emotional and spiritual support.

Nurse Practitioners

As shown in **Figure 16**, 74% of all homes did not have a nurse practitioner in 2022/23. Nurse practitioners can assess, diagnose and treat residents (including prescribing most medications and introducing other interventions); mentor and coach the home's clinical

team; and assist with resident care planning. Consistent with the staffing data in 2022/23, we found that about half of the homes we visited did not have an in-house nurse practitioner at the time of our visit.

We found that homes that do not have in-house nurse practitioners typically have some form of access to these professionals from the community. For example, nurse practitioners from programs like the Nurse-Led Outreach Team would support homes by reviewing resident care plans and providing education to staff on specialized areas, such as palliative care. However, the extent of support varies: some homes access these external resources on an as-needed basis; others receive scheduled visits at differing frequencies, ranging from weekly to monthly. While homes acknowledged the external support, they indicated that having in-house nurse practitioners to provide timely and continuous monitoring of resident conditions, as well as staff education, would be more beneficial. Homes indicated that external nurse practitioners were not always available to assist on urgent matters.

The importance of the nurse practitioner's role in long-term care was highlighted in past reports, such as the *Long-Term Care COVID-19 Commission Report*. In its 2020 staffing study, the Long-Term Care Staffing Study Advisory Group also recommended that the Ministry consider opportunities to further expand the use of nurse practitioners. In October 2022, the Province announced an investment of $57.6 million over three years (2022/23–24/25) in a program to recruit and retain up to 225 additional nurse practitioners in the long-term care sector. The Ministry informed us that 66 full-time-equivalent nurse practitioners had been hired and retained through this program as of August 1, 2023, and confirmed that funding for nurse practitioners hired under this program will continue beyond the original funding end-date of March 31, 2025.

Therapists

Regulation requires every home to provide therapy services to residents, including on-site physiotherapy and occupational therapy. Despite the requirement, our analysis of 2022/23 data noted that 68% did not have an occupational therapist, 54% did not have a restorative aide and 12% did not have a physiotherapist or physiotherapy aide/assistant (see **Figure 16**). Some of these homes did not have any of these three AHPs to support the rehabilitation of residents at all.

Falls are a common cause of injury and emergency department admissions among long-term care residents. According to Ontario Health's system performance reporting, the percentage of long-term care residents who fell increased from 13.8% in 2012/13 to 16.2% in 2021/22, exceeding the provincial benchmark of 9%. Better access to physiotherapy and occupational therapy could potentially improve the trend, as research suggests that effective interventions from these therapies can help prevent falls in long-term care homes and can deliver other benefits to residents, such as improved physical performance and pain reduction.

Social Workers and Spiritual Support

Spiritual well-being and physical health are both important to quality of life. However, our analysis of 2022/23 data indicated that 39% of homes did not have a social worker or social service worker, and 72% of homes did not have religious or spiritual support staff (see **Figure 16**).

While some residents shared with us their positive experiences with the social workers, others indicated that they have never met one in their homes. For example, we noted the following from our visits to homes:

- Five homes did not have a social worker on staff at the time of our visit.
- Six homes had a vacancy in the social work department at the time of our visit. One of them had the position vacant for three months, during which the one remaining social service worker was overseeing the needs of over 170 residents. Another home had two full-time social workers remaining, overseeing the needs of 249 residents.
- One home had only one full-time position budgeted to meet the needs of 160 residents.

The homes we visited informed us that, as well as providing direct care to residents and communicating with their families, their social workers (or social

service workers) also perform a wide variety of tasks, such as reviewing applications, conducting home tours, putting together tour packages, and other administrative tasks as needs arise. One social worker we interviewed estimated that the amount of time they spent on tasks not involving direct care and communication with residents was approximately 55–60%.

In December 2022, the Province announced that it would be providing close to $20 million over three years (2022/23–24/25) to increase social support services for long-term care residents. The funding aims to support the provision of services, mainly by registered social workers and social service workers, toward a best-practice minimum of 30 minutes of care per resident every four weeks. Comparing the fourth quarter of 2022/23 to the previous year, long-term care homes reported an increase of 51 social workers and social service workers in total, which resulted in an increase of 5.8 minutes of direct care provided by these professionals every four weeks. As of September 2023, the Ministry does not yet have approval for funding to sustain this program beyond 2024/25.

Activity Directors or Activity Assistants

While regulation requires every home to have a designated lead for the recreational and social activities program, we noted that about 2% of homes still did not have an activity director or activity assistant in 2022/23 (see **Figure 16**). We also noted that the homes we visited differed in their recreation staff-to-resident ratio. Some homes had ratios as poor as 1:35 (1 staff person for 35 residents), which was three or more times worse than other homes with a ratio of 1:10 or better.

Various studies have stressed the importance of meaningful recreational activities for residents' quality of life and well-being. For example, a study published by the National Institutes of Health in March 2015 noted that having a choice of meaningful activities is important for improving residents' sense of independence and positive self-image. This study also mentioned past research, which found that nursing home residents with Alzheimer's disease demonstrated less agitated behaviours when activities were tailored to their skill level and interests.

RECOMMENDATION 2

To provide residents of long-term care homes with sufficient and timely access to allied health professionals (AHPs), we recommend that the Ministry of Long-Term Care:

- analyze hours of direct care by AHPs at the home level to identify homes with challenges meeting the target, work with those homes on strategies to improve their care hours, and monitor the outcomes of the strategies;
- monitor staff-to-resident ratios and determine whether certain key AHP services should be provided in all homes; and
- project future needs for different AHP services in long-term care and work with homes to develop plans to address potential shortages.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to analyze hours of direct care by AHPs, monitor staff-to-resident ratios, and project future needs for different AHP services.

The Ministry recognizes that allied health professionals (AHPs) provide a critical component of care to long-term care residents. The Ministry implemented targets in legislation for direct care by AHPs and is committed to supporting increases in direct care for residents in long-term care homes, not only through staffing funding but also funding for the Resident Health and Wellbeing Program. This program supports hiring more AHPs (for example, social workers and social service workers) into long-term care, and contributes to the AHP direct-hours-of-care target, and by extension to enhanced resident well-being. The Ministry is actively undertaking home and regional-level direct-hours-of-care analysis and will continue with that effort to better understand

where there are opportunities to increase direct-hours-of-care performance.

While there are some AHP services currently named in regulation (for example, physiotherapy), long-term care homes are best positioned to determine the appropriate staffing complement based on their own knowledge of the needs of the residents living in the home; the Ministry will continue to monitor staff-to-resident ratios to inform ongoing supports to the sector. The Ministry is committed to working with the sector to ensure the funding and regulatory framework for staffing enables long-term care homes to support meeting resident care needs and to address potential shortages. As part of work to develop and amend regulations under the *Fixing Long-Term Care Act, 2021*, the Ministry has made it easier for homes to hire from a broader pool of qualified staff while ensuring safety for residents. The Ministry is also involved in work to clarify and codify the important role that resident support personnel play as AHPs in homes.

4.3 Personal Support Workers Lack Regulation and Standardized Education

As noted in **Section 2.2.3** and **Figure 5**, personal support workers (PSWs) constitute the largest workforce in long-term care homes, making up approximately 60% of the homes' 85,000 direct-care staff. Although they carry out most of the day-to-day care, we found insufficient regulation of the PSW profession and inconsistencies in PSW education to help ensure the quality of care.

4.3.1 PSWs Are Unregulated with No Accountability Mechanisms for Standard of Care

Unlike most health-care professions (for example, physicians and nurses), PSWs are not regulated in Ontario or the rest of Canada; they are not licensed and their actions are not governed by professional practice standards or a code of ethics or code of conduct. There is no regulatory body for long-term care homes to report professional misconduct, incompetence, incapacity or harmful behaviour of PSWs, or for members of the public to make a complaint about a PSW, to ensure the consistent investigation and enforcement of disciplinary measures in all cases.

Homes we visited have terminated PSWs for misconduct or incompetence in the past. For example, several PSWs were terminated by a home when these individuals were found to be physically abusive to a nonverbal resident on multiple occasions by providing care in rough and undignified ways (such as pushing, pulling and grabbing) and unsafely repositioning the resident. Another home terminated a PSW for the individual's aggressive and emotionally abusive behaviour toward a resident and another staff member. In the absence of a regulatory body, it is easier for PSWs who display these problematic behaviours to move from job to job, and difficult for their future employers to know of the risks.

In June 2021, the *Health and Supportive Care Providers Oversight Authority Act, 2021* received royal assent, which led to the creation of the Health and Supportive Care Providers Oversight Authority (Authority) to serve as a new regulatory body providing oversight of PSWs. To date, however, the Authority has not performed any oversight activities because all of the legislation that enables the Authority to fulfill its mandate is not yet in force. But even if the legislation were fully enforced, the effectiveness of the regulatory regime remains uncertain because the legislation does not require PSWs to register with the Authority.

PSWs play a vital role in long-term care homes; it is important to have appropriate accountability mechanisms to ensure they deliver safe, competent, ethical and high-quality care to residents. Accountability mechanisms would also benefit the PSW profession as a whole by disciplining individuals who discredit the profession and removing them from the sector if necessary.

4.3.2 Some PSW Education Programs Did Not Provide Adequate On-the-Job Training

As stated in Ontario Regulation 246/22 (Regulation) under the *Fixing Long-Term Care Act, 2021* (Act), anyone who provides personal support services in long-term care homes must successfully complete a PSW program that meets the standards set by the Ministry of Colleges and Universities (MCU) and has a minimum duration of 600 hours. Neither the MCU's PSW program standard nor the Regulation has prescribed the delivery method or how program hours should be divided between class time and practical experience. In our review, we noted a high degree of variability among programs—both in the practical experience they provide and in the duration of the programs.

The issue of inconsistencies in PSW program offerings was identified in our Office's 2021 audit, *COVID-19 Preparedness and Management: Special Report on Pandemic Readiness and Response in Long-Term Care*. This special report noted that programs offered at community colleges ran for about 24–30 weeks and included 140–438 hours of practical experience; whereas programs offered at private career colleges ran for about 29–52 weeks and included approximately 350–400 hours of practical experience. Although the Act and the PSW program standard have been updated since the 2021 audit, we noted from our visits to homes that inadequate on-the-job training remains a concern. For example:

- One home has PSWs who studied predominantly through online courses. The PSWs exhibited poor communication skills when having difficult conversations with residents. More practical training would have better equipped them for the role.
- Another home indicated that the PSW educational curriculum does not offer sufficient training in soft skills, such as teamwork and customer service, which are essential for the role. More on-the-job training would allow PSWs to gain exposure to these skills before they start working in homes.

Homes we visited also informed us that more on-the-job training could have a positive impact on the preparedness of PSW graduates from the different programs and, consequently, on the quality of care that residents receive.

Long-term care homes are accountable for ensuring that the credentials of all their staff are meeting the legislated requirements. However, without a public registry of qualified PSWs or a published list of accredited PSW programs that meet MCU standards, it is difficult for homes to validate a PSW's credentials, given the variation in PSW programs offered by different institutions.

RECOMMENDATION 3

To help ensure that personal support workers (PSWs) are appropriately trained, professional, and accountable to the public, we recommend that the Ministry of Long-Term Care:

- fully launch the Health and Supportive Care Providers Oversight Authority and strengthen its oversight by requiring mandatory registration for PSWs who provide health or supportive care services in long-term care homes; and
- work with the Ministry of Colleges and Universities to review and amend the current education standards to make the proportion of in-class versus practical experience more consistent across PSW certificate programs offered by different institutions.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to fully launch the Health and Supportive Care Providers Oversight Authority and strengthen its oversight, and to work with the Ministry of Colleges and Universities to review and amend the current education standards.

