Ministry of Health and Long-Term Care

Long-term-care Home Quality Inspection Program

1.0 Background

1.1 Overview of Long-term-care Homes

Ontario's long-term-care homes provide accommodation and care in a home-like environment to adults who are unable to live independently and/or require round-the-clock nursing care in a secure setting. There are about 630 long-term-care homes in Ontario. They provide care to approximately 77,600 residents, most of whom are over 65 years old.

The Ministry of Health and Long-Term Care (Ministry) funds, licenses and regulates Ontario's long-term-care homes. Homes can be either for-profit or not-for-profit, which are further categorized as municipal and non-municipal homes, as shown in **Figure 1**. In the 2014/15 fiscal year, ministry funding to long-term-care homes through the province's Local Health Integration Networks totalled $3.6 billion. Most residents make a co-payment of between $1,800 and $2,500 a month, depending on whether they occupy a basic, semi-private or private room.

The *Long-Term Care Homes Act, 2007* (Act) came into effect on July 1, 2010. The Act and its regulations set out standards for all long-term-care homes in Ontario. The Act covers residents' rights, care and services; admission of residents; operation of homes; and funding and licensing of homes. The Act provides the Ministry with the power to ensure homes are in compliance with the legislation and to take enforcement actions, if necessary. By law, every long-term-care home must have a residents' council (made up of people who live in the home). A home may also have a family council (made up of family members of current or past residents). The purpose of these councils is to provide a voice for residents and their family members on how the home is operated.

The Canadian Institute for Health Information (CIHI) reports regularly on a number of quality indicators based on the information self-reported by long-term-care homes in Ontario. In 2015, CIHI published nine quality indicators on homes, such as the percentage of residents who are in daily restraints, the percentage of residents who are

Figure 1: Long-term-care Homes in Ontario, March 2015

Source of data: Ministry of Health and Long-Term Care

Type of Long-term-care Home	# of Homes	# of Beds
For-profit homes	360	41,800
Not-for-profit homes (other than municipal homes)	170	20,300
Not-for-profit homes (municipal homes)	100	16,400
Total	**630**	**78,500***

* Of which, approximately 77,600 beds were occupied as of March 2015.

taking antipsychotic drugs without a diagnosis of psychosis, the percentage of residents who fell in the last 30 days and the percentage of residents with a worsened pressure ulcer. **Appendix 1** shows the results for the nine quality indicators by region for 2013/14 (2013/14 is the most recent year for which data from individual homes is available), as well as the change in overall provincial performance between 2010/11 and 2013/14. Overall, results for four of the nine indicators improved by between 6% and 45% over these three years, while the results for the other five indicators worsened by between 2% and 7% over the same three years.

1.2 The Ministry's Long-Term Care Homes Quality Inspection Program

1.2.1 Program Overview

The aim of the Long-Term Care Homes Quality Inspection Program (Program) is to focus on residents' quality of care and quality of life by protecting and safeguarding residents' rights, safety and security as well as ensuring that long-term-care homes comply with legislation and regulations. A similar program existed before but was transformed to align with the Act when it came into effect in 2010.

The Program is administered by the Ministry's Performance Improvement and Compliance Branch, which falls under its Health System Accountability and Performance Division. The Program consists of a head office with a centralized intake unit and five regional offices. In total, the Program has about 200 staff, including over 150 inspectors. Each regional office has a manager and two inspector team leads who prioritize and assign inspections to inspectors and oversee their work. **Appendix 2** summarizes the key roles, responsibilities and accountability relationships in long-term-care home oversight.

1.2.2 Types of Inspections

Under the Act, the Ministry may conduct inspections of long-term-care homes at any time without having to alert the homes beforehand. There are four types of inspections: comprehensive inspections, complaint inspections, critical-incident inspections and follow-up inspections. **Figure 2** shows the number for each type of inspection conducted between 2012 and 2014. During 2014, the Ministry performed a total of 2,630 inspections, 210 more than the number performed in 2013. The increase is mainly due to additional comprehensive inspections that year. The process for each type of inspection is described in the following subsections.

Comprehensive Inspections

In early 2011, the Ministry implemented comprehensive inspections, which aim to assess residents' satisfaction and homes' compliance with legislative requirements. To increase inspection efficiency and avoid duplication, the Ministry can inspect complaints, critical incidents and/or follow up on compliance orders during a comprehensive inspection. On average, a comprehensive inspection involves three or four inspectors examining the home over an eight-day period. This inspection process has two stages and 31 inspection protocols, five of which are mandatory protocols (medication; infection prevention and control; residents' council and family council interviews; and dining observation).

In the first stage of a comprehensive inspection, inspectors review health records, make observations

Figure 2: Number of Inspections by Type, 2012–2014[1]
Source of data: Ministry of Health and Long-Term Care

Type of Inspection	2012	2013	2014
Comprehensive[2]	60	50	590
Critical-incident[3]	700	940	810
Complaint[3]	1,190	1,140	970
Follow-up[4]	290	290	260
Total	**2,240**	**2,420**	**2,630**

1. Based on calendar year. Data prior to 2012 is either incomplete or not available.
2. When conducting comprehensive inspections, Ministry inspectors may also address critical incidents or complaints, or follow up on orders issued.
3. The Ministry addressed approximately 2,970, 2,540 and 3,840 complaints and critical incidents in 2012, 2013 and 2014, respectively.
4. The Ministry followed up on approximately 510, 610 and 770 compliance orders in 2012, 2013 and 2014, respectively. Compliance orders can also be followed up during any types of inspection.

in the homes, and interview a sample of residents, their family members and/or staff members who care for them. Inspectors analyze the information collected and identify areas for further, more in-depth inspection in stage two.

See **Appendix 3** for a more detailed overview of the comprehensive inspection process and inspection protocols.

Complaint Inspections

The Ministry receives complaints from residents, their family members, and the public mostly by phone (through a toll-free ServiceOntario Action Line) but also in person and by email or fax. Long-term-care homes are also required to immediately forward any written complaints they receive to the Ministry.

Since November 2012, the Ministry's centralized intake unit has responsibility for reviewing every complaint it receives and to decide whether an inspection is warranted (i.e., any indications of a home failing to comply with the legislation). In 2014, the Ministry received close to 3,300 complaints (2013—2,910). If it decides that an inspection is required, the unit assigns a risk level to each case: high, medium or low. High-risk cases involve alleged improper care, abuse, neglect, unlawful conduct, or retaliation by the homes' staff—anything that places resident(s) in serious (or significant risk of serious) harm and in immediate jeopardy if the Ministry or the home fails to intervene. Medium-risk cases involve any alleged violation of the Act that result in moderate (or risk of moderate) harm to a resident(s). Low-risk cases involve minimal (or risk of minimal) harm. The Act stipulates that high-risk complaints be inspected immediately, while the Ministry aims to inspect medium-risk complaints within 30 days and low-risk complaints within 120 days.

On average, it takes one or two inspectors over a two-day period to perform a complaint inspection. In 2014, the Ministry inspected about 1,810 complaints (2013—1,280). Inspectors use the inspection protocol(s) (see **Appendix 3**) that best match the nature of the complaint. The Ministry has an internal policy that requires inspectors to report the outcome of a complaint inspection to the complainant(s).

Critical-incident Inspections

Long-term-care homes must immediately report critical incidents to the Ministry, such as: fire, neglect or abuse of residents, improper care, misuse of residents' money, unlawful conduct, unexpected or sudden death, residents missing for more than three hours, missing residents who return with an injury or adverse change in condition, outbreaks of reportable or communicable diseases, and contamination of the drinking water supply. For other incidents, such as resident falls resulting in significant change in condition that require a hospital visit, failures of the home's security or other major systems for more than six hours, and missing medication, the homes are required to inform the Ministry within one business day. Homes report critical incidents through a web-based tool called the Critical Incident System or through a pager if the incident occurs after business hours. In 2014, the long-term-homes reported over 12,900 critical incidents (2013—15,300) to the Ministry.

The Ministry's centralized intake unit reviews every critical incident reported to decide whether an inspection is warranted. The inspection process to address a critical incident is the same as the process for complaint inspections described in the previous section. Inspectors typically determine whether the homes complied with the legislative requirements for reporting, handling and documenting the incident, and whether the incident was a result of not complying with other sections of the Act. In 2014, the Ministry inspected approximately 2,030 critical incidents (2013—1,260).

Follow-up Inspections

If an inspection results in the home being issued with an order to comply with the legislation, there

must be a follow-up inspection to ensure that the home has followed the order by the deadline given and that the issue has been rectified. During 2014, the Ministry conducted about 260 follow-up inspections (2013—290) and addressed about 770 compliance orders (2013—610) issued to the homes.

1.2.3 Types of Enforcement Actions

If, after conducting any type of inspection mentioned above, inspectors find a long-term-care home is not in compliance with the Act—for example, residents' rights, safety and well-being are not protected—they shall take one or more of the following five enforcement actions:

1) issue a written notification;
2) issue a voluntary plan of correction;
3) issue a compliance order;
4) issue a work-and-activity order; or
5) refer the matter to the Ministry's Program Director, who may issue an order.

Figure 3 describes in detail each type of enforcement action and its follow-up requirement. When deciding what type of enforcement action to take, inspectors consider the severity and scope of the problem along with the home's history in dealing with deficiencies. **Figure 4** shows the number of enforcement actions taken by the Ministry between 2012 and 2014; the total number had increased by more than twofold during the last two years. The significant increase is primarily due to the Ministry having performed 540 more comprehensive inspections in 2014 than in 2013 (see **Figure 2**). Over the last three years, the Ministry had not issued any work-and-activity orders that require the home to pay for necessary work performed by the Ministry on the home's behalf in order for them to achieve compliance.

1.2.4 Reporting Inspection Results

After they complete an inspection of a home, inspectors are required to prepare a report documenting all instances of non-compliance they identified and the enforcement action(s) to be taken for each. Copies of the inspection report go to the home's operator, the residents' council and the family council, if there is one. The Ministry is also required to publish every inspection report on its website. Reports must be edited to remove personal and health information about individual residents before they can be made public and/or shared with the councils.