The Ministry continues to work with the Ministry of Health as they lead the implementation of the new Health and Supportive Care Providers

Oversight Authority. Working in collaboration with the Ministry of Health, the Ministry will seek stakeholder feedback regarding the proposed education, training, and experience requirements to register with the new Oversight Authority. The Ministry may seek approval to amend its regulations, as needed, to ensure consistency with the Oversight Authority requirements and clarity for the sector. Long-term care homes will continue to be responsible for ensuring those working as PSWs meet the criteria outlined in regulation.

The Ministry acknowledges that consistency of educational requirements is vitally important to ensure personal support worker (PSW) graduates are appropriately prepared to work in long-term care. The Ministry will work with the Ministry of Colleges and Universities (MCU) as they amend the program standard in response to educational requirements developed by the Health and Supportive Care Providers Oversight Authority during MCU's future reviews.

4.4 Homes Struggled to Cope with Complex Behavioural Issues

Residents have varying levels of cognitive abilities. About 63% of residents have a dementia diagnosis (see **Section 2.1.2**), meaning most have at least some loss of cognitive functioning and loss of behavioural abilities, which could interfere with daily life and activities. A considerable number of residents (12%) also have a mental health history of psychiatric illness or developmental disability.

4.4.1 Responsive or Aggressive Behaviours Remain Prevalent in Long-Term Care Homes

Responsive behaviours are actions, words and gestures presented by people in response to something negative, frustrating or confusing in their social and physical environment. These behaviours are common among people living with dementia, complex mental illness, substance use and/or other neurological disorders. Examples of responsive behaviours include, but are not limited to, hitting, pushing, throwing things, biting, hurting oneself or others, pacing/wandering, general restlessness, screaming, sexually expressive behaviours and repetitive sentences or questions.

Responsive behaviours are prevalent in long-term care homes, given the high percentage of residents with dementia and mental disorders. A 2021 paper published by the Journal of Long-Term Care studied residents from 1,319 long-term care facilities across Canada, spanning a 16-year period from 2002 to 2018, and found that the rates of severe aggressive behaviours were more than three times higher among residents with dementia and/or mental disorder compared to those without either diagnosis.

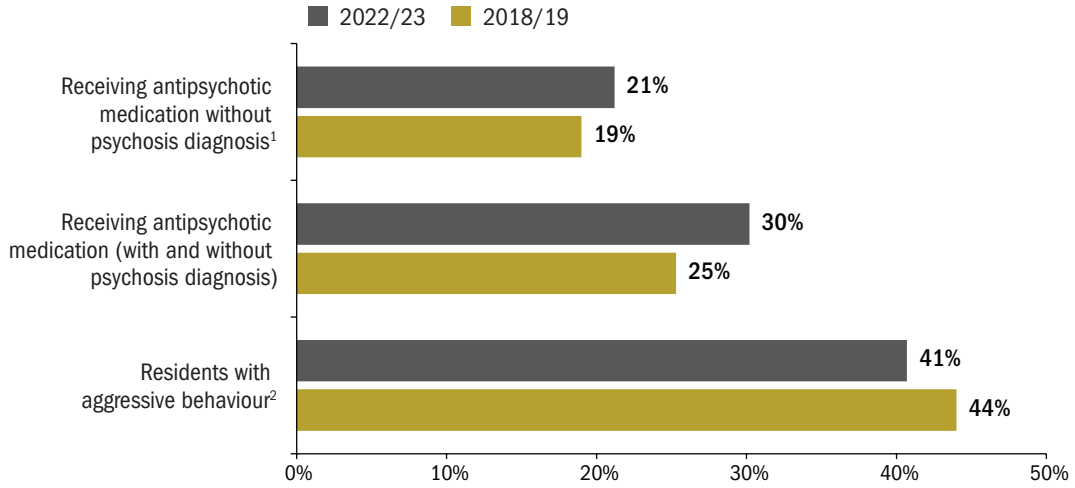
Based on our review of data from the Canadian Institute for Health Information (CIHI), the percentage of long-term care home residents with aggressive behaviours has fluctuated slightly over the last five years (2018/19–22/23) but remained high, ranging from 41% to 44% (see **Figure 17**).

The regulation requires every long-term care home to have strategies and plans developed to meet the needs of residents with responsive behaviours. However, many homes we visited indicated that managing responsive behaviours continued to be a challenge due to limited access to resources and supports (see **Section 4.4.3**) and increasing mental health issues (see **Section 4.6.2)**, and that these behaviours sometimes threatened the safety or well-being of others. For example:

- A resident's responsive behaviours escalated, resulting in a Code White (a code for violent behaviour) when staff determined that the behaviours were becoming an endangerment to the individual and others and causing destruction of property. Emergency services and police were called on scene. Following the incident, the resident continued to exhibit aggressive behaviours, both verbally and physically.
- A resident, who had an increase in physical expressions and was verbally abusive (including

Figure 17: Percentage of Residents with Aggressive Behaviour and Residents Receiving Antipsychotics, With or Without a Diagnosis of Psychosis, 2018/19 and 2022/23

Source of data: Canadian Institute for Health Information



1. The percentage excludes residents with a diagnosis of schizophrenia or Huntington's chorea, experiencing delusions or hallucinations, with an end-stage disease, or receiving hospice care.
2. The percentage includes all residents with an Aggressive Behaviour Scale score higher than zero (zero indicates no aggressive behaviour).

expressing threats of violence), attacked another resident twice within a week, resulting in the other resident becoming fearful of leaving the room. As a result of these incidents, the home had tried to transfer the resident to an alternative community-based facility. However, the transfer process was challenging, as the resident refused to complete an assessment for the transfer.

- A resident sexually harassed other female residents. The home referred the resident to a hospital's inpatient adult mental health program, but the referral was declined as the resident was not meeting the program's criteria for admission. The program acknowledged the home's difficult situation, but indicated that it could not take urgent acute cases directly from the community—including long-term care homes. The program would only accept patients transferred from a designated psychiatric hospital if they were deemed treatment resistant.
- A resident yelled at and hit staff and refused to let anyone touch her, making it difficult for staff to provide personal care assistance, such as changing incontinence products.

4.4.2 Antipsychotic Drug Use Raised a Potential Quality-of-Care Concern

Antipsychotic drugs are used to manage symptoms of psychosis, but are also prescribed for residents to manage severe behavioural and psychological symptoms of dementia. As noted in the 2021 study published by the Journal of Long-term Care (see **Section 4.4.1**), the use of psychotropic drugs (including antipsychotics) may have contributed to residents being asleep for most of the day, keeping their activity and social engagement levels low. Other studies also showed the side effects and dangers of using antipsychotic drugs, which include an increased risk of falls and fractures in older adults.

As shown in **Figure 17**, we noted that use of antipsychotic drugs in long-term care homes has increased over the last five years (2018/19–22/23). Specifically, in 2022/23, 30% of residents were on antipsychotics (up from 25% in 2018/19) and 21% of residents were on antipsychotics without a diagnosis of psychosis (up from 19% in 2018/19), which still slightly exceeded the provincial benchmark of 19% set for these cases. This raises a concern as to whether these drugs are sometimes used inappropriately, especially when the percentage of residents with aggressive behaviours has

declined over the same period (from 44% in 2018/19 to 41% in 2022/23).

Our observation is in line with a study published in Health Services Insights in May 2023, which also raised the question of whether antipsychotics were used pre-emptively in anticipation of challenges during outbreaks and staffing shortages. The study showed that the percentage of residents on antipsychotics without a diagnosis of psychosis also increased during the COVID-19 pandemic in other provinces, including Alberta, British Columbia and Manitoba.

4.4.3 Homes Had Limited Access to Behavioural Support Resources

The ability of long-term care homes to prepare and care for residents with responsive behaviours could be affected by a number of factors, such as the level of staffing, the adequacy of staff training and the availability of dedicated resources for behaviour supports.

Low Staffing Level

As discussed in **Section 4.1.1**, staff-to-resident ratios are not regulated and vary across homes. A home we visited estimated that, with a 1:8 staff-to-resident ratio in the morning, a personal support worker (PSW) could only spend approximately eight to 10 minutes on average to get each resident ready for breakfast within a two-hour window, excluding the time spent on charting and documenting the care provided. This means that within eight to 10 minutes, the staff would have to wake the resident and help the resident use the bathroom (or change their diaper), brush their teeth and get dressed.

Given the current cognitive and physical state of residents, some residents would benefit from or need more one-to-one care. It can be difficult to properly care for residents within the time available, let alone deal with a sensitive population of residents who have more severe behavioural issues. This becomes even more challenging for homes with poorer staff-to-resident ratios, which we observed to be as severe as 1:10 in the morning shift in the homes we visited. For example, a home indicated that it could take up to three staff to provide care for one of its residents, as the resident would resist and react aggressively to care. This had left staff members with less time to attend to the needs of other residents.

Lack of Staff Training/Education

Homes we visited agreed that more in-person, practical training is beneficial because work performed in long-term care homes can be very hands on, which makes in-person training more effective. However, a widespread shortage of resources in the sector (see **Section 4.1.1**) has prohibited homes from providing more in-person training. Homes advised us that it was challenging to find the backfill support necessary to free up staff on the floor to attend training. Of the homes we visited, all have provided some level of training, but the training was mostly provided online, with at least two homes offering only online training.

With over 40% of residents exhibiting aggressive behaviours, it is important that staff at long-term care homes are sufficiently trained to identify behavioural triggers and to manage such behaviours, including ways to communicate with residents. We identified some examples from homes we visited, where resident care could have been enhanced with more training:

- A staff member declared a Code White (a code for violent behaviour) immediately when a resident with severe dementia slammed the table, which triggered an emergency procedure. The supervisor at the home suggested that staff might be able to recognize behavioural clues earlier and prevent the behaviour (or de-escalate the situation differently) if the staff received more training on dealing with residents with severe dementia.
- A resident with a long history of schizophrenia and bipolar disorder would become agitated and verbally abusive towards staff, and staff were unable to manage those behaviours with the same strategies they used to care for residents with dementia. The home felt that it would be beneficial for staff members to receive training on mental disorders and mental health.

- A staff member attempted to stop a resident from entering other residents' rooms, but was unsuccessful and sustained injury as a result of the resident's responsive behaviour. The home indicated that it would be beneficial if the staff had been trained with gentle persuasive techniques.

Limited Beds in Behavioural Specialized Units (BSUs)

The Ministry of Long-Term Care (Ministry) has established Behavioural Specialized Units (BSUs) within some long-term care homes. These units specialize in caring for those with complex behaviours by providing increased staffing, a tailored environment, focused behavioural assessment and enhanced care planning. While each BSU has its own unique admissions criteria designed to align with local needs, in general, BSUs are meant to provide transitional care support for new or existing long-term care residents who have responsive behaviours that cannot be managed in the regular long-term care environment. Residents in BSUs are expected to return to their regular long-term care home setting once their behaviours have stabilized and the extra care requirements gradually taper off.

There were 307 BSU beds in the province as of March 31, 2023. As shown in **Figure 18**, these beds had 94 individuals on wait lists as of March 31, 2023, and a median placement time that ranged from 24 days to 223 days in 2022/23, depending on the region. Aside from those on the wait list, we noted that 142 BSU bed applications were rejected in 2022/23 for reasons such as a lack of nursing expertise or physical facilities needed to provide the care. Ontario Health also informed us that some residents that would benefit from a BSU bed may not be added to the wait lists as the wait is too long.