The Ministry's policy is that inspection reports are to be submitted to the regional office manager and/or inspector team lead for review, and that any reports with compliance orders must be submitted to the regional office manager for approval. The Ministry aims to deliver the inspection report to operators of the homes within two weeks of an inspection, and to publish the report on the Ministry's website within two months.

Figure 3: Types of Enforcement Actions and Follow-up Requirements

Source of data: Ministry of Health and Long-Term Care

Enforcement Action	Description	Follow-up Requirement
Written notification	Specifies the details of each instance of non-compliance.	A follow-up inspection is not required.
Voluntary plan of correction	Requests that the home prepares a written plan of correction for achieving compliance, but it does not require the home to submit the plan.	
Compliance order	Requires the home to take action, stop doing an action or prepare a plan in order to achieve compliance by a deadline.	A follow-up inspection is required once the deadline has passed.
Work-and-activity order	Requires the home to pay for the necessary work performed by the Ministry on the home's behalf to achieve compliance.	
Director's order	May withhold ministry funding to the home; order the home to return funding; require the home to retain a person to manage or assist in managing the home at the home's expense; and revoke a home's licence.	

Figure 4: Number of Enforcement Actions Taken by the Ministry, 2012–2014 *

Source of data: Ministry of Health and Long-Term Care

Enforcement Action	2012	2013	2014
Written notification	1,650	1,490	4,030
Voluntary plan of correction	1,940	2,000	4,450
Compliance order	640	670	1,040
Work-and-activity order	0	0	0
Director's order	1	0	0
Total	**4,231**	**4,160**	**9,520**

* Based on calendar year. Data prior to 2012 is either incomplete or not available.

1.2.5 Summary of Key Events and Program Expenditures

Figure 5 summarizes the key events relating to the Program since the *Long-Term Care Homes Act, 2007* (Act) became effective in 2010. The Act stipulates that every long-term-care home must have an unannounced inspection at least once a year. Although the Act does not specify that the annual inspection is to be a comprehensive one, in June 2013 the then Minister of Health and Long-Term Care publicly committed to completing comprehensive inspections of all Ontario long-term-care homes by the end of 2014, and every year after that. The Minister's commitment was made in recognition that more frequent comprehensive inspections would help identify systemic issues in long-term-care homes.

Soon after the Minister's public commitment, the Ministry announced its plans to hire about 100 new inspectors in addition to the 80 inspectors it already employed. In July 2013, the Ministry began conducting comprehensive inspections of each of the approximately 630 homes across Ontario. The Minister's commitment was 95% achieved by the end of 2014 and fully achieved by the end of January 2015.

As a result of the significant changes to the Program since 2010 (see **Figure 5**), its expenditures have fluctuated over the past five years. **Figure 6** shows the changes in expenditures for the fiscal years from 2010/11 to 2014/15. Spikes during the first two fiscal years are mainly related to the cost of developing and implementing the information systems that support the new inspection process. The increases over the last two fiscal years are mainly related to the cost of hiring close to 100 new inspectors.

1.3 Other Key Players in the Long-term-care Home Sector

In addition to the Ministry, there are several other key organizations and stakeholders involved in various aspects of long-term-care homes. Each of them plays a key role in providing and/or supporting quality of care and quality of life for long-term-care residents. **Appendix 4** provides more detail on the key players and their roles in the long-term-care home sector. Some of the main stakeholders are as follows:

- The Ministry's Long-Term Care Homes Licensing and Program Unit is responsible for licensing long-term-care homes.
- Ontario's 14 Local Health Integration Networks (LHINs) fund and monitor the performance of long-term-care homes.
- Ontario's 14 Community Care Access Centres (CCACs) determine applicants' eligibility and manage the admission process to long-term-care homes.
- Health Quality Ontario is an agency funded by the Ministry to evaluate the effectiveness of health-care services.
- Municipal fire departments conduct inspections at long-term-care homes to enforce the Ontario Fire Code. The Office of the Fire Marshal and Emergency Management, under the Ministry of Community Safety and Correctional Services, monitors service levels of fire departments as part of its oversight role.
- Several other associations and advocacy groups provide a wide range of support and services for seniors, residents, family members of residents, physicians, and operators in long-term-care homes.

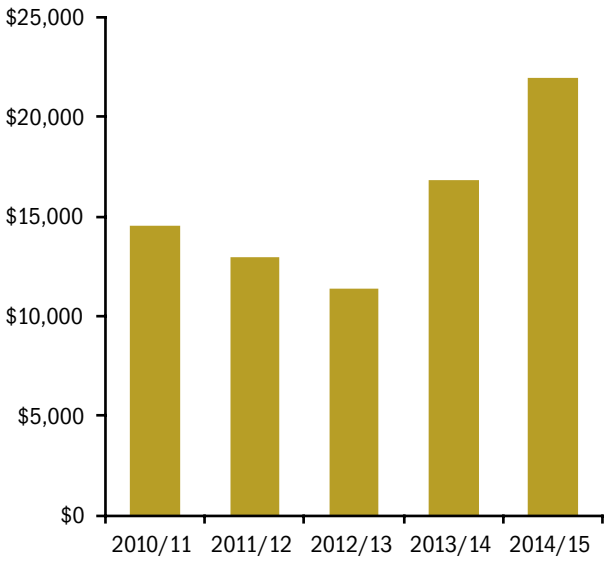
Figure 5: Long-Term Care Homes Quality Inspection Program, Key Events 2010–2015

Prepared by the Office of the Auditor General of Ontario

Date	Event
July 1, 2010	The *Long-Term Care Homes Act, 2007*, comes into effect. The Compliance Monitoring Program is renamed the Long-Term Care Homes Quality Inspection Program (Program).
February 2011	The Program launches a new two-stage comprehensive inspection process (see Appendix 3).
November 2012	The Program establishes a centralized intake unit to standardize the process for assigning complaints received from residents of long-term-care homes and their family members, and critical incidents reported by homes' operators to regional offices. (Before this, each regional office was responsible for handling the complaints and critical incidents reported for the homes in its region.)
June 2013	The Minister of Health and Long-Term Care publicly commits to conducting comprehensive inspections for all long-term-care homes by December 31, 2014, and annually after that. The Ministry commits to hiring about 100 new inspectors in addition to the 80 that the Program already employs.
July 2013	The Ministry begins its project to accelerate comprehensive inspections.
June 2014	The centralized intake unit develops an information system to track and assign all complaints and critical incidents received to regional offices.
December 31, 2014	The Program has conducted at least one comprehensive inspection at 95% of the 630 long-term-care homes across Ontario, largely meeting the Minister's June 2013 commitment.
January 31, 2015	Comprehensive inspections were completed for the remaining 5% of long-term-care homes.

Figure 6: Program Expenditures by Fiscal Year, 2010/11–2014/15

Source of data: Ministry of Health and Long-Term Care



2.0 Audit Objective and Scope

The objective of our audit was to assess whether effective systems and procedures were in place to:

- ensure that inspections of long-term-care homes are conducted efficiently and consistently across the province on a timely basis and in compliance with applicable legislative requirements; and
- measure and report on the effectiveness of the inspection program as it relates to the quality of care and quality of life for residents in long-term-care homes.

Senior management at the Ministry reviewed and agreed to our objective and associated audit criteria. We conducted our audit fieldwork from October 2014 to April 2015.

In conducting our audit, we reviewed applicable legislation, regulations, policies, information systems, case files, inspection reports and other relevant documents. We interviewed appropriate staff at the Ministry's head office, at the centralized intake unit and at all five regional offices. We also visited eight long-term-care homes, covering all five regions.

We met with representatives from Health Quality Ontario, as well as from several associations and advocacy groups, such as the Ontario Long Term

Care Association, Ontario Association of Non-Profit Homes and Services for Seniors, Ontario Association of Residents' Councils, Family Councils' Program, Advocacy Centre for the Elderly, and Ontario Long Term Care Physicians. These associations represent residents, families, physicians and long-term-care home operators across the province. We also met with the representatives from the Office of the Fire Marshal and Emergency Management and contacted several municipal fire departments to obtain a better understanding of their role in providing fire protection and prevention at long-term-care homes.

In addition to interviewing the residents' councils at the homes that we visited, we surveyed two key stakeholder groups—home administrators and family councils across the province—to get their perspectives on the Program and their experience with inspections conducted by the Ministry. The response rate was close to 30% from home administrators and 17% from the family councils.

We conducted research on similar inspection programs in other jurisdictions. We also engaged an independent expert with knowledge of the long-term-care home sector to advise us.

As part of our planning for this audit, we reviewed the Ministry's internal audit report on the inspection of trust accounts in long-term-care homes, and considered these audit findings when scoping our audit.

3.0 Summary

Since the *Long-Term Care Homes Act, 2007* (Act) came into effect in 2010, the Long-Term Care Homes Quality Inspection Program (Program) has undergone a number of changes to help ensure that homes comply with the legislation. Our audit found that delays by the Ministry in conducting complaints and critical-incident inspections and ensuring that homes correct deficiencies identified place residents at risk. We found that the Ministry often did not take timely action to ensure residents were safe and their rights were protected.

Since 2013, the Ministry has focused a great deal of its attention and resources—including the hiring of close to 100 new inspectors—on meeting the Minister's commitment of completing planned comprehensive inspections of approximately 630 long-term-care homes of the province by the end of 2014 and every year after that. At the same time, the Program has had to deal with a growing workload in other areas: addressing an increasing number of complaints and critical incidents at homes, following up on orders issued for non-compliance found in previous inspections, and reporting on inspection results.

The Ministry needs to strengthen its oversight of the Program to address the significant variations in inspectors' workloads, the number of compliance orders issued, and inspection and reporting timeliness across the province. Depending on the location of the home, residents' concerns might be inspected or followed up sooner, later or not at all. While the Canadian Institute for Health Information publishes quality-of-care indicators that are self-reported by long-term-care homes in Ontario, the Ministry did not link the information to its inspection results. Because the Ministry has neither monitored nor set targets for most aspects of the Program, it was unable to demonstrate the extent of the improvement that the inspection program has had on residents' quality of care and quality of life.