Homes we visited had varying experiences with the application process. For instance:

- One home applied for BSU beds twice, with each application rejected after the BSU reviewed the resident's behavioural assessment. According to this home, one BSU indicated that it was not suited to care for the resident, who expressed physical aggressions and was previously involved in two critical incidents. Another BSU indicated that the resident was difficult to redirect, required several staff to assist, was impulsive and reacted with aggression when feeling threatened. These rejections raise a question about the accessibility of BSUs and their ability to provide specialized care to those with complex behaviours.
- One home indicated that it attempted to apply for a BSU bed several years ago, but none were

Figure 18: Beds in Behavioural Specialized Units (BSUs) in Long-Term Care Homes, and Wait Lists and Placement Time by Region

Sources of data: Ontario Health and Home and Community Care Support Services

Region	BSU Beds (#)	Individuals on Wait List as of March 31, 2023 (#)	Individuals Placed in 2022/23 (#)	Median Time to Placement in 2022/23 (days)*
Toronto	86	24	11	223
West	70	5	52	27
Central	65	35	72	28
East	46	25	32	40
North West	32	1	18	24
North East	8	4	3	87
Total	**307**	**94**	**188**	

* Median time to placement is provided by the region.

available. The home ended up managing the resident with involvement from the resident's family.

- One home indicated that it never applied for a BSU bed for its residents, as its understanding was that the process could be lengthy.

Our review of the eligibility criteria of six out of 14 BSUs in operation as of March 31, 2023, also noted that the criteria are restrictive. While there are variations across BSUs, all of them require applicants to be medically stable, have a diagnosis of dementia, and exhibit responsive behaviours that are challenging or cannot be managed in the current environment. Some BSUs have explicitly excluded individuals with active substance abuse or whose behaviours are primarily caused by brain injury, mental illness or a neurological condition. Although long-term care homes have a large population of residents with dementia, they also care for residents with other conditions, such as mental illness, substance use disorder and neurological illness, which are especially common among younger residents (refer to **Section 4.6**). By restricting admission to only those diagnosed with dementia, BSUs are not accessible to certain residents whose responsive behaviours cannot be managed in the standard long-term care environment, and homes are left to deal with the behaviours of these residents with their limited resources.

The Ministry is working with Ontario Health to expand BSU capacity and expects that approximately 70 new BSU beds will be added in 2023/24, with an allocated funding of $5.5 million. However, with 41% of long-term care residents having aggressive behaviours (see **Figure 17**) and with over 6,000 residents assessed with more severe aggressive behaviours, there is a risk that the number of BSU beds is still inadequate to meet the needs of the population, even with the additional beds.

Lack of Dedicated Behavioural Support Resources

In 2010, the then Ministry of Health and Long-Term Care launched an initiative called Behavioural Supports Ontario (BSO), through which homes receive funding to hire dedicated staff to support the home in caring for residents with complex and responsive behaviours. While the homes we visited viewed BSO staff as valuable resources, funding for those positions is only provided to homes that Ontario Health has identified in its BSO action plan. Over one-third of the homes we visited were declined funding for BSO staff. Although resources such as mobile BSO support services are available on an as-needed basis in the regions where these homes were situated, the homes indicated that in-house support would provide greater benefits due to the ongoing behavioural issues of residents.

While long-term care homes also have access to a variety of regular or referral-based external behavioural supports (such as psychiatric evaluation and medication recommendation for residents) through partnerships with hospitals or other community resources, we noted from our visits to homes that most homes did not always have adequate or timely access to these services. For example:

- A home with over 150 residents had a psychiatrist visiting the home only once a month, through the Psychiatrist Outreach Program in its local health network. To supplement this, the home paid to contract a geriatric psychiatrist to visit the home once a month to obtain more specialized service.
- A home had access to the Behavioural Support Services in a hospital, which would assign a nurse and PSW team to perform onsite observation and provide recommendations on non-pharmacological interventions (that is, not involving the use of medications) to help the home manage residents' behaviour. However, it could sometimes take a few months for a team to be assigned to the home, depending on the availability of resources.
- A home accessed a hospital's senior mental health behavioural program for two residents, but the wait time was approximately nine to 10 months.

RECOMMENDATION 4

To help ensure that long-term care homes are able to manage responsive and aggressive behaviours of residents, we recommend that the Ministry of Long-Term Care work with Ontario Health to:

- monitor staff-to-resident ratios for residents with more severe responsive behavioural issues;
- consult with homes to identify gaps in behavioural support resources for long-term care (including resources within homes, external support networks, and behavioural specialized units at both the regional and home level), and develop and implement action plans to address the gaps; and
- provide centralized expertise and a forum for homes to share ideas and practices related to behavioural management.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to monitor staff-to-resident ratios for residents with more severe responsive behaviour issues, and consult with homes to identify gaps in behavioural support resources for long-term care.

The Ministry recognizes the importance of helping to ensure long-term care homes are able to effectively support residents with responsive behaviours. The Ministry has invested in high-quality, innovative programs that provide appropriate care to residents with responsive behaviours, including Behavioural Supports Ontario (BSO) and through behavioural specialized unit beds. In addition, to enable centralized supports for BSO services, the Ministry has invested in the operation of the BSO Provincial Coordinating Office (PCO). BSO PCO helps to bring together BSO teams of specialized staff to share best practices and develop practical clinical tools for long-term care staff.

The Ministry also initiated the Local Priorities Fund to enable Ontario Health to make investments in targeted specialized staffing, equipment and supports aimed at removing barriers to alternate level of care in the respective regions. This includes funding for staff training regarding patients with dementia in order to support overall quality of life for residents and reduce the risk of behaviours that could lead to hospital transfer. Separately, the Ministry's High Intensity Needs Fund supports the costs for residents with acute or intensive service needs. This includes funding for supplementary staffing required as a result of ongoing or emerging responsive behaviours and funding for preferred accommodations.

Ontario Health, in partnership with long-term care homes, is best positioned to determine the appropriate BSO staffing complement based upon in-depth knowledge of the needs of residents living in the home and on available investments. The Ministry will continue to monitor BSO staffing mix ratios to inform ongoing supports to the sector and will continue to work with Ontario Health, long-term care homes and other sector partners to identify best practices for maximizing available investments, as well as gaps and opportunities for improved supports for residents who exhibit higher risk, aggressive responsive behaviours.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Auditor General's recommendation. Ontario Health coordinates and integrates several programs that support long-term care homes to manage residents with responsive and aggressive behaviours, including Behavioural Supports Ontario (BSO), Behavioural Support Units (BSUs), the Local Priorities Fund, and High Intensity Needs Fund.

Ontario Health will continue to work with the Ministry and system partners (for example, the BSO Provincial Coordinating Office) and local BSO lead organizations to implement programs and identify mechanisms to share best practices and ideas to support homes in providing care for individuals with responsive behaviours, ensuring quality care

and safety for all residents, in alignment with provincial investments. The target completion date is March 31, 2026.

4.4.4 Incomplete, Inaccurate or Outdated Information about New Residents Hindered Preparation by Homes

Before accepting an admission, long-term care homes receive information about the applicant from Home and Community Care Support Services, which includes health, functional, behavioural and other supplemental assessments as appropriate. However, homes we visited informed us that assessments regarding the applicant's behaviours were not always complete or accurate. For example, certain behavioural issues were not mentioned, and information fields on behaviour triggers could be left blank.

Homes we visited also informed us that the assessments do not always capture the applicant's current condition, as they could be completed up to three months before the authorization of admission. During the three-month period, there can be changes to the applicant's care needs due to advanced age and comorbidities. Although a reassessment is supposed to be completed whenever an applicant's condition has changed significantly, this depends on whether the placement co-ordinator, the applicant, or the applicant's primary care provider, caregiver or substitute decision-maker would initiate it.

Incomplete, inaccurate or dated assessments can hamper a home's ability to prepare for the arrival of new residents. For example:

- A resident's pre-admission assessment did not indicate any wandering or exit-seeking behaviour and so the resident was initially admitted to a non-secure unit at the home. However, soon after admission, the resident wandered away from the home twice within a month, resulting in two critical incidents reported to the Ministry. As a result, the home had to move the resident to a secured unit. The resident's family subsequently informed the home that the resident did exhibit exit-seeking behaviour in the previous home.
- One home noted that an applicant's pre-admission behavioural assessment indicated that the applicant had no explicit behaviours. However, upon admission, it was clear that the resident was verbally and physically aggressive, prompting the home to change plans and move the resident to a high-intensity care room. Had the behaviours been more accurately described in the pre-admission assessment, the home indicated that it could have planned ahead and been better prepared to provide high-intensity care.

Transitioning into long-term care is especially difficult for those living with dementia, and their behaviours could escalate during the initial period of home admission. Having incomplete or inaccurate assessments would only increase the stress on both the residents and staff during the transition period, and should be prevented.

RECOMMENDATION 5

To help ensure that long-term care homes are well informed of the condition of prospective residents in preparation for their admission, we recommend that the Ministry of Long-Term Care work with Home and Community Care Support Services and with homes to review the pre-admission assessment process; determine whether changes can be made to improve the completeness, accuracy, consistency and timeliness of information provided to homes; and then to implement the necessary changes.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to work with Home and Community Care Support Services and with homes to review the pre-admission assessment process and to implement the necessary changes.

The government released Your Health: A Plan for Connected and Convenient Care (the Plan), which aims to connect people in Ontario to the health care they need, when they need it. Through the Plan, Ontario will modernize home care and provide connected care through Ontario Health Teams to support the right care in the right place.

The Ministry recognizes the need to modernize admissions and placement processes to make it more transparent, more user friendly and less burdensome, and has initiated a review of current assessment tools. This work will include engagement with the Ontario Medical Association and Home and Community Care Support Services to inform work that will ensure the tools contain relevant information related to long-term care applicants' health conditions and care needs, in order for homes to assess if they have the nursing expertise as well as facilities to support the admission of applicants. In addition, the government is proposing to develop a new agency—Ontario @ Home—that, if passed, will assume the responsibilities of long-term placement.

4.5 Long-Term Care Sector Was Not Responsive to Cultural Needs of Residents

Ontario's population is highly diverse. According to the 2021 census by Statistics Canada, for example, about 34% of Ontario's population is made up of members of visible minorities, about 30% are immigrants and about 3% have an Indigenous identity. With a resident mix resembling the diverse population of the province, there is a high demand for culturally sensitive long-term care services in Ontario.

Cultural accommodation is important for improving the quality of life for long-term care residents. One important aspect of cultural accommodation is food. Research shows that culturally appropriate meals can encourage residents to eat and drink, which in turn reduces the risk of malnutrition and unintended weight loss. Another important consideration is care in the residents' own language. Communication is essential for one's social life, and people with dementia often lose command of their second language and revert to their mother tongue as their condition intensifies. Culturally appropriate care is also an important element in palliative care. For example, different cultures can have differing ideas of the meaning of life and death, as well as differing involvement of friends and family in care. Stakeholders in long-term care recognize culturally appropriate palliative care as an aspect that needs improvement in long-term care.

Despite the obvious benefits of culturally sensitive care, we found that Ontario's long-term care sector has gaps in delivering such care to those who need it.

4.5.1 Culturally Specific Long-Term Care Homes Are Limited Across the Province

Out of 626 long-term care homes across the province, there are currently 57 designated homes (or about 9%) across the province focused on serving specific ethnocultural groups (for example, Indigenous, Chinese, Finnish, French, Greek, Italian and Ukrainian) or religious groups (for example, Christian, Catholic and Jewish). We visited three ethnocultural homes during the audit and observed various ways in which these homes create a familiar environment for their residents of specific ethnicity. For example:

- A majority of staff members speak the residents' native language or share the same culture as the residents. At one of the three homes we visited, over 95% of staff spoke the native language of residents.
- Signs and information, such as recreational calendars, are posted in the residents' native language.
- Menus are designed to suit the tastes of their residents and reflect their cultural heritage—for example, serving traditional Eastern European and Asian meals daily.
- Elements of the residents' culture are incorporated in activities, with activities conducted in the residents' native language.

- The residents' cultural background is incorporated into the home's décor, television programs and music.

Ethnocultural homes are popular among ethnic communities and tend to have much longer wait times. Our examination of placement data noted that the median wait time for an ethnocultural home was up to 1,843 days (or approximately five years) in 2022/23. This is significantly longer than the provincial median time for placement into a long-term care home, which ranged from 50 days to 223 days in 2022, depending on the region. The long wait times clearly illustrate the popularity of these homes and an insufficient supply to meet the demand—especially since the introduction of the *More Beds, Better Care Act, 2022* to facilitate the flow of alternate level of care (ALC) patients from hospitals to long-term care homes (refer to **Section 4.7**).

Our analysis of regional demographics and long-term care homes noted that, while certain regions have a high concentration of particular ethnic groups, there are no ethnocultural homes in those areas to serve that need. For example, based on 2021 Census data, Peel Region has a high concentration of South Asians (about 14%), but there are no ethnocultural homes in that region designated to support South Asian residents. There is currently one capital development project, comprising 97 new beds and 159 redeveloped beds, planned for this region to meet the needs of the South Asian community. As of September 2023, the project is in the early planning stage and a completion date is not available.

Two international reports, issued in 2011 and 2015, have compared the effect of ethnocultural and mainstream homes on ethnic-specific residents. Both papers found that those living in ethnic-specific homes perform better physically and mentally (for example, exhibiting a less stressful transition into long-term care, more interactions with other residents, higher morale, and lower prescription rates for antipsychotic medication). To date, the Ministry has not completed an analysis of the quality of care, approach to care, and impact on residents of ethnocultural homes versus mainstream homes in Ontario. Such an analysis would provide an opportunity for the Ministry to identify best practices that could be shared across homes to improve care for culturally diverse populations.

The Ministry also has not assessed whether the supply of long-term care homes meets the needs of Ontario's diverse population, considering factors such as ethnicity, cultural heritage, and sexual and gender diversity, among others. Socio-demographic data of existing long-term care residents is limited and does not show where residents of different backgrounds are living.

4.5.2 Level of Cultural Accommodation Varied Across Mainstream Homes

Though having more long-term care homes catering to specific ethnic, cultural or religious groups would be ideal, it is not feasible to have a home for every ethnocultural or religious community in Ontario. A diverse resident population is a reality that mainstream homes have to manage. For example, in one of the homes we visited in the Greater Toronto Area, 20 different languages were spoken by residents. Mainstream homes should be sensitive to the diverse languages and cultural needs of their residents.

We noted from our visits that non-ethnocultural and non-religious homes adopt cultural accommodations to varying extents. For example, some homes use cue cards, sign boards, electronic translation applications or translation by volunteers to overcome communication barriers, and get help from family members to take residents to religious services. Knowledge could be shared among homes to improve care for a culturally diverse population.

We also noted that the need for, or importance of, cultural accommodation in long-term care homes, especially for food, has been raised by homes and stakeholder groups in the past. For example, in October 2016, Toronto City Council requested that the provincial government develop a separate, case-specific funding mechanism for the provision of cultural and religious meals in long-term care homes, in support of the 10 city-operated homes that serve a very diverse

resident population. A similar recommendation was made in 2016/17 by AdvantAge, a provincial association representing not-for-profit homes and services for seniors. Since 2016/17, the Ministry has increased funding to the Nutritional Support category—from $8.33 per resident per day to $12.07 per resident per day (see **Section 4.8.1**). However, the recommendation for a separate funding mechanism to provide cultural and religious meals has not been directly addressed. We noted from our visits to homes that mainstream homes sometimes have difficulty creating meal plans to meet the requests and cultural preferences of individual residents.

RECOMMENDATION 6

To help ensure that long-term care homes are able to care for the culturally specific needs of a diverse resident population, we recommend that the Ministry of Long-Term Care:

- analyze the supply and demand of culturally specific homes in Ontario, factoring the results of the analysis into long-term home development planning; and
- work with long-term care homes to identify best practices for culturally sensitive care and provide homes with guidance for developing practical improvement plans (for example, in the areas of staff training, communication technology investments, and engagement of community and religious organizations).

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to analyze the supply and demand of culturally specific homes in Ontario, and work with long-term care homes to identify best practices for culturally sensitive care.

As of November 2023, the Ministry is working with the sector on more than 100 capital projects that propose to serve the needs of Francophone, Indigenous and other culturally specific populations. The Ministry will continue to work with the Ministry of Health and Ontario Health, as well as key sector stakeholders, to assess the capacity needs of the long-term care sector to support an informed approach to system planning within the broader health sector, including the need for services and supports that meet the diverse needs of residents.

Furthermore, the Ministry funds the Centres for Learning, Research and Innovation to educate and train current and future long-term care staff in areas including cultural competency and equity, diversity and inclusion. The Ministry is also exploring the opportunity to establish a Long-Term Care Quality Centre that could support homes by identifying and sharing best practices for culturally sensitive care, so that residents can benefit from culturally appropriate care and services.

The Ministry is committed to goals that advance long-term care services that better meet the unique histories, perspectives and needs of residents. Consistent with this goal, Ontario enacted the *Fixing Long-Term Care Act, 2021*, which included more closely aligning the language in the Residents' Bill of Rights with the grounds of discrimination in the Ontario Human Rights Code; and palliative care requirements were expanded to reflect a more holistic approach that accounts for residents' physical, emotional, psychological, social, cultural and spiritual needs. In addition, ongoing initiatives, including the development and redevelopment of long-term care homes, are enhancing programs and services for long-term care residents.

4.5.3 Prospective Residents with Cultural Needs Lacked Information About Long-Term Care Options

We found that prospective long-term care residents from diverse backgrounds do not have sufficient information to make their home choices.

The Ministry does not publicly list long-term care homes by ethnicity or by the particular group or community served (for example, with respect to religion or sexual and gender diversity), and the Ministry website does not support the filtering of homes by any characteristics other than home name, home address (complete or partial) and user location.

Ontario Health reports on the performance of long-term care homes across the province on its website, using a number of quality indicators—for example, residents who fell, were physically restrained, had pressure ulcers, experienced pain, or had worsened symptoms of depression. Although data on each home is available on the website, it is not easy to compare performance across homes. Each time, users of the website can only select a maximum of five homes for comparison against the Ontario average, indicator by indicator.

RECOMMENDATION 7

To help ensure that prospective long-term care residents from specific cultural groups or communities have access to essential information for home selections, we recommend that the Ministry of Long-Term Care work with Ontario Health to enhance features on their websites by publishing the list of culturally specific homes by type of community served (for example, ethnicity, religion, sexual and gender diversity) and allowing for filtering by home characteristics and performance.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to work with Ontario Health to enhance features on their websites by publishing the list of culturally specific homes by type of community served and allowing for filtering by home characteristics and performance.

Transparency and ease of access to information are of utmost importance to prospective long-term care home residents and their families. The Long-Term Care Home Finder tool, launched in 2022, enables people to find and compare long-term care homes across the province and provides other resources to help people make an informed choice when considering long-term care. The Ministry recognizes that making even more information available will help prospective residents and their family members make informed decisions and is committed to working collaboratively with Ontario Health and other partners, as needed, to ensure websites can support prospective long-term care applicants in searching for culturally specific homes by type of community served.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Auditor General's recommendation. Ontario Health will work in collaboration with the Ministry and other partners, as needed, to support easier access to information about ethnocultural homes.

4.6 Homes Were Not Fully Able to Serve Younger Residents

Most people think that long-term care homes are only for the elderly. But long-term care homes provide a residential alternative for individuals 18 years of age or older who have a valid Ontario health card and have high care needs that cannot be met with any combination of caregiving in their own home or community. As of 2022/23, about 6,200 (6.3%) of the residents in long-term care homes were under the age of 65, including some who were around 20.

Younger people need to be in long-term care because they suffer various conditions that affect their ability to care for themselves, such as brain injury, stroke, physical disability, mental illness or developmental disabilities. Although younger residents are a minority in long-term care homes, it is important that their needs are satisfied. The *Fixing Long-Term Care Act, 2021* (Act) prescribes that every resident has the right to an optimal quality of life.

4.6.1 Homes Lacked Age-Appropriate Supports for Younger Residents

While long-term care homes have the skills to care for the physical needs of younger residents, the environment and recreational programs do not always provide these residents with the stimulation and social surroundings that are vital to a good quality of life—especially for those with better cognitive ability.

Various studies conducted in long-term care homes have demonstrated that social connection is linked to both mental and physical health outcomes, which in turn impact residents' quality of life. However, in a population that is made up predominantly of seniors (over half are 85 years or older and many have dementia), it is difficult for younger residents to develop social relationships and cultivate connections with fellow residents.

Also, younger residents often do not have access to age-appropriate recreation and leisure programs, as the programs at long-term care homes primarily cater to the senior residents. For example, activities like bingo, Elvis-themed music activities, and movies from the 60s are popular in the homes we visited, while activities catering to younger residents—such as outings to movies and shopping centres—are limited. Homes also informed us that community resources that help connect younger residents to age-appropriate activities and peers of similar age are also limited.

We identified cases at the homes we visited where the social, recreational and intellectual needs of younger residents could not be met by the programs at the home. For example:

- A home had only two residents (1%) under the age of 60. One of these residents, around 20 years of age with a brain injury, enjoyed attending a community program to socialize with peers closer to the resident's age. However, the resident required supervision to attend the program and could only afford one such supervised trip per month. The home and the resident's family were trying to find ways to send the resident to these events more often.
- A home had a younger resident, around 50 years of age with a memory disorder, who would need more activities and stimulation geared toward that age group. However, younger residents in this home were offered the same programming as the rest of the, more senior, population. While the resident participated in swimming activities outside the home, these were set up by the resident's family.
- A 35-year-old resident with cerebral palsy required nursing care but was cognitively intact and could converse very well. From the home's perspective, the resident could benefit from living in a group home, as group homes provide a supervised living environment designed to offer care (including daily living assistance and medical services) in a more intimate setting than a long-term care facility can provide.

4.6.2 Younger Residents with Aggressive Behaviours Posed Safety Risks to Frail Residents

Responsive or aggressive behaviours are not only common among people living with dementia, but also displayed by some of those with complex mental illness, substance use disorder or neurological issues—conditions seen in the younger population in long-term care homes. Some homes we visited noted that they are seeing more younger residents with mental illness and/or addiction issues.

We observed a wide age range among residents living in some long-term care homes. For example, in one of the homes we visited, the youngest resident was 35 while the oldest was 100. According to the Act, it is the home's responsibility to ensure the safety and security of all residents. However, maintaining the security of residents over 65, who tend to be frailer due to age, can be difficult when they are cohabitating with younger residents who exhibit aggressive behaviours.

While it is challenging for homes to manage responsive behaviours as a whole (see **Section 4.4**), it is even

more challenging when younger residents who are physically strong are involved in altercations. As one home put it: "how can you protect a 90-year-old confused resident from a 55-year-old physically capable person if that person turns aggressive?"