The following are some of our more significant findings:

- **Complaint and Critical-Incident Inspection delays place residents at risk**—While the commitment to conducting comprehensive inspections was met, the backlog of complaints and critical incidents was more than doubled—from about 1,300 as of December 2013 to about 2,800 as of March 2015. We found that 40% high-risk complaints and critical incidents that should have been inspected immediately took longer than three days; over a quarter of these cases took

between one and nine months for inspection. Sixty percent of our sample of medium-risk cases that should have been inspected within 30 days took an average of 62 days. In one case, the Ministry received a complaint in 2014 from a concerned family about a resident whose bed lacked bed rails, but an inspection was only conducted over six months later, by which time the complaint could not be verified. As well, during that inspection, the inspector reported that another resident at the same home who also lacked bed rails had fallen at night and sustained a serious head injury.

- **The Ministry did not prioritize comprehensive inspections based on homes' risk level**—We found that only a few homes that were considered high- or medium-risk underwent comprehensive inspections from June to December of 2013. Furthermore, almost all comprehensive inspections of high-risk homes were performed relatively evenly throughout 2014. If the Ministry prioritized the inspections based on risk, the issues identified by the Ministry later in the year could have been prevented or rectified by the homes sooner. The Ministry informed us that the primary reason it had not inspected higher-risk homes first was because lower-risk inspections provided training opportunities for new inspectors hired at the beginning of the year.
- **Homes are given inconsistent timelines to rectify issues identified by inspectors**—The Ministry does not provide clear guidance on how much time long-term-care homes should be given to comply with orders. For example, in 2014, inspectors in one region gave homes an average of 34 days to comply with orders relating to key risk areas (such as carrying out a resident's plan of care, protecting residents from abuse and neglect, and providing a safe, secure, and clean home), while inspectors in another region gave homes an average of 77 days to comply with similar orders. The Ministry could not explain the variance because it does not track and compare such information between regions.
- **The Ministry has not properly conducted secondary review of cases initially deemed not to require inspections**—The Ministry did not regularly conduct secondary reviews of the almost 10,800 complaints and critical incidents received in 2014 to ensure they were appropriately closed without inspection. This presents a risk that cases are being closed without the Ministry verifying that homes had taken proper action, were in compliance with the Act, and that residents' quality of care and quality of life were protected. Our survey of the family council representatives who had filed a complaint with the Ministry indicated that approximately 80% of them were not satisfied with how the cases were addressed by the Ministry. Reasons cited include no investigation took place and/or the outcome was never communicated back to the complainant.
- **Situations placing residents at risk are not followed up by the Ministry in a timely manner to ensure resolution**—The Ministry does not have an effective process for monitoring compliance orders that require follow-up. Specifically, two-thirds, or about 380, of compliance orders due in 2014 had not been followed up within the Ministry's informal 30-day target. On average, it took the Ministry two months after an order's due date to perform a follow-up inspection. For example, the Ministry issued a compliance order in January 2014 relating to a sexual harassment case; however, the Ministry did not follow up until eight months later when it found the home was still not in compliance. In another case, the Ministry did not follow up for over four months on a compliance order relating to a staff member verbally and physically abusing residents in 2014. In both cases, the inspectors had to re-issue new compliance orders to the homes for protection of the residents.

- **The Ministry's actions are not sufficient to address the repeated non-compliance in certain long-term-care homes**—We noted that homes in one region did not comply with almost 40% of the compliance orders issued by the Ministry in 2014, while homes in another region did not comply with about 17% of orders. The Ministry did not know the reasons why the homes repeatedly failed to correct certain deficiencies.
- **Inspection timeliness and effectiveness varies across the province**—We found that the timeliness of the whole inspection process (which we have defined as, from the receiving of complaints or critical incidents to conducting follow-up inspections) varied significantly across the province. In 2014, the Hamilton and Toronto regions took almost twice as long as the London region to complete the whole inspection process. Our analysis indicated that the Hamilton region issued, on average, 75% more compliance orders than the London region, which contributed to longer inspection times. Furthermore, the primary cause for inspection delays in the Toronto region was due to staffing and management issues, which resulted in it having the largest backlog of complaints and critical incidents.
- **Ontario legislation does not require a minimum front-line-staff-to-resident ratio at long-term-care homes**—Home administrators identified insufficient staffing and training as the main reasons for their failure to achieve compliance. In 2014, long-term-care homes provided an average of 3.4 direct care hours per resident per day, while the Ontario Association of Non-Profit Homes and Services for Seniors recommends four hours. Home administrators also said that the provincial funding of $7.87 per resident per day is not sufficient to meet residents' nutritional needs (three meals plus two snacks).
- **The Ministry does not consolidate useful quality-of-care information along with inspection results on long-term-care homes**—Apart from the Ministry's inspection program, other organizations report on the quality of long-term-care homes, covering indicators such as wait times, direct-care hours per resident per day, and the use of physical restraints and anti-psychotic drugs. The Ministry has made no attempt to consolidate and publish its inspection results with other useful information available, such as reports by Health Quality Ontario and Canadian Institute for Health Information. This information would help to provide a complete picture of how well a home is performing compared to other homes or compared to the provincial average.
- **The Ministry needs to pay more attention to fire safety at long-term-care homes**—The Ministry confirmed that 30% of Ontario long-term-care homes did not have automatic sprinklers installed as of March 2013. Furthermore, at the end of our audit, the Ministry still had no information on whether these 200 homes (representing over 20,000 residents) were complying with the Fire Code requirements aimed to reduce risk in dwellings with no automatic sprinkler systems. Municipal fire departments are responsible for attending fire drills and conducting fire inspections at long-term-care homes, but there is no formal protocol to share inspection results with the Ministry on a regular basis. By sharing the fire inspection results, the Ministry and municipal fire departments can better ensure that homes are assisted in correcting the fire safety deficiencies or, if necessary, the Ministry would have the knowledge to be able to intervene and relocate residents from unsafe homes in a timely manner.

This report contains 13 recommendations, consisting of 30 actions, to address the findings noted during this audit.

OVERALL MINISTRY RESPONSE

The health, safety and well-being of residents in Ontario's Long-Term Care (LTC) Homes are of paramount importance to the government of Ontario. Long-term-care homes are the *homes* of over 77,000 people. In these dwellings residents can continue to live with dignity, security, safety and comfort, and have their physical, psychological, social, spiritual and cultural needs met. As such, the Ministry welcomes and appreciates the comprehensive audit conducted by the Auditor General on the Long-Term Care Homes Quality Inspection Program. The recommendations in this report will be used to build upon existing success and will support continuous quality improvement.

The *Long-Term Care Homes Act, 2007* (Act) came into force on July 1, 2010. The Act and Ontario Regulation 79/10 were developed to improve the resident experience and quality of life in LTC homes. The Act sets clear and detailed standards for residents' rights, care and services, and for the operation of LTC homes.

Within the context of the Act, the Ministry has transformed the inspection process to achieve a more accountable, consistent and transparent compliance inspection program that focuses on risk issues and resident-care outcomes. The Long-Term Care Homes Quality Inspection Program (Program) safeguards resident rights, safety, and quality of care through various types of inspections including comprehensive inspections, complaint and critical-incident, and follow-up inspections.

Since the implementation of the Act, the Ministry has completed over 12,900 inspections and over 1,100 comprehensive inspections. Ministry inspectors have a duty under the Act to identify in an inspection report all non-compliances found during the course of an inspection.

To comply with the requirements of the Act, the Ministry launched a refreshed public website in February 2012. This site contains links to the public versions of all inspections reports and orders related to inspections conducted in LTC homes across the province since July 1, 2010.

The Ministry is continually working to refine and improve the Program to ensure its effectiveness and, ultimately, to provide security, safety, and comfort to its residents. The Program has experienced significant growth of 150% over the past 18–24 months with the addition of up to 100 new inspectors. This has enhanced the Ministry's ability to complete more timely inspections; it has also helped meet the government's commitment as noted above. The Ministry implemented IT improvements in 2015 to support management reporting. These improvements will help the Program better address the recommendations of the Auditor General.

In recognition of the important role that LTC homes play in the health care system, subsequent to the audit the Ministry created a new Long-Term Care Homes Division which came into effect October 2015. As part of the new division, a new LTC Homes Inspection Branch was also established to help the Ministry in its continued focus on resident care and safety and to enhance program oversight.

4.0 Detailed Audit Observations

4.1 The Ministry is Slow in Addressing Complaints and Critical Incidents at Long-term-care Homes

4.1.1 Inadequate Resource Planning Has Contributed to a Backlog of Complaint and Critical-incident Inspections

The Minister's commitment to perform comprehensive inspections of the roughly 630 long-term-care homes in the province was met by January 2015. But that meant the Program had fewer resources

available for other types of inspections. At the same time, the Ministry has received a significant increase in complaints and critical incidents requiring inspections—from approximately 3,640 in 2013 to 5,440 in 2014. The result is a serious backlog.

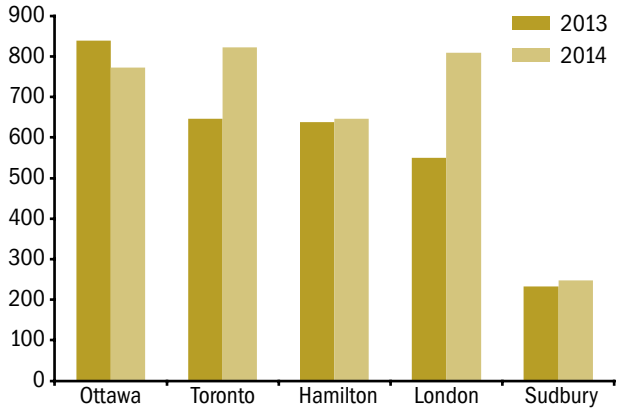
Backlog of Complaint Inspections

As of March 31, 2015, the Ministry had about 960 complaints outstanding, an amount that has increased by almost 70% (from about 570) since December 2013. The increased backlog mainly stems from a greater number of complaints received and those requiring inspections.

- In 2014, the Ministry received a 13% increase in complaints—from about 2,910 in 2013 to about 3,300 in 2014. The London region, in particular, had experienced the most significant increase—a 47% increase in complaints between the two years (see **Figure 7**). The Ministry indicated that the increase was due to an improved public awareness, a reflection of the Minister's heightened commitment to these matters. However, the Ministry could not explain why the London region had experienced the most increase in complaints compared to the other regions. Our further analysis indicated that it could relate to the difference in quality of care across the province. Based on the information reported by the Canadian Institute for Health Information, we noted that, for example, the results of eight out of nine quality-of-care indicators at long-term-care homes in the London region were below the provincial average in 2013/14.
- The Toronto region experienced a 26% increase in complaints from about 650 cases in 2013 to about 820 cases in 2014. The increase was primarily due to the geographic re-allocation of the 23 long-term-care homes (representing approximately 4,500 residents) from the Ministry's Ottawa regional office to the Toronto regional office in 2014.
- As the Ministry received a higher number of complaints in 2014, the number of these cases requiring inspections also increased by 31%, from approximately 1,600 cases in 2013 to approximately 2,100 cases in 2014. The Ministry assessed that of the 2,100 complaints requiring inspections, 2%, 53%, and 45% were high-, medium-, and low-risk, respectively, as shown in **Figure 8**. **Figure 9** indicates that the most frequent public complaints

Figure 7: Number of Complaints Received, by Region, 2013 and 2014*

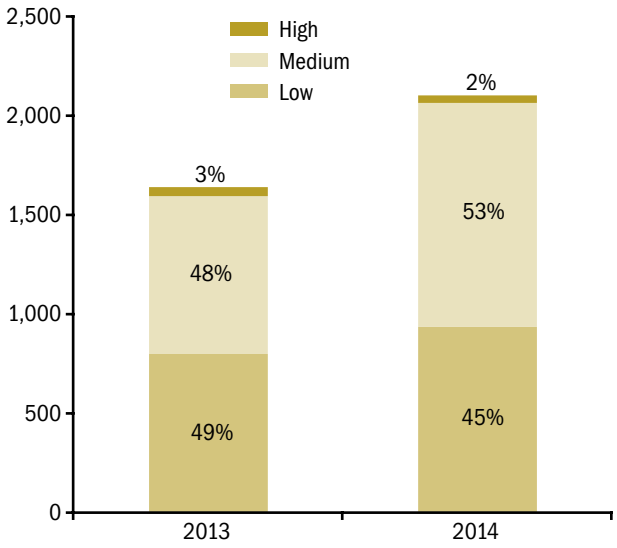
Source of data: Ministry of Health and Long-Term Care



* Based on calendar year. Regional data prior to 2013 is not available because the Ministry did not track the information.

Figure 8: Number of Province-wide Complaints Requiring Inspections, by Risk Level, 2013–2014*

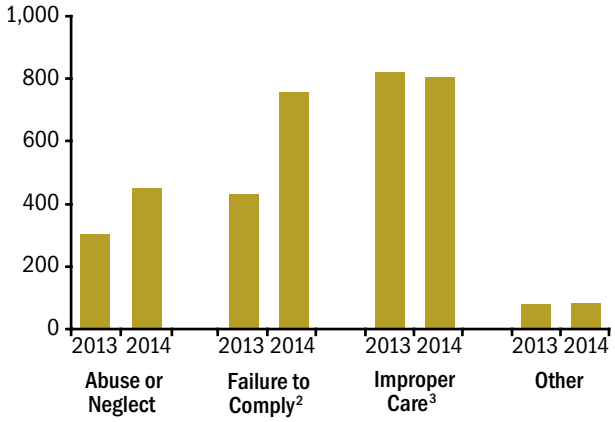
Source of data: Ministry of Health and Long-Term Care



* Based on calendar year. Data prior to 2013 is not available.

Figure 9: Number of Province-wide Complaints Requiring Inspections, by Category, 2013–2014[1]

Source of data: Ministry of Health and Long-Term Care



1. Based on calendar year. Data prior to 2013 is not available.
2. Failure to Comply: issues related to home operations (e.g., emergencies, outbreaks, infection control, safe and secure home, and staffing and care standards).
3. Improper Care: issues related to direct resident care (e.g., pressure ulcers, physical restraints, weight loss, bowel or bladder incontinence, pains, falls, responsive behaviours and medication misappropriation).

were of homes not providing proper care to residents or not meeting other operational standards such as in handling emergencies, outbreaks, and infection control.

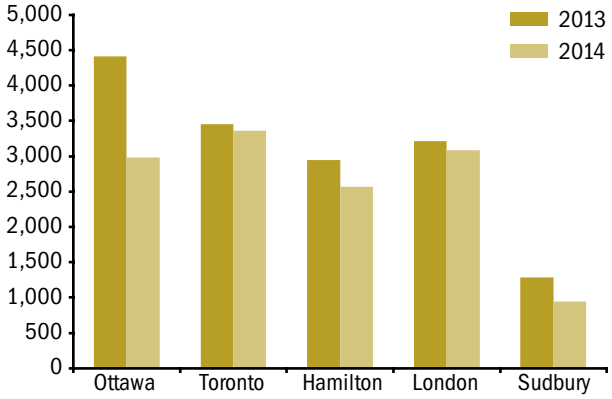
Backlog of Critical-incident Inspections

The Ministry also had a backlog of critical-incident inspections. As of March 31, 2015, the Ministry had about 1,840 critical incidents outstanding, an amount that has increased by more than two-and-a-half times (from about 700) since December 2013. The increased backlog mainly stems from a greater number of critical incidents requiring inspections.

- In 2014, the Ministry determined that about 3,340 critical incidents should be inspected (from 2,040 in 2013) despite long-term-care homes in all regions self-reporting a fewer number of critical incidents in 2014 than in 2013 (see **Figure 10**). In late 2013, the Ministry revised the reporting requirements for critical incidents. For example, homes do not need to report every instance that a resident is taken to a hospital if his/her health did not change significantly.

Figure 10: Number of Critical Incidents Reported by Long-term-care Homes, by Region, 2013 and 2014*

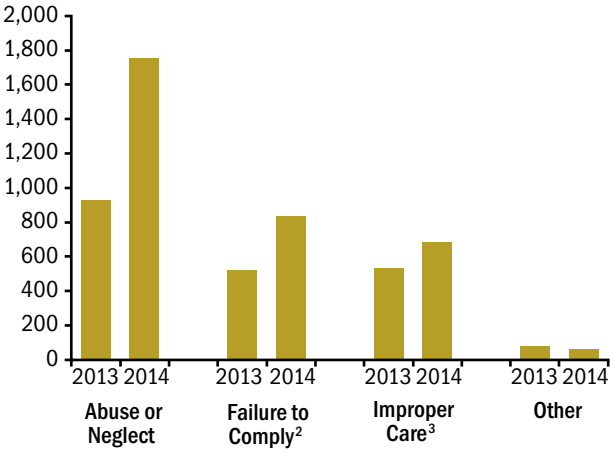
Source of data: Ministry of Health and Long-Term Care



* Based on calendar year. Regional data prior to 2013 is not available because the Ministry did not track the information.

Figure 11: Number of Province-wide Critical Incidents Requiring Inspections, by Category, 2013–2014[1]

Source of data: Ministry of Health and Long-Term Care



1. Based on calendar year. Data prior to 2013 is not available.
2. Failure to Comply: issues related to home operations (e.g., emergencies, outbreaks, infection control, safe and secure home, and staffing and care standards).
3. Improper Care: issues related to direct resident care (e.g., pressure ulcers, physical restraints, weight loss, bowel or bladder incontinence, pains, falls, responsive behaviours and medication misappropriation).

- In 2014, the majority of critical incidents requiring inspections was in the abuse-and-neglect category, a number that had increased by 90% from about 930 cases in 2013 to about 1,750 cases in 2014 (see **Figure 11**). The increase is primarily due to the homes

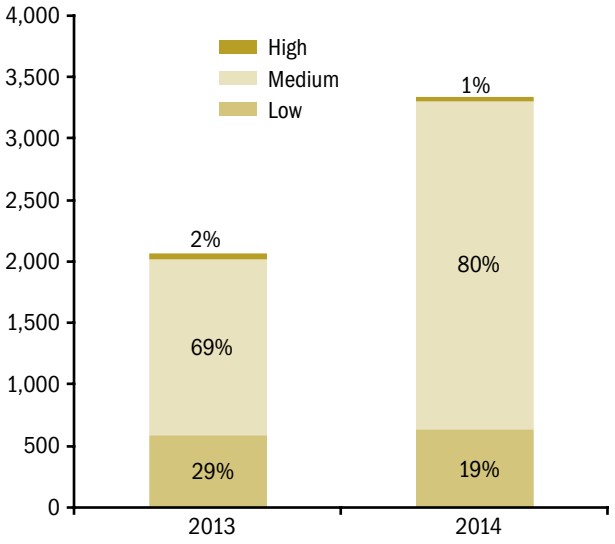
being better trained by the Ministry on their obligation to report abuse and neglect cases. Because the homes reported a greater number of abuse-and-neglect critical incidents in 2014, many of these cases that warranted an inspection were assessed as medium risk by the Ministry as shown in **Figure 12**.

As of March 31, 2015, four of the five regional offices had complaints or critical incidents that had been outstanding for more than a year with no inspection. The number of such cases per office ranged from two at one office to 94 at another.

We found that the Ministry had not undergone a thorough analysis of the projected and actual workload in each region before deciding to hire an additional 100 inspectors in July 2013. Instead, the decision was based solely on the resources the Ministry estimated would be needed to meet the Minister's commitment of conducting comprehensive inspections of every home by the end of 2014. As such, it didn't take into account the Program's other responsibilities, such as conducting complaint, critical-incident and follow-up inspections, as well as reporting inspection results. Once the Ministry realized it had insufficient staff to meet both the Minister's commitment and the growing backlog of complaint, critical-incident and follow-up inspections, in September 2014 it approved the hiring of an additional 24 employees, including 12 inspectors and 12 administrative staff.