We noted cases in the homes we visited that illustrate the challenge in managing the behaviours of younger residents with a history of mental illness, addiction or autism. For example:

- A home had a younger resident under the age of 65, who was diagnosed with early dementia and appeared to have an alcohol problem in the past. Unlike other seniors in the home, the behaviour of this resident was unpredictable, without warning signs, and staff were not able to figure out the trigger. The resident punched and kicked a staff member and pushed another resident on different occasions. The resident was eventually released as the home was not suitable to provide care.
- A home has a younger resident, who is about 40 years of age, is cognitively intact and has a history of heavy drug use. The resident was sent to the hospital for psychiatric evaluation as the individual was threatening to commit suicide and also made threats to staff members and distressed other residents. The resident was discharged from the hospital within 48 hours. The resident does not like being at a long-term care home and is waiting for a group home, with an estimated wait time of five to seven years.
- A home has a younger resident in their mid-40s, who was sent to hospital due to intoxication and suicidal ideation. The resident was previously involved in an incident where the individual had slapped the head of another resident who was over 80 years of age, for which a Code White (a code for violent behaviour) was declared and police were notified.
- A home was scheduled to provide respite care (that is, short-term caregiver relief) for an autistic resident, about 20 years of age, for two weeks. However, the home had to send the resident back to the primary caregiver after a couple of days as a staff member was severely assaulted. The home indicated that staff were not trained to care for someone with moderate to severe autism (see **Section 4.6.3** for further discussion on autistic residents).

Homes indicated that they are not equipped to manage the aggressive behaviours of younger residents because education and training for staff at long-term care homes are geared toward providing care for seniors with dementia. Because staff have less training about mental illness, drug addiction or autism, they are not as proficient in caring for younger residents with these conditions. For example, individuals suffering from these conditions could have different behavioural triggers than those with dementia, which staff might not be able to identify and address due to lack of training and experience. Staff also lacks the skills to interact with these residents.

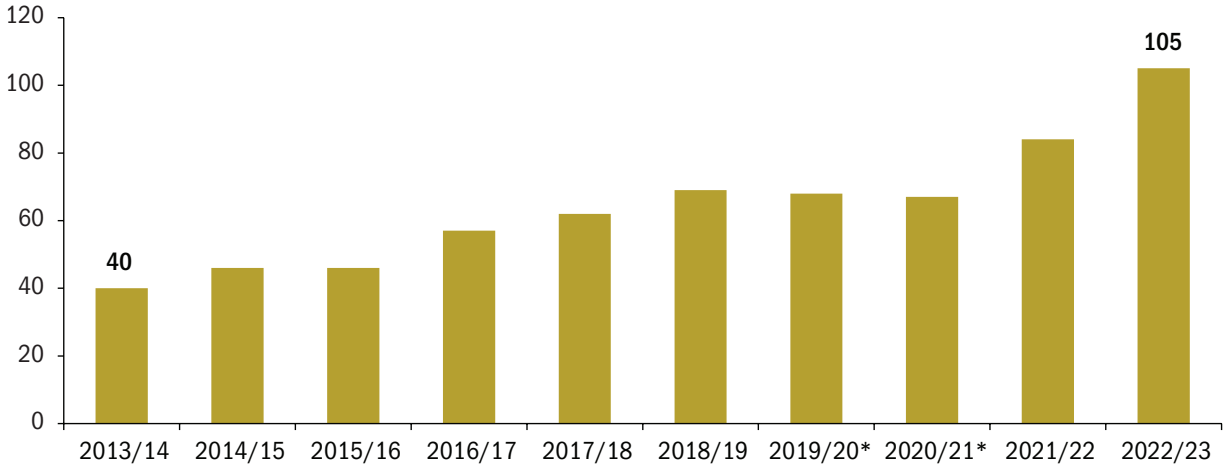
We also noted that homes have limited external resources to help them manage behavioural issues among younger residents, especially those with mental illness or addictions. The Behavioural Supports Ontario (BSO) initiative supports long-term care homes (refer to **Section 4.4.3**), but focuses on older adults. Many homes are also linked to psychogeriatric or senior mental health resources, which generally do not accept referrals for residents under the age of 65. While psychiatric hospitals are able to accept younger residents, obtaining timely access is a challenge due to strict eligibility or admission criteria.

4.6.3 Long-Term Care Staff Lacked Knowledge and Skills to Care for Autistic Residents

In analyzing the changes in resident profiles in Ontario's long-term care homes over time, we noted that the number of autistic residents has increased by approximately 162% over the last decade, from 40

Figure 19: Number of Autistic Residents in Long-Term Care Homes, 2013/14–2022/23

Source of data: Ministry of Long-Term Care



* Data for 2019/20 and 2020/21 may be incomplete because data submissions to the Continuing Care Reporting System were postponed during the COVID-19 pandemic.

in 2013/14 to 105 in 2022/23 (**Figure 19**). While these residents remain a minority within the total population of long-term care homes, no other physical or mental characteristics have had such a significant increase among residents over the same period.

This increasing trend aligns with findings from the 2019 Canadian Health Survey on Children and Youth, which indicated that approximately one in every 50 Canadian children and adolescents is autistic and that the rate has continued to rise over time. While autistic individuals are mostly cared for by their parents during their childhood and throughout adolescence, external support and care are needed for some individuals as their parents age or die. Hence, some younger autistic people end up living in long-term care if they require 24/7 care.

While there is a wide spectrum in the type and severity of symptoms, many autistic individuals have communication problems, difficulty with social interactions, a tendency to repeat specific patterns of behaviour and a restricted range of activities and interests. Many also have co-occurring health conditions, such as sleep disorders and other mental health issues. Hence, caring and planning activities for autistic residents can be challenging.

Homes we visited acknowledged that they do not have enough trained staff to properly care for autistic residents, who are small in overall numbers but high in specific needs. For example, one home indicated that with only one recreational staff person to plan and assist with activities for approximately 32 residents, it would not be able to provide more customized, one-to-one activities to fully attend to the unique needs of an autistic resident. The home indicated that a group home would be a better option for these individuals because, as noted in **Section 4.6.1**, group homes are designed to help individuals with complex health-care needs in a more intimate setting compared to a long-term care facility.

RECOMMENDATION 8

To help ensure that the needs of the younger residents in long-term care homes are met, we recommend that the Ministry of Long-Term Care, in collaboration with Ontario Health:

- identify and connect long-term care homes with community programs and external resources to provide additional support for younger residents who have social and recreational needs or have mental health and addiction issues;
- work with homes to identify additional training that long-term care staff need to enhance their knowledge and skills in caring for residents with mental illness, addictions and developmental disabilities (for example, autism), and support homes in obtaining the training; and
- engage homes to identify and assess if more suitable living options are available, or should be developed, for certain groups of younger residents, and work with other partner ministries, as applicable, to develop a plan to implement these options.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to identify and connect long-term care homes with community programs and external resources; work with homes to identify additional training to enhance staff knowledge and skills in caring for residents with mental illness, addictions and developmental disabilities; and engage homes to identify and assess if more suitable living options are available for certain groups of younger residents.

The Ministry has launched many initiatives to address the complex needs of long-term care residents, including the Local Priorities Fund and High Intensity Needs Fund that aim to meet the care requirements of high-needs residents.

The Ministry will continue to work with Ontario Health and other partners to improve long-term care staff capacity to respond to the diverse needs of residents, including younger residents with responsive behaviours and those on the autism spectrum, and will collaborate with the Ministry of Health and Ministry of Children, Community and Social Services to identify, assess and implement more options that improve access to alternative care and community activities and supports for younger Ontarians when they are admitted to a long-term care home.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Auditor General's recommendation. Ontario Health works with the Ministry, long-term care homes, and system partners to support the provision of high-quality, safe care to all long-term care home residents, including those who are younger, have special social and recreational needs, or mental health and addictions issues. We are committed to working with the Ministry and system partners, including Ontario Health Teams, to identify ways to better meet the needs of younger residents and the staff who care for them in long-term care homes. Ontario Health's recommendations for a tactical plan will be developed by March 31, 2025.

4.7 Implementation of Legislation That Increased the Flow of Hospital Patients to Long-Term Care Was Not Transparent to the Public and Not Adequately Monitored

Long-term care homes admit residents from the community and also admit hospital patients when they are identified for alternate level of care (ALC). An ALC patient is someone occupying a hospital bed who does not require the intensity of services provided in the hospital care setting and who can be discharged in the opinion of the attending clinician. A long-term care home, rehabilitation facility or the patient's own residence are examples of preferred discharge destinations for ALC patients.

On September 21, 2022, the *More Beds, Better Care Act, 2022* came into full effect. To facilitate the flow of ALC patients from hospitals to long-term care homes, the new legislation authorized the placement

co-ordinator of Home and Community Care Support Services to take certain actions without the patient's consent, after reasonable efforts have been made to engage the patient (or the substitute decision-maker) to obtain consent. Examples of these actions include determining the patient's eligibility for long-term care, selecting homes for the patient within defined geographic parameters, and providing assessments and information about the patient to selected homes. For these patients, when a bed in one of the selected homes becomes available, they have 24 hours to accept the offer or risk being charged $400 per day to remain in the hospital (as stated in Regulation 965 under the *Public Hospitals Act*).

4.7.1 Transparency Was Lacking in the Implementation of New Legislation

In 2022/23, almost 12,500 ALC patients were admitted to long-term care, with 7,357 of these admissions occurring after the full implementation of the *More Beds, Better Care Act, 2022* on September 21, 2022 (**Figure 20**).

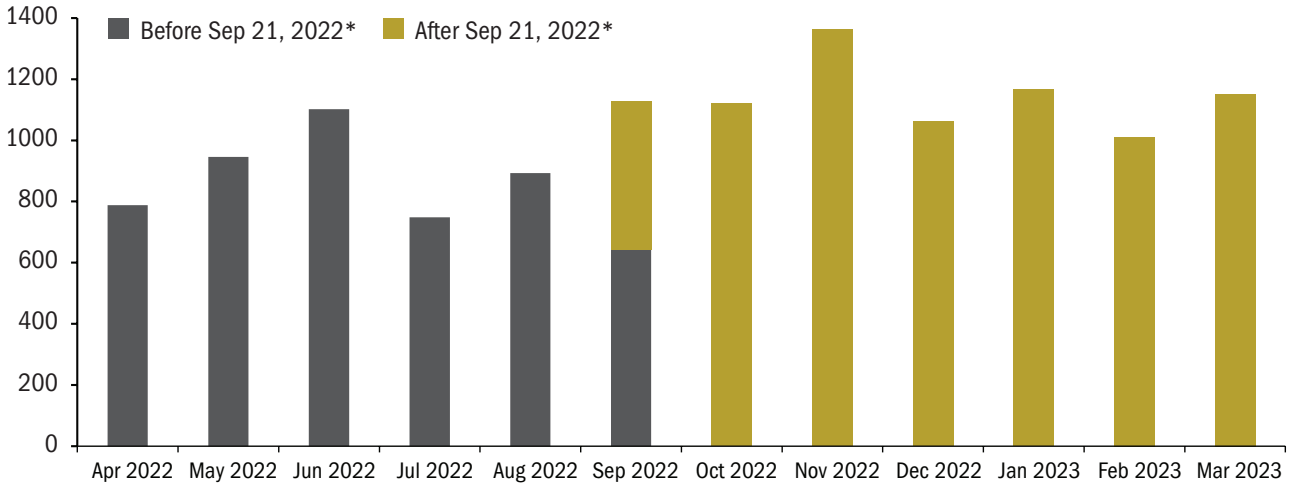
Our analysis of the placement of these 7,357 ALC residents between September 21, 2022 (effective date of the *More Beds, Better Care Act, 2022*) and March 31, 2023, noted the following:

- The new legislation resulted in 99 ALC patients being placed in homes that were not selected by the patients but by placement co-ordinators without the patient's consent.
- The other 7,258 ALC patients were placed into one of the patient-selected homes, with about 40% being placed in their first-choice home. However, the remaining approximately 60% were placed in a lower-ranked patient-selected home, which was comparable to the 58% observed in the six-month period prior to the new legislation's implementation. As of June 2023, less than 1% of these individuals had subsequently been transferred to a higher-ranked patient-selected home, with the rest remaining on the wait list for the opportunity to transfer if desired.

We found that the Ministry of Long-Term Care (Ministry) has not disclosed any of the above information to the public. The Ministry also does not know how many ALC patients (if any) were charged the $400 daily hospital fee for declining a long-term care bed offer since the implementation of the *More Beds, Better Care Act, 2022*; the information is neither collected by the Ministry nor by its partners, including the Ministry of Health and Ontario Health.

Figure 20: Number of Alternate Level of Care (ALC) Patients Transferred to Long-Term Care Homes, 2022/23

Source of data: Home and Community Care Support Services



* September 21, 2022 was the effective date of the *More Beds, Better Care Act, 2022* to facilitate the flow of ALC patients from hospitals to long-term care homes.

The *More Beds, Better Care Act, 2022*, which is intended to help free up hospital beds by increasing the flow of ALC patients to long-term care, has come under scrutiny from the public and some health-care advocates due to the actions that can be taken without consent. Stakeholders have also raised concerns over the impact that the new legislation has on the capacity of ethnocultural homes, as well as the ability of other long-term care homes to meet the respective ethnic, religious and linguistic needs of ALC patients. The Ministry's examination of long-term care placement data confirmed that the number of applicants admitted to cultural homes from the community has been declining over the years as various legislative changes were made to give patients waiting in hospitals the highest priority for admission into long-term care, with the implementation of the *More Beds, Better Care Act, 2022* in September 2022 further exacerbating the issue (refer to **Section 4.5.1** regarding the demand for culturally specific homes).

4.7.2 Outcomes of ALC Patients in Long-Term Care Homes Were Not Monitored to Assess Whether Needs Were Met

When the *More Beds, Better Care Act, 2022* was proposed, the Province indicated that the new legislation was intended to provide ALC patients with the care they need and a better quality of life in a more appropriate setting ("providing the right care in the right place"), while freeing up hospital beds for those who need them. However, the Ministry has not monitored the care outcomes of ALC patients after their admission to long-term care homes to determine if these patients are doing well after being discharged from hospitals. Existing clinical datasets are aggregated and outcomes cannot be readily separated between ALC patients and residents from the community.

Through our review and comparison of data on residents' health conditions, we noted that ALC patients transferred to long-term care homes are frailer, with higher health instability, compared to average long-term care residents. Our review of data on ALC patients noted that almost 80% of these patients were assessed at Score 2 or above on the Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) scale, which is designed to predict mortality associated with frailty and to measure instability in health (see **Figure 21**). Based on our observation and discussion with staff at the long-term care homes we visited, while some homes receive ALC patients who are similar to their residents from the community, others receive ALC patients that are frailer or with more complex needs, which creates care and resource challenges for the homes.

Although homes are responsible for providing quality care to residents, the Ministry can play a greater oversight role by monitoring, at the provincial level, the care outcomes of ALC patients after their transition into long-term care homes. Trends and findings identified from the analysis would help inform the Ministry's future decision-making and improvements to policies and processes. For example, the Ministry could obtain a better understanding of the following:

- whether ALC patients (especially those who went to homes outside of their preferred list or to homes selected by the placement co-ordinator without the patient's previous consent) have worse health outcomes (for example, higher hospital readmission rates); and
- whether long-term care staff require more training or have the capacity to care for the higher proportion of residents who were ALC patients from hospitals, given the homes' current staffing levels.

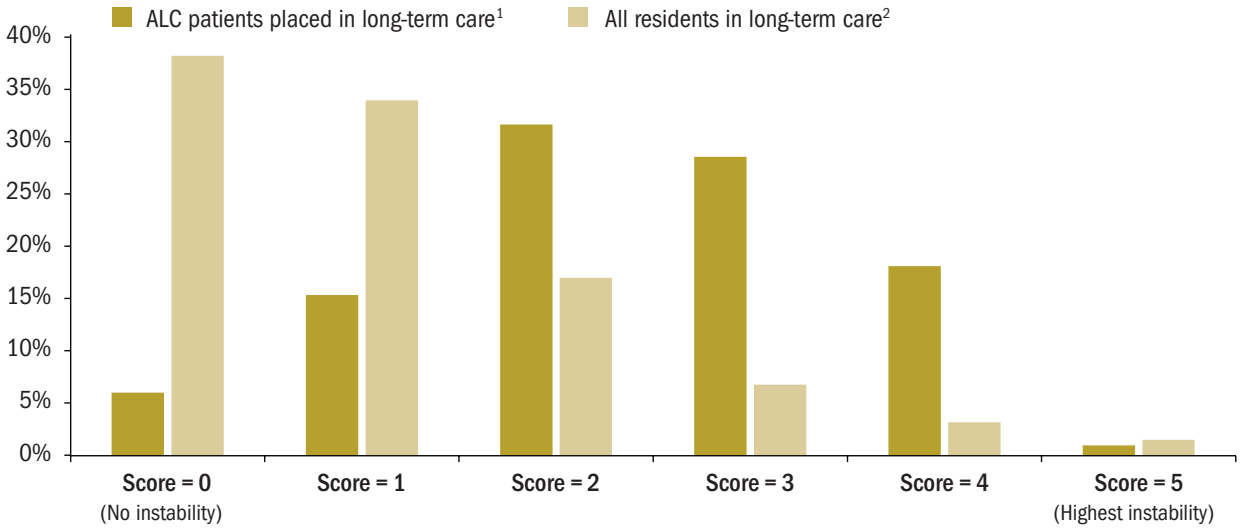
RECOMMENDATION 9

To help ensure alternate level of care (ALC) patients entering long-term care homes are receiving the care they need and that the public is well informed, we recommend that the Ministry of Long-Term Care, in collaboration with Home and Community Care Support Services:

- improve transparency around the use of the *More Beds, Better Care Act, 2022*, by providing the public with more information on the

Figure 21: Health Stability Scores for Alternate Level of Care (ALC) Patients Compared to All Residents in Long-Term Care Homes in Ontario

Sources of data: Home and Community Care Support Services (HCCSS) and Canadian Institute for Health Information (CIHI)



Note: Health stability is scored on the Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) scale. The scale ranges from 0 to 5, with higher scores representing an increased risk of mortality, more intense service needs, and increased health instability.

1. Data for ALC patients is sourced from HCCSS and reflects the CHESS scores of ALC patients placed in long-term care in 2022/23, based on their most recent assessment before placement.
2. Data for all residents in long-term care homes is sourced from CIHI and reflects the CHESS scores of all residents—including residents from the community and ALC patients from hospitals—assessed in 2022/23.

transfers of ALC patients (for example, the number and frequency of transfers, use of the authority under the new legislation, and impacts of ALC transfers on hospitals, long-term care homes and the community);

- collect data related to care outcomes of ALC patients admitted to long-term care homes and work with homes to analyze the data and identify potential improvements for future admission processes; and
- work with homes to determine if long-term care staff require additional training to meet the needs of ALC patients, and support homes in obtaining the training.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to improve transparency around the use of the *More Beds, Better Care Act, 2022*, collect data related to care outcomes of ALC patients admitted to long-term care homes, and work with homes with respect to staff training to meet the needs of ALC patients.

In collaboration with Home and Community Care Support Services (HCCSS) and the Ministry of Health, the Ministry will explore opportunities for potential improvements in the placement process through data collection and transparency to support all applicants, including ALC patients transitioning into long-term care and their families or caregivers.

The Ministry is working with long-term care homes, Ontario Health, HCCSS and the Canadian Institute for Health Information (CIHI) to collect and analyze data that allows for standardized evaluation and identification of potential improvements. The data includes information about long-term care residents who potentially could have been cared for at home, as well as residents' preferences, needs and strengths. Some of this

information about residents is available online, including on CIHI's website on the Ministry's Long-Term Care Home Finder webpage.

To support training needs of staff, the Ministry funds the Centres for Learning, Research and Innovation to educate and train current and future long-term care staff in areas including cultural. The Ministry is also exploring opportunities to establish a Long-Term Care Quality Centre that could provide additional support by identifying and sharing best practices for homes that have identified the need for training to better meet the needs of ALC patients.

The *Fixing Long-Term Care Act, 2021* (Act) and Ontario Regulation 246/22 (Regulation) require every home to have a plan of care in place for every resident living in the home. These plans are unique for each resident and focus upon the resident's individual needs and preferences. Care plans are developed for every resident whether they have previously resided in the community or transferred to the long-term care home from hospital. In addition, the Act sets requirements for staff training that can help to meet the needs of all residents, including those who were previously ALC patients—for example, to address infection prevention and control, pain management, fall prevention and management, skin and wound care and palliative care. The Ministry will work with and support homes with staff who require training to meet the needs of ALC patients.

4.8 Funding Changes Are Required to Meet Residents' Current Needs and Improve Responsiveness

As discussed in **Section 2.3**, the Province provides funding to long-term care homes through the Level-of-Care funding model and additional direct funding targeted at specific program objectives. Our review noted various deficiencies in the funding methodology and the process requires improvement.

4.8.1 Funding Method Lacked Up-to-Date Information to Meet Residents' Current Care Needs

We found that the largest portion of funding for long-term care homes, the Level-of-Care per diem, is based on out-of-date information, and therefore does not reflect current resident care needs.

The basic Level-of-Care funding for beds in long-term care homes includes funding in multiple categories, or envelopes. The largest of these categories is the Nursing and Personal Care envelope, which accounts for more than half of the Level-of-Care funding that the Ministry of Long-Term Care (Ministry) provides to each home (see **Figure 22**). A home's Nursing and Personal Care envelope is adjusted every year based on the condition of the home's residents. Funding is increased for homes where residents show higher levels of acuity (more severe conditions), and reduced for lower levels of acuity, in order to align funding with care needs.

The adjustment factor—called the Case Mix Index—is based on resident acuity data collected from homes and is intended to represent the average resource intensity needed to care for the residents of a home for a given year. However, we noted that the information the Ministry uses to calculate the Case Mix Index is based on resident acuity data collected by homes two years prior, which does not necessarily reflect the current needs of residents since health conditions can change significantly over that time period. Moreover, with residents spending an average of two to three years in a home, it means that the Ministry could be paying homes based on the health status of residents who are no longer at the home.

In comparing the Case Mix Index that was used to adjust funding between 2021/22 and 2023/24, we noted that the index can fluctuate significantly for some homes, with an increase of up to 18% for one home and an increase of 5% or more in over 40 homes over the two-year time gap. Decreases in the Case Mix Index are capped at 5% per year, as the Ministry

Figure 22: Base Level-of-Care Per Diem Funding Envelopes, April 1, 2023

Source of data: Ministry of Long-Term Care

Funding Category or Envelope	Coverage	Per Diem Rate ($ per resident, per day)
Nursing and Personal Care[1]	• Direct-care staff • Supplies and equipment to provide care	105.96
Program and Support Services	• Program staff • Equipment related to programs • Therapies provided to residents	12.48
Nutritional Support[2]	• Raw food • Nutritional supplements	12.07
Other Accommodations[3]	• Housekeeping services • Building and property operations and maintenance • Dietary services • Laundry and linen • General and administrative services	57.65
Total		**188.16**

Note: The per diem amounts do not include each home's allocation of an additional amount, called the global per diem. Long-term care homes can use the surplus funds within each envelope to balance expenditures across envelopes, as needed. Some restrictions apply (for example, homes cannot reallocate surplus funds from any envelope to the Other Accommodations envelope).