Figure 12: Number of Province-wide Critical Incidents Requiring Inspections, by Risk Level, 2013–2014*

Source of data: Ministry of Health and Long-Term Care



* Based on calendar year. Data prior to 2013 is not available.

4.1.2 Complaint and Critical-Incident Inspection Delays Place Residents at Risk

The Ministry's policy is to conduct inspections of homes with complaints and critical incidents in accordance with their risk level: high-risk cases should be inspected immediately and medium-risk cases within 30 days. We found that the Ministry was not always meeting its targets.

We reviewed all high-risk and a sample of medium-risk complaints and critical incidents in 2014 and found that about 40% of high-risk cases and about 60% of medium-risk cases had not been inspected on a timely basis. Forty percent of the high-risk cases that we reviewed should have been inspected immediately but took longer than three days; over a quarter of the 40% high-risk cases took between one and nine months for inspection. We also found that medium-risk cases in our sample that should have been inspected within 30 days took an average of 62 days. We noted some cases where inspection delays had negatively impacted residents' quality of care and quality of life:

- The Ministry was informed of a high-risk critical incident in August 2014 relating to a resident who had difficulty swallowing and died from choking while eating under the supervision of a long-term-care home staff member. An inspection took place over three months later because no inspectors were available until then. During the inspection, the inspector found that the home had failed to prepare a care plan (a care plan or plan of care sets out clear directions to staff covering how a resident's care, such as medical, nursing, personal support and dietary care, should be delivered) to ensure that the resident was eating safely. The inspector also found seven other incidents where orders

from residents' physicians and dieticians were not followed, which increased the risk of harm to these residents.

- In August 2014, the Ministry received a medium-risk complaint about a resident whose family believed he/she was unsafe due to sleeping in a bed that lacked bed rails. No inspection took place until February 2015, more than six months later, by which time the complaint could not be verified because the resident had passed away. As well, during the inspection, the inspector reported that another resident who also lacked bed rails had fallen at night and sustained a serious head injury.
- In May 2014, the Ministry received a critical-incident report relating to the alleged physical abuse of a resident by a home's staff member. Yet, no inspection took place until February 2015—more than eight months later. The Ministry informed us that the inspection had been delayed because of insufficient resources, and that it was told the home had put the staff member on paid leave. However, without performing an inspection, the Ministry could not ensure that the action was actually taken by the home or that it was providing adequate training for its staff on residents' rights. When the inspection finally did take place, the inspector issued an order that required the home to provide staff with training on abuse policy and residents' rights.

We also found little consistency from one region to the next in terms of the time it takes to complete each step of the inspection process—which we have defined as, from receiving a complaint or critical incident to performing an inspection; from the inspection end date to the completion of the inspection report; from the date an order is issued to its due date; and from an order's due date to the date of performing a follow-up inspection. Because the Ministry does not track the inspection process from beginning to end, we used the best information available to estimate the time it took to complete medium-risk complaint or critical-incident inspections in each region. We found that, depending on where a medium-risk complaint or critical incident originated, the Ministry took between 126 days (or about four months) to 248 days (or about eight months) to complete the entire inspection process, with the provincial average 188 days (or about six months), as shown in **Figure 13**.

We found that the Hamilton and Toronto regions took almost twice as long as the London region to complete the whole inspection process. Upon further analysis, we noted that the Hamilton region issued, on average, 75% more compliance orders than the London region, which led to longer inspection times. We also found that the primary cause for inspection delays in the Toronto region was due to staffing and management issues, which resulted in it having the largest backlog of complaints and critical incidents—fives times more than the London region.

RECOMMENDATION 1

To ensure that the Program significantly improves the timeliness of inspecting complaints and critical incidents, the Ministry of Health and Long-Term Care should:

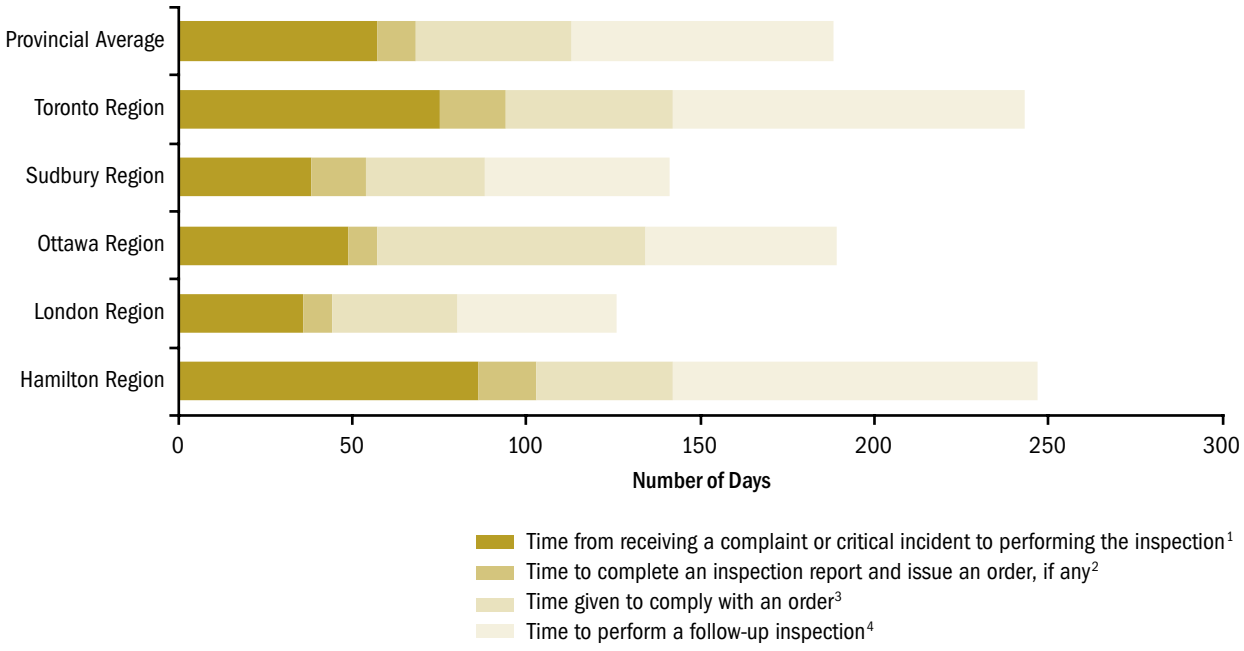
- identify the reasons for the significant fluctuation in the number of complaints and critical incidents as well as cases requiring inspection;
- collect and analyze all the information needed (including total projected workload, the number of inspectors available compared to demand, inspection duration and timeliness, regional circumstances, and other risk factors) to develop a detailed resource plan and distribute resources accordingly; and
- regularly monitor and evaluate the resource plan against actual performance to determine if further action is required.

MINISTRY RESPONSE

The Ministry accepts this recommendation and has established criteria for the Centralized

Figure 13: Estimated Average Number of Days the Ministry takes to Complete the Inspection Process (from Receiving a Medium-risk Complaint or Critical Incident to Conducting a Follow-up Inspection) by Region, 2014[a,b]

Prepared by the Office of the Auditor General of Ontario



a. Because the Ministry of Health and Long-Term Care does not track the inspection process from beginning to end, we used the following sources of data/assumptions to create this figure:
   1. The time from receiving a complaint or critical incident to performing the inspection. It is based on a sample of inspections for medium-risk complaints and critical incidents.
   2. The time from the end of an inspection to the inspection report completion date. It is based on a sample of complaint inspection reports, critical-incident inspection reports and follow-up inspection reports.
   3. The time from the date an order is issued to the date the non-compliance must be rectified by the home. It applies to orders in "key risk areas" identified by the Ministry.
   4. The time from the date an order is due to the date of performing a follow-up inspection to ensure compliance of the order. It includes all orders that call for a follow-up inspection.

b. Based on calendar year.

Intake Assessment and Triage Team's (CIATT) assessment of all critical incidents and complaints. Using these criteria, the CIATT will be able to determine potential legislative or regulatory non-compliance with one or more of the requirements in the Act and, if necessary, the potential risk to one or more residents associated with the complaint or critical incident.

The CIATT utilizes the established criteria and program policies and procedures to determine whether a critical incident or complaint needs to be triaged to the respective regional office for inspection. As well, the Ministry has recently implemented a formal audit of a random sample of cases to ensure the criteria, policies and procedures are applied consistently.

The volumes of complaints and critical incidents vary from month to month. Fluctuations in numbers of complaints or critical incidents being identified as requiring inspection is expected, as every case is assessed individually and decisions on inspection will differ based on the specific set of circumstances associated with the case.

The Ministry will conduct an analysis of the current organizational structure of its Long-Term Care Homes Quality Inspection Program (Program). This will include an analysis of staff and management complements and workload,

intake functions, administrative functions, specialized resources and operating budget, as well as strengths, opportunities and risks of the current program structure.

This analysis will inform potential organizational strategies to support a more efficient deployment of program resources, more manageable workload, the sustainability of the program, and promote provincial consistency in the management and delivery of the program.

Included in the organizational strategies will be an evaluation plan to ensure there is regular evaluation of the resources against program requirements to determine if further action is required.

4.2 Tracking of Complaints and Critical Incidents is Inconsistent and Inadequate

4.2.1 The Ministry Is Not Tracking Complaints and Critical Incidents Effectively

We found that the Ministry did not know how many inspections were overdue or for how long because it does not have an effective system in place to track complaints and critical incidents that require inspections. Also, inconsistent practices from one region to another mean that inspection timelines differ widely across the province. For example, one region took, on average, 36 days to conduct medium-risk complaint and critical-incident inspections, while another took 86 days, far exceeding the Ministry's 30-day target for medium-risk inspections. During our visits to the five regional offices and discussions with program staff, we found the following:

- The electronic logs for tracking complaints and critical incidents used in regional offices are prone to human error and do not flag when key information is missing. For example, regional offices did not always note the risk level of a complaint or critical incident in their tracking logs. Without this information, the Ministry has no way of effectively demonstrating that higher-risk cases, such as abuse and neglect incidents that place residents in immediate jeopardy, are being addressed within an appropriate time frame. We found that, of the approximately 2,800 complaints and critical incidents outstanding as of March 31, 2015, about 800 (or 30%) did not have a risk level assigned to them.
- None of the regional offices track and monitor the number of complaints and critical incidents that are past due for inspection. Based on our own calculations, we found that, for the 2,000 cases that did have a risk level noted, about 1,200 (or 60%) were past their inspection time frame. Close to 90%, or 1,070, of the complaints and critical incidents that were overdue as of March 31, 2015 were assessed by the Ministry to be medium-risk.
- Although the logs for tracking complaints and critical incidents are standardized for all regions, their use was inconsistent. One regional office had missing fields in its tracking log, another maintained two separate logs and a third was using its own internally developed tracking system. Inspector team leads in each regional office may also use their judgement in prioritizing and assigning complaints and critical-incident inspections. We found their methods varied widely. For example, one regional office's informal policy is that all low-risk complaints should be inspected within 30 days of receiving them. (The Ministry has no policy regarding when to inspect low-risk cases, but has set an informal target of 120 days, which can be followed at each regional office's discretion.) The other four regional offices schedule inspections based primarily on risk, regardless of the order in which they were received. One regional office informed us that, for the sake of efficiency, it did not conduct separate inspections for medium-risk complaints and critical incidents, inspecting them instead when it was time for the home's annual comprehensive inspection. In this region,

the Ministry's 30-day inspection target for medium-risk cases was often not followed.

4.2.2 The Ministry Has Not Reviewed Cases That Were Closed Without Inspections

In 2014, the Program's centralized intake unit determined that only about one-third of the approximately 16,240 complaints and critical incidents required an inspection. We reviewed a sample of the remaining two-thirds of complaints and critical-incident cases that had been closed without inspection and found that 65% of them had insufficient documentation to show why an inspection was not required. After a further review of the case details, we found the decision not to inspect could be justified for half the cases, but it was not clear why an inspection had not been required for the other half. This presents a risk that cases are being closed without the Ministry confirming the homes had taken proper action, the homes are in compliance with the Act, and that residents' quality of care and quality of life are protected. In addition, the Ministry did not always contact the family members to ask if they were satisfied that any problems or concerns affecting the residents were resolved appropriately.

For example, the Ministry closed a complaint received in May 2013 without an inspection. The complaint was from a resident's family member who was concerned about the resident's loss of appetite, vomiting and weight loss. The family member requested twice that the resident be examined at a hospital. But the Ministry could not demonstrate it had made sufficient efforts to ensure the resident was properly cared for and that the complainant was satisfied with the result. We noted another example where the Ministry closed a critical-incident case, reported in April 2015, without an inspection. The Ministry did not contact the family member to confirm that they were satisfied with the result. Instead, the Ministry relied solely on the report filed by the home claiming that it had resolved the case appropriately. Believing the critical incident was much more serious than the home reported, the family member was later surprised to hear that the Ministry decided not to perform an inspection. Subsequently, the family filed a formal complaint alleging the home did not treat the resident with respect when handling the critical incident.

Our survey of family council representatives conducted in March 2015 indicated that approximately 80% of those who had filed a complaint with the Ministry were not satisfied with the outcome. Reasons cited included lack of investigations and outcomes not being communicated back to complainants. The Ministry's policy requires inspectors to report back to complainants on the outcomes of their inspections, but we found no documentation in the Ministry's tracking system to show that this had been done for over 20% of the files we examined.

RECOMMENDATION 2

To better track, prioritize and monitor the handling of complaints and critical incidents, the Ministry of Health and Long-Term Care should:

- perform periodic secondary reviews of complaints and critical incidents received by the Program's centralized intake unit to ensure that reasons for not conducting an inspection are justified and documented;
- track and monitor complaints and critical incidents that are overdue for inspections;
- clarify expectations on how to prioritize and when to inspect complaints and critical incidents to ensure consistency throughout the province; and
- inform complainants and the family members of inspection results or why an inspection was not conducted, and document the action taken.

MINISTRY RESPONSE

The Ministry supports this recommendation and has introduced business processes and procedures as of June, 2015 to formalize the review

process (random audit samplings). Currently, the CIATT manager conducts random audits of all cases (closed and triaged for inspection) and addresses any identified concerns with CIATT staff. Information gathered through the randomized audit process will inform quality improvement opportunities including training and updates to policies and procedures.

The Ministry tracks the number of new and yet to be inspected complaints and critical incidents on a monthly basis. In May 2015 changes were implemented in the Intake Application to allow reporting of additional fields, including target dates for inspection along with their risk level. This allows reports to be generated, identifying which intakes are overdue for inspection. As of September 2015, this data has been reported from the Intake Application. Regional offices' staff are being trained to run the reports. This will be in place for all regional offices with standardized business processes by November 2015.

Criteria related to prioritizing inspections is outlined in the policy, shared with all inspectors during orientation and reinforced during CIATT/regional office staff meetings as required. The Ministry will review the current policy to identify any opportunities for further guidance for inspectors in order to support a consistent approach across the province.

The current policy requires inspectors to contact the complainant after the inspection to let them know the results of an inspection. This policy is reinforced through the training of inspectors and monthly regional office meetings, as required. At CIATT, complainants are informed that, where their concern is not covered by the Act, an inspection will not be conducted. In these cases complainants are advised on alternative resources (where appropriate) to help them address their issue. There are also situations, determined either by CIATT or at the regional offices, where sufficient information has been gathered to determine that an inspection is not required. The policy will be updated to formalize the requirement to inform the complainant if an inspection will not be conducted.

4.3 Comprehensive Inspections Are Not Prioritized By Risk

Given that the Ministry had to conduct a comprehensive inspection of every long-term-care home by the end of 2014 to meet the Minister's commitment, we expected that it would have a system in place to prioritize inspections of higher-risk homes within the targeted time frame. However, we found that higher-risk homes were not being inspected before lower-risk homes.

When we reviewed the actual sequence in which homes received comprehensive inspections, we found that very few medium- and high-risk homes had been inspected from June 2013 to December 2013; instead, almost all comprehensive inspections of high-risk homes were performed relatively evenly throughout 2014. The Ministry informed us that it did use a risk-based framework to schedule comprehensive inspections. This framework is supposed to assign a risk level to each home using factors such as the number of complaints and critical incidents, the number of orders the home had been previously issued, and a quarterly risk report that includes an assessment of every home in the province. However, we did not find that the Ministry had conducted inspections based on its own risk levels.

If the Ministry prioritized the inspections based on risk, issues at homes that were later identified by the Ministry could have been prevented or rectified by the homes sooner. We found that the Ministry inspected over 50 higher-risk homes after the first half of 2014 which resulted in close to 90 orders issued to these homes. For example, the Ministry found that numerous homes had failed to update and/or follow residents' plan of care which contributed to the residents sustaining injuries such as bone fractures from falls. At one home, the inspectors found that residents were

suffering increased level of pain because the home had insufficient nursing staff to reassess residents' medical needs. At a few other homes, inspectors found that home staff refused to provide residents with basic care such as bathing, maintaining oral hygiene and bringing residents to the washroom.

The Ministry informed us that the primary reason higher-risk homes had been inspected later was because training opportunities were needed for new inspectors, so the Ministry had them perform inspections at lower-risk homes at the beginning of the year.

We found that the Ministry's new comprehensive inspection process was an improvement over its previous inspection program. The two-stage inspection process, which was implemented in February 2011, is more extensive than those in other provinces. For example, inspection procedures are now standardized for improved consistency; inspectors conduct interviews and record reviews and observations using a statistically representative sample of residents; and automated systems help ensure that high-risk areas are inspected as needed. However, given the increase in complaints and critical incidents requiring inspections (see **Section 4.1**) and the extensive resources that are required to complete a comprehensive inspection, the Ministry needs to better prioritize comprehensive inspections, allocate resources more efficiently and assess the frequency of comprehensive inspections based on risk.

RECOMMENDATION 3

To put the safety of residents first by focusing on high-risk areas, the Ministry of Health and Long-Term Care should:

- prioritize comprehensive inspections based on long-term-care homes' complaints and critical incidents, compliance history and other risk factors; and
- consolidate past inspection results and conduct a cost-benefit analysis to determine the frequency in which comprehensive inspections should take place in the future.

MINISTRY RESPONSE

The Ministry accepts this recommendation and currently has a Risk Management Framework that sorts all homes in risk priority based on an established number of factors. The factors include: compliance history, complaint and critical-incident inspections resulting in non-compliance, qualitative information (e.g., leadership turnover) and other risk factors. Comprehensive inspections are scheduled based on a number of factors including: risk level of the home, inspector experience and availability, and geographic considerations. Regional office managers review this information quarterly and assign/reassign comprehensive inspections based on the above factors.

The Ministry is evaluating options to consider a focused, comprehensive inspection which would be shorter and less resource intensive for homes that are substantially compliant and lower risk.

4.4 The Ministry Needs to Pay More Attention to Fire Safety at Long-term-care Homes

Ministry inspectors do not examine a long-term-care home's fire safety measures as part of their comprehensive inspections unless a fire has been reported by the home, a resident or the public. If an incident or complaint triggers the inspector to review the emergency management process, inspectors will determine whether the home has written plans to deal with emergencies such as fires and other disasters, and the evacuation and relocation of residents and staff.