1. The per diem for each home is adjusted by the Case Mix Index, which represents the average acuity of the home's residents in a given year. Only a portion of the per diem ($103.80 per resident, per day) is subject to the adjustment.
2. Excludes costs related to other food programs and the cost of food preparation.
3. Includes $0.37 for Quality Attainment Premium funding, which is subject to full recovery if homes have not met the accreditation requirements.

has imposed a "stability floor" to minimize the impact and prevent homes from being financially penalized excessively in any one year. Based on the current Level-of-Care per diems (see **Figure 22**), a 1% difference in the Case Mix Index is equivalent to a $1.04 difference in funding per resident, per day. For a 100-bed home, an 18% increase in the Case Mix Index translates to an increase of about $680,000 in annual Level-of-Care funding. The fluctuations we observed illustrate the need to use more current information to determine funding for individual homes.

In addition to not reflecting the current care needs of residents, stakeholders have expressed concerns that the existing funding model could inadvertently provide disincentives for homes to improve resident care and outcomes. To illustrate, if a home implements effective programs or practices that improve residents' quality of services and life, the residents' acuity may decrease accordingly. This means that the home's Case Mix Index would also drop, which in turn would reduce funding from the Ministry. The unintended consequence is that the home may obtain less funding as a result of improving care to its residents. In order to maintain or increase funding, homes would not have an incentive to improve resident care and outcomes. We noted from our visits to homes and from stakeholder interviews that some homes have hired consultants to help them optimize their Case Mix Index in order to maximize their funding.

We note that these concerns—the lack of timeliness and the operation of the CMI as a disincentive—were also identified in the 2020 Staffing Study carried out by the Ministry. The Ministry is evaluating its funding model and expects a technical advisory group to propose recommendations by late 2023 for its consideration.

4.8.2 Long-Term Care Homes Faced Barriers in Navigating and Accessing Funding Initiatives

Aside from Level-of-Care funding (see **Section 4.8.1**), the Ministry provides additional funding to long-term care homes through a broad range of funding initiatives directed at specific issues and expenses of homes. The Ministry's direct funding initiatives have increased by more than 400% over the past five years, rising from $0.4 billion in 2018/19 to $1.8 billion in 2022/23, excluding funding related to the COVID-19 pandemic (see **Figure 23**). However, navigating through and accessing these initiatives is difficult and administratively burdensome for homes, which could impede uptake and hence reduce the effectiveness, or defeat the purpose, of these initiatives.

Funding Information was Hard to Navigate

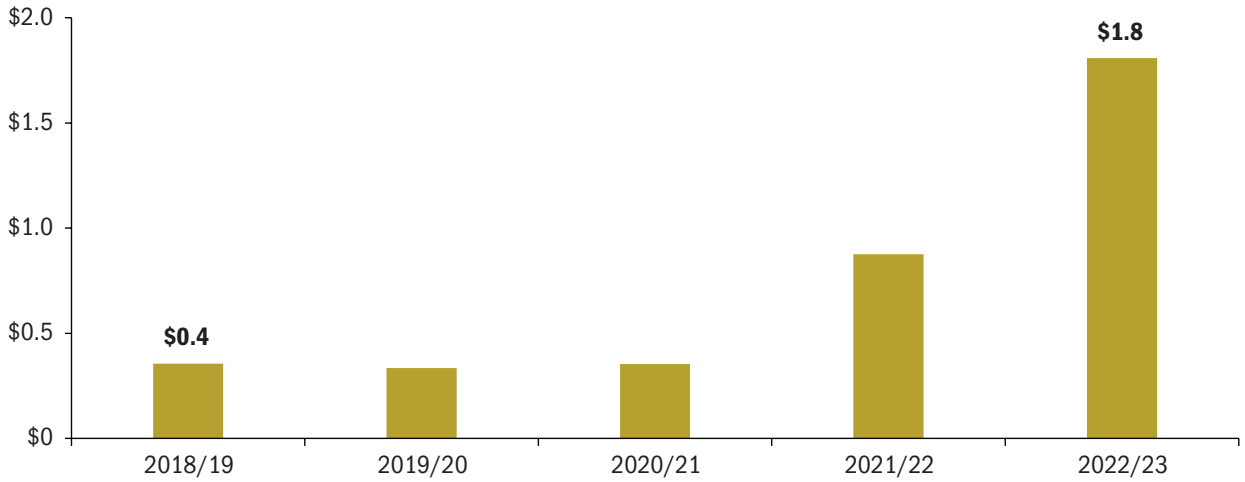
The Ministry currently has over 40 direct funding initiatives. We found that there is neither comprehensive funding information nor a single authoritative listing of funding initiatives available to long-term care homes. Although these initiatives are communicated to homes at their inception and funding documentation can be found on the Ministry's long-term care homes portal (ltchomes.net), relevant information is embedded in a large number of other announcements, correspondence and technical documents, which complicates access. Some homes we visited indicated that the large number of initiatives and the lack of centralized, organized information makes it difficult to navigate through the information, and also difficult to determine whether specific initiatives are still in effect.

Fund Administration was Complex

Some of the over 40 direct funding initiatives from the Ministry are claims-based or require an application for funding. For most of the initiatives though, the Ministry allocates funds to homes without requiring an application. However, to use the allocated funds, homes must first determine whether they meet the eligibility requirements for each funding initiative, and then must maintain the required documentation and identify the reporting requirements specific to each initiative in their annual filings with the Ministry. If a home does not meet all of the requirements, the Ministry will claw back the funding after

Figure 23: Provincial Funding Provided for Long-Term Care Through Direct Funding Initiatives, 2018/19–2022/23 ($ billion)

Source of data: Ministry of Long-Term Care



Note: The figure includes initiatives funded by Ministry of Long-Term Care, except those related to COVID-19 pandemic from 2019/20 to 2022/23.

reconciliation and settlement, which will be years later (see **Section 4.8.3**).

Given that each funding initiative has its own eligibility criteria, timeline, documentation and reporting requirements, homes must invest considerable time and effort to access these funds. We heard from long-term care homes as well as stakeholder groups about the complexity of this funding system and the administrative burden it imposes, with smaller homes being affected the most as they do not have the same amount of administrative resources as the larger or chain-operated homes.

Funding Initiatives Had Limitations and Uptake Was Unknown

We found that the Ministry has not consistently analyzed the uptake of its funding initiatives to determine which homes have benefited from initiatives, which ones have not, and why. Such analysis is necessary to help the Ministry determine whether the initiatives have met their intended purposes (providing homes in need with additional funding) and what are the barriers, if any, that impede homes from taking advantage of the Ministry's initiatives. The Ministry advised that one impediment in carrying out such an analysis is the delay in the reconciliation and settlement process with long-term care homes (see **Section 4.8.3**).

Through our interviews with homes and examination of initiative policies or documentation, we observed potential design limitations in certain funding initiatives that have impeded homes from benefitting from the funds. For example:

- The **High Intensity Needs Fund** is a claims-based program designed to provide additional funding for residents with acute or intensive care needs. We examined Ministry records for the fund and found that, for the five years from April 2018 to March 2023, the Ministry turned down 24% of the amounts claimed by homes. For over half of the claims that were turned down, the reason was that homes did not fill out the forms correctly. This was confirmed in our discussions with homes, which indicated that their funding requests were rejected for not having the form filled out correctly, though the criteria applied by the Ministry appeared to be inconsistent (for example, a form could be filled out in the same way, but get rejected or approved on separate occasions).
- The **Resident Health and Well-Being Program** provides funding to homes to enhance resident access to social support services. At the time of the announcement, only three months remained in 2022/23. A home that did not have existing staff for this function would need to hire the person within three months (that is, before year-end), as otherwise the amount would be clawed back by the Ministry. The short turnaround time had limited the ability of homes to use the fund for its first year.
- The **Nurse Practitioner Initiative** was introduced to provide additional funds for homes to hire nurse practitioners. The initiative required homes to hire first and then apply for funding. We heard from stakeholders that homes did not want to incur the financial risk of hiring staff when funding to pay for the staff was uncertain. We note that the Ministry added additional flexibility for homes for this initiative in its second year.
- The **Local Priorities Fund** provides funding to certain homes for the costs of specialized staff, equipment and services needed to support individuals requiring specialized care. A home informed us that, although its application for funding to purchase equipment was approved, it could not use the full approved amount because equipment could not be obtained within the short time frame permitted by the funding policy.

Since 2020/21, the Ministry has increased its funding in long-term care to support homes in improving their quality of care, with the largest amount invested in staffing-related initiatives. Timely analysis of the utilization of funding initiatives is important for the Ministry to assess whether the funds are effectively

addressing the staffing issues in individual homes and across the sector (refer to **Section 4.1** and **Section 4.2** for staffing issues).

4.8.3 The Ministry Was Almost Five Years Behind in Settling Finances with Homes

Through Ontario Health, the Ministry advances funds to homes based on estimates. To determine the actual amount of funding for which a home is eligible, the home must submit to the Ministry an audited annual report that provides detailed information on its actual revenue and expenditures for the year. The Ministry undertakes a reconciliation of this information and then either asks the home to pay back any overpayment or provides additional funding to the home in the case of underpayment. Timely settlement would help homes manage their cash flow, especially in cases where the home is owed money.

However, we found that the Ministry was significantly behind in reconciling and settling with long-term care homes. As of July 2023, the Ministry had only fully completed reconciliations up to calendar year 2018. This has resulted in a delayed recovery of approximately $30 million from homes due to overpayment and a delayed payout of about $3 million to homes due to underfunding. The Ministry advised that it has hired four additional staff to address the backlog and intends to complete all reconciliations up to 2021 by March 2024. As of early October 2023, the Ministry indicated that it had completed almost all reconciliations for the 2019 calendar year, but those from 2020 onwards were yet to be done.

RECOMMENDATION 10

To help ensure that funding aligns with resident care needs and is accessible to long-term care homes, we recommend that the Ministry of Long-Term Care:

- complete its evaluation of the Level-of-Care funding model, with participation from homes, and implement changes to ensure that funding is based on current resident care needs and provides incentives to improve residents' condition;
- analyze the uptake of various direct funding streams, consult with homes to determine why certain homes are not taking advantage of these funding programs, and identify ways to make the programs more accessible to all homes in need; and
- clear the backlog of annual reconciliations and settlements.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to complete its evaluation of the Level-of-Care funding model, analyze the uptake of various direct funding streams, and clear the backlog of annual reconciliations and settlements.

The Ministry is continuously monitoring the operating funding model and exploring opportunities to improve how the model contributes to improving the quality of resident care. The Ministry is holding consultations with a technical advisory group comprising long-term care homes and other sector stakeholders to review operating funding, and will put forward recommendations for consideration to ensure current resident care needs are being met. Additionally, the advisory group will develop recommendations related to funding streams such as the High Intensity Needs Fund. This work will inform program changes intended to ensure that programs are accessible to those who need it.

The Ministry continues to make significant investments of up to $4.9 billion in staffing and specialized supports to complement the ongoing investments in the Level-of-Care funding model. In addition, the Ministry is exploring, in conjunction with the Canadian Institute for Health Information (CIHI), the potential implementation of the new interRAI Long-Term Care Facility (LTCF) instrument in Ontario long-term care homes. The new interRAI (LTCF) is expected to reduce the

administrative burden and improve the collection of resident care data. The Ministry will work with partners to explore opportunities to ensure funding is based on more recent resident care data and intends to undertake a review of its staffing funding lines to streamline and clarify them. Consideration will also be given to appropriate funding flexibility to support the hiring of more staff into the long-term care sector.

The Ministry is also making significant progress in expediting the annual reconciliation process to clear the backlog, and is committed to enhancing the timeliness of this work going forward.