According to the Ministry, a home-reported survey found that 30% of long-term-care homes did not have automatic sprinkler systems as of March 2013. This represents about 200 homes that accommodate over 20,000 residents across the province. Furthermore, the Ministry did not know whether these 200 homes were complying with Fire Code requirements

aimed at reducing risk in buildings where automatic sprinkler systems are not in place, such as having a fire safety plan approved by the local fire department and carrying out annual fire drills and mock evacuations. By the end of our audit, the Ministry, which funds and regulates long-term-care homes, could not provide us with an updated list of long-term-care homes that had been retrofitted to have automatic sprinklers installed since 2013.

Municipal fire departments are responsible for attending fire drills and conducting fire inspections at long-term-care homes, but there is no formal protocol in place for sharing their inspection results with the Ministry. By sharing fire inspection results, the Ministry and municipal fire departments can better coordinate efforts to assist homes in correcting the fire safety deficiencies or, if necessary, to relocate residents from unsafe homes in a timely manner.

On January 1, 2014, Ontario made comprehensive changes to its fire safety regulations. All vulnerable occupancies (any residence that houses the vulnerable population), which include long-term-care homes, will be required to have fire safety measures, such as automatic sprinkler systems, in place. Municipal fire departments are responsible for ensuring that, by January 2025, long-term-care homes meet the new fire safety standards, including the installation of automatic sprinklers.

We acknowledge that the Ministry has, since 2014, put in place a strategy to help home operators redevelop approximately 300 older homes to bring them up to the most current design standards. However, the 2025 compliance timeline is still about 10 years away from the time of our audit. The Ministry should consider the impact of the homes not having automatic sprinklers installed and ensure that the residents and family members are aware of the situation if their long-term-care homes have not yet been equipped with an automatic sprinkler system.

RECOMMENDATION 4

To mitigate the risk of fire at long-term-care homes, the Ministry of Health and Long-Term Care should work with the Office of the Fire Marshal and Emergency Management and municipal fire departments to establish a formal protocol to regularly share information with the Ministry on homes' non-compliance with fire safety regulations, focusing on homes that do not yet have automatic sprinklers installed.

MINISTRY RESPONSE

The Ministry supports this recommendation and recognizes that the Fire Marshal, local fire departments, and the Chief of Emergency Measures have jurisdiction over inspections for fire and safety measures.

The Ministry has an established relationship with the Office of the Fire Marshal and Emergency Management and will engage with the Office to explore opportunities to develop a formal protocol where the Ministry will be notified should there be significant risks related to fire safety identified in a home.

4.5 Long-term-care Homes are Given Inconsistent Deadlines to Rectify Issues

The Ministry does not provide clear guidance on the appropriate length of time that inspectors should give long-term-care homes to comply with orders to correct issues identified during inspections. Although each case is different, depending on the types and areas of non-compliance and the circumstances surrounding the home, we expected to see some consistency in the time frames given to comply with orders of similar risk and non-compliance areas. Instead, we found that time frames varied widely by region. For example, in 2014, inspectors in one region gave homes an average of 34 days to comply with orders relating to key

risk areas (such as carrying out a resident's plan of care, protecting residents from abuse and neglect, and providing a safe, secure and clean home) and respecting the Resident's Bill of Rights (the Act lists 27 rights that residents are entitled to, such as the right to be treated with courtesy and respect, the right to be protected from abuse and the right not to be neglected). Meanwhile, inspectors in another region gave the homes an average of 77 days to comply with similar orders.

The Ministry has not tracked and compared the different information between regions and could not provide reasons for the variations that we found.

RECOMMENDATION 5

To ensure residents across the province are equally protected by the *Long-Term Care Homes Act, 2007*, the Ministry of Health and Long-Term Care should:

- establish a clear policy and guidelines for inspectors to use in determining an appropriate time frame for homes to comply with orders addressing similar risk and non-compliance areas; and
- periodically review whether the policy and guidelines are being followed consistently by regional offices.

MINISTRY RESPONSE

The Ministry accepts this recommendation. The Ministry, through policy, has a judgement matrix tool to guide inspectors in making decisions about what action/sanction (e.g., order) to apply when there's a finding of non-compliance.

Orders are typically issued in areas that pose a higher risk to residents or as a result of recurring non-compliance. While orders may be issued under a similar section or subsection of the legislation, the circumstances and set of facts that give rise to the issuance of the orders are unique.

The Ministry will review and refine related policies to provide criteria/additional guidance to inspectors to promote greater consistency in the time frames for compliance of orders where the orders address similar risk and non-compliance areas.

The Ministry will develop an audit mechanism to periodically review the consistency with the revised policy across the regional offices.

4.6 The Ministry's Actions Are Not Sufficient to Deter Homes from Repeating Non-Compliance

4.6.1 Homes Are Struggling with Similar, Serious Compliance Issues

There are over 50 different areas in which homes have failed to comply with an order, with ten areas accounting for nearly 50% of all these cases. **Figure 14** shows the top 10 areas where orders have been re-issued from follow-up inspections conducted in 2013 and 2014. Several areas within the top 10 are serious, what the Ministry calls "key risk areas": failing to carry out a resident's plan of care, failing to protect residents from abuse and neglect, failing to provide a safe, secure and clean home, and failing to respect the Resident's Bill of Rights. Eight of the 10 areas in 2013 re-appeared in the top 10 list in 2014.

We found that, even when the Ministry deemed an instance of non-compliance to be serious enough to warrant a compliance order, long-term-care homes were often not taking the necessary steps to become compliant. In 2014, the Ministry performed follow-up inspections on approximately 770 compliance orders of which 570 were due at 210 homes that year. It found that 78 homes had failed to comply with 142 (or 25%) of the 570 compliance orders. Of these 142 orders, 31 (or 22%) of them related to one of the Ministry's key risk areas. One home failed to comply with 18 orders the Ministry has issued over the past two years.

In our discussions with long-term-care home administrators, they identified the main reasons for failing to achieve compliance: insufficient

Figure 14: Top Ten Areas of Re-issued Orders,[1] 2013 and 2014

Source of data: Ministry of Health and Long-Term Care

Areas of Non-compliance	2013	2014
1	Complying with residents' plans of care[2]	Proper use of bed rails
2	Policies, procedures and records	Complying with residents' plans of care[2]
3	Ensuring residents have a plan of care[2]	Policies, procedures and records
4	Reassessing residents and revising plan of care[2]	Respecting Residents' Bill of Rights[3]
5	Duty to protect residents from abuse and neglect	Communication and response systems
6	Cleanliness and repair of homes	Duty to protect residents from abuse and neglect
7	Proper use of bed rails	24-hour nursing care
8	24-hour nursing care	Ensuring residents have a plan of care[2]
9	Doors in home (locking, closing, etc.)	Cleanliness and repair of homes
10	Dining and snack service	Doors in home (locking, closing, etc.)

1. If an inspector determines during the course of a follow-up inspection that a home has not complied with an order, that compliance order is closed and a new order is issued. Re-issued orders show continued non-compliance.
2. Plan of care—A plan setting out clear directions to staff covering how a resident's care, including medical, nursing, personal support, dietary, etc., should be delivered.
3. Resident's Bill of Rights—The Act lists 27 rights that residents are entitled to, such as the right to be treated with courtesy and respect, the right to be protected from abuse and the right not to be neglected.

staffing and training. Over 50% of the home administrators we surveyed believed that staffing levels are generally not sufficient to meet residents' needs and comply with Ministry requirements. In Ontario, the legislation does not require a minimum front-line-staff-to-resident ratio at long-term-care homes. The Ministry informed us that, in 2014, the number of direct care hours per resident per day was 3.4, less than the four hours recommended by the Ontario Association of Non-Profit Homes and Services for Seniors in its recent 2015 submission to the government.

Other home administrators expressed concerns that the provincial funding of $7.87 per resident per day (three meals plus two snacks) is not sufficient to meet residents' nutritional needs. The Ontario Association for Not-Profit Homes and Services for Seniors' has reported that, over the last five years, Ontario food inflation has increased by 11.5% whereas the cumulative increase in food funding for long-term-care homes has grown by less than 7%, or 50 cents per resident per day.

4.6.2 The Ministry Is Not Doing Enough to Address Repeated Non-Compliance

Although the Ministry has a process for tracking homes' compliance with orders, it has not adequately addressed systemic issues and determined where further improvement is needed. For example, we noted that homes in one region failed to comply with almost 40% of their compliance orders due in 2014, while homes in another region failed to comply with only about 17% of their orders. The Ministry did not know the reasons for this variation. We also found that 78 homes failed to comply with at least one order in 2014, and 24 of these had failed to comply with orders in key risk areas. But the Ministry had no plans in place to address this repeated non-compliance.

In addition, the Ministry was taking too long to escalate cases of recurrent non-compliant homes to the Program Director for further action, such as having an in-depth discussion with the home to deal with long-standing problems, or issuing a director's order. For example, from 2011 to 2014, the Ministry referred six homes to the Director,

but only did so after at least a year of multiple, re-issued compliance orders. Despite the fact that the Program Director was involved in these cases, we noted the recurrence of similar issues during the comprehensive inspections at three out of four homes in the first six months of 2015.

The Ministry seldom uses the stronger enforcement actions that it has at its disposal, such as ordering funding to be returned or withheld, ordering a home's management to be replaced, or revoking a home's licence. Since 2010, the Ministry has revoked the licence of only one long-term-care home, and has taken action to recover monies related to that home's closure after the home failed to correct serious fire and safety concerns. We noted that other jurisdictions have additional enforcement options available to inspectors. For example, inspectors for nursing homes in Alberta, British Columbia, United States and United Kingdom can fine the homes in cases of serious non-compliance.

Almost all of the homes we contacted, including the ones that we surveyed, advised us that they would benefit from an advisor or being able to access an advisory function within the Ministry for clarification and guidance on the Act and order issues. However, the Ministry has concerns with providing this advisory function because it believes that there would be an inherent conflict of interest if inspectors had to verify whether their own advice was followed. The Ministry's position is that its role is only to determine whether homes are in compliance with the Act; how compliance is achieved is ultimately the homes' responsibility.