4.9 Accountability Framework Was Not Clear to Ensure Effective Oversight of Long-Term Care Homes

The Ministry of Long-Term Care (Ministry) and Ontario Health have shared funding and accountability authorities for long-term care under the *Connecting Care Act, 2019*. The accountability framework is outlined in the accountability agreement between the Ministry and Ontario Health, under which Ontario Health has the general obligation to manage the long-term care system and home performance, provide and reconcile funding, and implement provincial priorities. However, we found that the actual authorities of Ontario Health in relation to the long-term care sector are limited, and the oversight of long-term care homes' performance could be enhanced.

4.9.1 Not All Key Indicators Had Targets

Ontario Health signs service accountability agreements with long-term care homes, as required under the *Connecting Care Act, 2019*. The accountability agreements hold homes accountable for operational, performance and funding expectations. However, we found that these agreements do not include targets for most of the indicators.

The service accountability agreements identify nine indicators, which are grouped into three categories (**Figure 24**). Targets, however, are only set for performance indicators that measure the home's financial

Figure 24: Long-Term Care Home Key Indicators

Source of data: Ontario Health

Category	Indicator	Type of Indicator	Target
Organizational Health and Financial	Debt service coverage ratio	Performance	1
	Total margin	Performance	0
Co-ordination and Access	Percent resident days—Long stay	Explanatory	n/a*
	Wait time from determining eligibility by Home and Community Care Support Services to receiving response from long-term care home	Monitoring	n/a*
	Long-term care home refusal rate	Explanatory	n/a*
Quality and Resident Safety	Percentage of residents who fell in the last 30 days	Monitoring	n/a*
	Percentage of residents whose pressure ulcers worsened	Monitoring	n/a*
	Percentage of residents on antipsychotics without a diagnosis of psychosis	Monitoring	n/a*
	Percentage of residents in daily physical restraints	Monitoring	n/a*

* No targets have been set for these indicators.

health. The agreement describes the remaining indicators as monitoring or explanatory in nature, hence no targets have been set. These monitoring or explanatory indicators include measures of the home's performance in relation to quality of care and resident safety.

We noted that Ontario Health publicly reports on several measures of long-term care home performance (refer to **Section 4.5.3**). An additional list of priority indicators is also recommended to long-term care homes for incorporation into the homes' quality improvement plans. However, the absence of targets for key indicators limits Ontario Health's ability to effectively monitor and hold homes accountable for their performance in critical areas, such as care quality and resident safety.

RECOMMENDATION 11

To help ensure that long-term care homes are meeting operational, performance and funding expectations, we recommend that Ontario Health:

- update the indicators in its service accountability agreements with long-term care homes to include performance targets—especially in the areas of quality of care and resident safety; and
- monitor long-term care home performance against targets, with timely follow-up of homes that fail to meet the targets or whose performance has consistently declined.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Auditor General's recommendation. Ontario Health will review and establish performance targets and corridors for appropriate and relevant quality and safety indicators as part of the next Long-Term Care Service Accountability Agreement refresh cycle, planned for implementation on April 1, 2025. Ontario Health will also introduce by April 1, 2025, a mechanism to identify and monitor long-term care homes with performance outside the established corridors.

4.9.2 Key Players' Actual Responsibilities Did Not Match Their Defined Roles in Accountability Agreement

Ontario Health Had Limited Authority for Funding

The Ministry and Ontario Health have shared funding and accountability authorities for long-term care under the *Connecting Care Act, 2019*. The accountability framework is outlined in the accountability agreement between the Ministry and Ontario Health, under which Ontario Health has the general obligation to provide and reconcile funding. While Ontario Health is technically the primary source of funding for long-term care homes, most decision-making and administration for both Level-of-Care and special initiative funding are performed by the Ministry.

The Ministry informs Ontario Health of the amount to advance to homes, and performs reconciliations to validate home spending and determine settlement amounts (that is, the amount to recover from homes for overpayment, and vice versa), as described in **Section 4.8.3**. For the few funding programs that Ontario Health is responsible for administering directly (for example, the Local Priorities Fund and Behavioural Supports Ontario), Ontario Health would maintain the service accountability agreements with applicable homes, but funding decisions are ultimately subject to the Ministry's approval. With little authority and involvement in the funding process, Ontario Health is not in a position to hold homes accountable for meeting funding expectations.

Performance Goals Were Limited for Ontario Health

The *Connecting Care Act, 2019* requires that the accountability agreement between the Ministry of Long-Term Care and Ontario Health include performance goals and objectives for Ontario Health, as well as standards and targets to measure the agency's performance. Our examination of the current accountability agreement found that it has only one performance

indicator, which is "Wait time for long-term care home placement." While Ontario Health contributes to the overall system performance on wait time, long-term care home assessment and placement is an activity primarily performed by Home and Community Care Support Services. The accountability agreement does not have any other performance indicators for Ontario Health.

RECOMMENDATION 12

To help ensure that oversight accountabilities are clearly defined and executed, we recommend that the Ministry of Long-Term Care work with Ontario Health to:

- review and update the accountability agreement between the two parties to ensure that key oversight accountabilities (for example, funding and performance monitoring) are clearly defined and that the framework is supported by authorities and processes; and
- establish performance goals, objectives and targets to measure Ontario Health's performance in fulfilling its accountabilities defined in the agreement.

MINISTRY RESPONSE

The Ministry of Long-Term Care (Ministry) acknowledges the Auditor General's recommendation to review and update the accountability agreement, and to establish performance goals, objectives and targets to measure Ontario Health's performance.

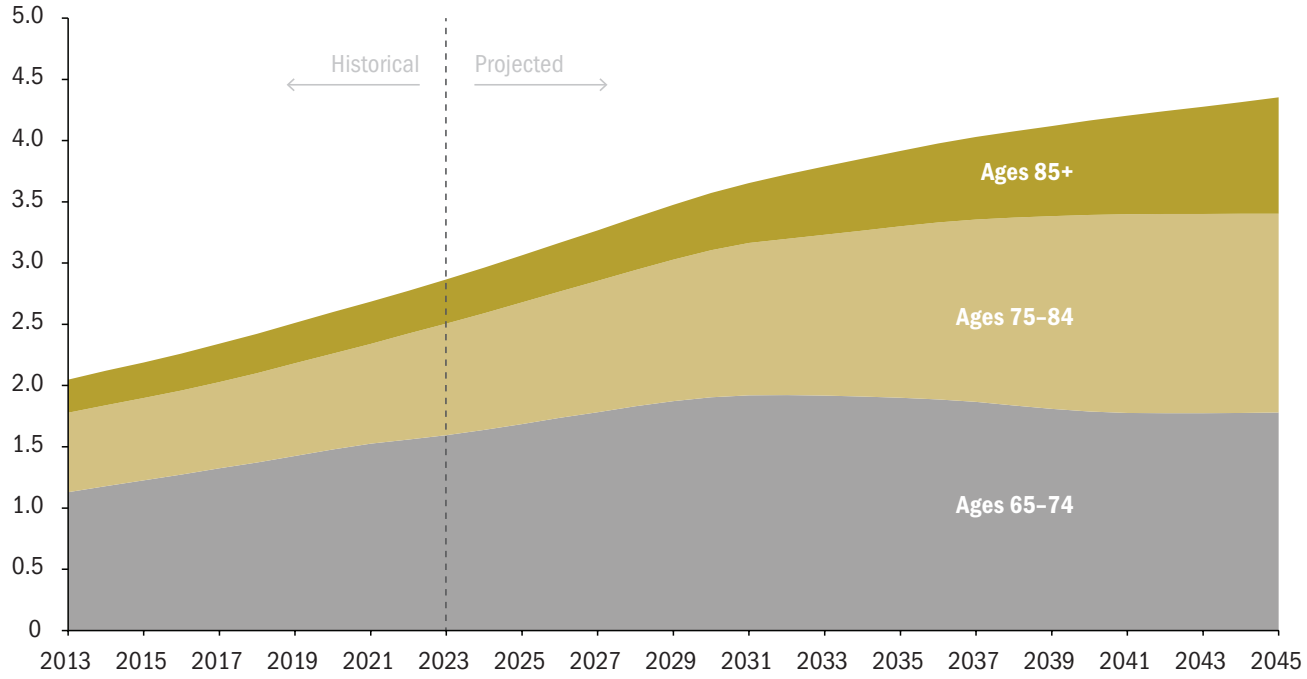
The Ministry has established a strong collaborative relationship with Ontario Health, which is critical to addressing the long-standing and systemic challenges facing the long-term care sector so that every resident can experience the best possible quality of life, supported by safe, high-quality care. The Ministry is committed to further strengthen that partnership. Specifically, the Ministry and Ontario Health have initiated the process to refresh the Ministry of Long-Term Care–Ontario Health Accountability Agreement to reflect evolving and maturing roles of both parties and to ensure responsibilities and accountabilities are clearly defined. As part of this work, the Ministry is working with Ontario Health to review and update the performance indicators used to measure and monitor Ontario Health's performance.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Auditor General's recommendation. Ontario Health is working with the Ministry on a review and update of the Ministry of Long-Term Care–Ontario Health Accountability Agreement to include clearer definition of accountabilities that are supported by authorities and processes. Indicators and targets for measuring Ontario Health's performance in fulfilling its accountabilities outlined in the Accountability Agreement will be part of the review and update process. The 2024–27 Accountability Agreement is targeted for completion by March 31, 2024.

Appendix 1: Age Distribution of Seniors in Ontario, 2013–2045 (million)

Sources of data: Statistics Canada and Ministry of Finance



Appendix 2: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1. Long-term care homes have stable and adequate staffing, an appropriate mix of resources and well-established programs to ensure that residents are safe and have high-quality care and services that meet their needs.
2. Long-term care homes have effective hiring and training processes to ensure that management and staff are competent, with the right qualifications and training to address the needs of residents.
3. Residents of different long-term care homes are subject to equitable levels of care and services, regardless of the size, location and type of home (for-profit, not-for-profit, or municipal).
4. Funding methods adequately address the different needs among long-term care homes and residents and respond to changes in needs on a timely basis. Also, processes are in place to validate the eligibility of home expenditures.
5. Meaningful performance measures and analytics are established to monitor home activities and identify areas for continuous improvement. Results are publicly reported and timely corrective actions are taken when issues are identified.

Appendix 3: Long-Term Care Homes We Visited

Prepared by the Office of the Auditor General of Ontario

Type	Name	Size[1]	City/Town
For-profit	Muskoka Shores Care Community	Large	Gravenhurst
	Cheltenham Care Community	Large	North York
	Roberta Place	Medium	Barrie
	Park Lane Terrace	Medium	Paris
	Port Perry Place	Medium	Port Perry
	Creedan Valley Care Community	Small	Creemore
	King City Lodge Nursing Home	Small	King City
Not-for-profit	Kensington Gardens	Large	Toronto
	West Park Long Term Care Centre	Large	Toronto
	Providence Manor	Large	Kingston
	Ukrainian Canadian Care Centre[2]	Medium	Etobicoke
	Villa Colombo Seniors Centre	Medium	Vaughan
	Yee Hong Centre – Scarborough McNicoll[2]	Medium	Scarborough
Municipal	Seven Oaks	Large	Scarborough
	The John M. Parrot Centre	Large	Napanee
	Tall Pines Long Term Care Centre	Medium	Brampton
	Elgin Manor	Small	St. Thomas
First Nations	Iroquois Lodge Nursing Home[2]	Small	Ohsweken

1. Small home is 96 beds or fewer; medium home is more than 96 but fewer than 161 beds; large home is 161 beds or more.
2. Home caters to residents of a specific culture.