RECOMMENDATION 6

To ensure that long-term-care homes are not repeatedly in non-compliance with the *Long-Term Care Homes Act, 2007*, the Ministry of Health and Long-Term Care should:

- strengthen its enforcement processes to promptly address homes with repeated non-compliance issues including when to escalate homes for further actions and the evaluation of the use of other enforcement measures (e.g., fines penalty); and
- help homes achieve compliance with the Act by providing additional information and support on how to rectify issues, and by sharing best practices between long-term-care homes.

MINISTRY RESPONSE

The Ministry supports this recommendation and is currently reviewing options to strengthen the existing enforcement framework and the feasibility of adding additional enforcement tools. One of these options is to develop and implement a comprehensive enforcement policy and procedure, which will include responses to repeated non-compliance in order to support a consistency in practice by inspectors across the province.

The Act outlines the powers of inspectors. Inspectors are not LTC home advisors and therefore not in a position to help homes achieve compliance with the Act. However, the inspection/order report frequently forms the basis of the licensee's quality management plan to rectify any issues.

Ministry management meet regularly with LTC homes' associations and related groups to identify LTC homes' trends and issues emerging through inspections so that the external stakeholders can consider strategies, identify available resources (e.g., Registered Nurses' Association of Ontario's best practices, communities of practice) and provide assistance to the LTC homes.

In addition, the Ministry will explore a partnership with Health Quality Ontario and other key stakeholders to identify options for additional supports to LTC homes.

4.6.3 The Local Health Integration Networks Do Not Use the Inspection Results in Monitoring the Performance at Long-term-care Homes

While inspection results on homes with long-standing problems were provided to Local Health Integration Networks (LHINs), such results were not used by LHINs to monitor the performance of homes through their service accountability agreements. Instead, LHINs rely on the Program Director to take actions whenever the Director considers it necessary to do so. Our audit report on the Local Health Integration Networks (refer to **Chapter 3**, **Section 3.08**) provides further details of the issues we identified.

RECOMMENDATION 7

To ensure the long-term-care homes are held accountable to their performance, the Ministry of Health and Long-Term Care should review the role and responsibility of the Local Health Integration Networks with regards to the use of inspection results in monitoring the performance of long-term-care homes.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. Regional offices' managers currently work with their respective Local Health Integration Network (LHIN) partners on a regular basis.

The Long-Term-Care Home Service Accountability Agreement Indicator Working Group, in partnership with the Ministry, has recommended that a mechanism be put in place between the Ministry and the LHINs to formally communicate and jointly manage performance and accountability for the LTC home sector.

Over the past few years representatives from the LHINs and the Ministry have been working on a framework for a cross-reporting process which would allow the LHINs and the Ministry to share LTC home information with respect to risks, performance, accountability and compliance.

The Ministry, working with their LHIN partners, is expected to implement this formalized cross-reporting process by April 2016.

4.7 Situations Placing Residents at Risk Are Not Followed Up in a Timely Manner or Not Followed Up At All

The Ministry has no formal policy on when follow-up inspections must be conducted, although it has an informal target of 30 days after the order's due date. However, as of March 2015, the Ministry had failed to follow up on about 250 (or 30%) of the compliance orders due in 2014 and 20 (or 4%) of the orders due since 2013. Furthermore, two-thirds, or 380, of the compliance orders due in 2014 were not followed up within 30 days of their due dates. In the same year, the Ministry took an average of two-and-a-half months after the order due date (an improvement over the four months it took in 2013) to perform a follow-up inspection. We found some cases of compliance orders that had been outstanding for more than a year past their due date with no follow-up inspection; approximately 85 compliance orders were not followed up more than six months past their due date.

There is a great variance in how regional offices prioritize their follow-up inspections. Not all regions have reliable processes in place to track and monitor order due dates so inspectors are not always aware that compliance orders are overdue. Some regions prioritize follow-up inspections according to risk level, while others base them chronologically on inspection due dates. This means that the highest-risk areas are not always followed up with inspections as promptly as they should be. For example, in 2014, we found that orders relating to high-risk areas such as abuse, neglect, home safety, security, cleanliness, repair, plans of care, and Residents' Bill of Rights took, on average, 89 days to be followed up, while lower-risk orders took 74 days, on average.

We identified a number of cases where the Ministry's failure to follow up on compliance orders on a timely basis increased the risk to residents by leaving them in situations of potential harm:

- In one case, a resident allegedly sexually harassed another resident with a cognitive impairment from November to December 2013, and harassed yet another resident in November 2013. The Ministry completed an inspection and subsequently issued the home with a compliance order in January 2014, asking the home to comply within two weeks to ensure that residents were protected. The Ministry did not follow up on the order until September 2014, almost eight months after the due date. The inspector found that the home had not implemented interventions to minimize the risk of altercations between residents and noted two additional cases of resident-to-resident abuse. The Ministry re-issued the same compliance order in February 2015.
- In a second case, there were multiple allegations of a staff member verbally and physically abusing residents in March 2014. The Ministry issued a compliance order in May 2014 and asked the home to comply within a week to ensure the protection of residents. The Ministry waited until October 2014, almost five months later, to follow up, and found the home had still failed to protect residents from abuse and neglect by all staff. During this inspection, inspectors found two more cases where residents were treated roughly by another staff member in the same home.
- In a third case from August 2013, a resident fell overnight and was injured, but staff did not notice until the next morning. As a result of the injuries, the resident was transferred to hospital and passed away the next day. The Ministry issued a compliance order requiring the home to implement a new policy for observing residents during overnight shifts in November 2013, with a due date of the end of the month. The Ministry did not follow up to ensure the home was in compliance (which it was) until September 2014, over ten months after the order due date.

RECOMMENDATION 8

To better ensure that residents at long-term-care homes are protected from harm, the Ministry of Health and Long-Term Care should:

- establish a formal target for conducting follow-up inspections on orders, and prioritize those inspections based on risk; and
- regularly track and monitor follow-up inspections to ensure they are conducted within the targeted time frame.

MINISTRY RESPONSE

The Ministry accepts this recommendation and is making improvements to the Inspectors' Quality Solution (IQS) inspection application to enable inspectors to flag high risk orders at the time of issuance that will allow the Ministry to more easily track these orders going forward. The improvements are targeted for implementation in 2016. Additionally, the Ministry will conduct a policy review to ensure formal targets for conducting follow-up inspections on orders are established.

With the assistance of increased tracking and reporting capability in the IQS, the Ministry will undertake regular reviews of the timeliness of follow-up inspections in relation to targets established, including flagging any overdue follow-up inspections. This information will be incorporated in the Ministry's on-going Quality Management program.

4.8 Inspection Results Are Not Reported in a Timely Manner or Not Reported at All

We found significant delays in reporting inspection results to both long-term-care homes and the public, with some inspection results—dating back

as far as 2011—not yet made public at the time of our audit.

After an inspection is conducted, it is important to promptly report any non-compliance issues to the home's operator to ensure that appropriate corrective action is taken as soon as possible. Delays could result in homes continuing to do, or not do, something that impacts the quality of care being provided to their residents. Delays may also communicate a lack of public accountability and transparency of the Program.

The Ministry has an informal target to deliver the inspection report to the operator of the home within two weeks from the end of the inspection, and to publish an edited version (without residents' personal and health information) of the report on its website within two months. However, we found that the Ministry does not monitor its reporting timelines to confirm whether it is meeting its informal targets.

4.8.1 Communication of Inspection Results to Long-term-care Home Operators is Not Always Timely

We found that the Ministry took, on average, 25 days to complete inspection reports for home operators following comprehensive inspections in 2014, well in excess of its informal two-week target. Again, we found significant variations among different regions, ranging from an average of 13 days in one region to 62 days in another. About 4% of the reports in our sample took longer than 100 days to be completed.

The Ministry informed us that comprehensive inspection reports generally take longer to complete than reports for other inspections because their coverage is broad, the inspections take longer, and multiple inspectors are involved. We found that complaint, critical-incident, and follow-up inspection reports were generally completed about two weeks after the end of inspection.

4.8.2 Communication of Inspection Results to the Public Is Not Timely

The Ministry took, on average, 80 days to publish the results of comprehensive inspections on its website in 2014, significantly longer than its 60-day target. Again we found variations among regions, ranging from an average of 70 days in one region to up to 100 days in another, in their publishing of results.

Results of complaint, critical-incident, and follow-up inspections took even longer to be published: 90 days, on average (ranging from 83 days in one region to 116 days in another). Some reports were not published for more than a year following the end of the inspection. The Ministry informed us that the main reason for delays was administrative because reports were not uploaded to the website immediately but only on a bi-monthly basis.

We found that reports for about 8% of the inspections in our sample were not available on the Ministry website, and some dated as far back as 2011. The Ministry confirmed that a total of 905 inspection reports had not been uploaded to its website—representing about 10% of all the inspections that took place from April 2011 to December 2014. The Ministry cited administrative errors again as explanation for the missing reports, such as electronic files that failed to transfer or that had been misplaced.

RECOMMENDATION 9

To ensure that inspection results are communicated on a timely basis, the Ministry of Health and Long-Term Care should:

- establish formal targets for reporting inspection results to both home licensees and the public;
- monitor and review actual reporting timelines against pre-established targets, and take corrective action when such targets are not met; and
- implement procedures to ensure that all inspection reports are posted on its public website.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and has established benchmarks for completion of inspection reports after on-site inspections are conducted, and for reporting inspection results to the LTC home licensees and the public. The reporting benchmarks are one of the key quality-management performance indicators, and actual reporting timelines will be evaluated against the benchmarks.

As of April 2015, the Ministry has introduced business processes for ensuring that reports are posted in a timely manner. The "Inspection Report Processing Administrative Operational Manual: Licensee and Public Inspection Reports & Order(s) of the Inspector" details procedures for the uploading of public inspection reports and order(s) of the inspector to the public website. This manual includes protocols for quality checks by inspection team leads (or designate) prior to uploading the reports. Business procedures are in place to identify where reports have not successfully been uploaded to the public reporting website.

4.9 Inspection Reports Need to Provide More Useful Information on Long-term-care Homes

Inspection results can provide information that is useful to both stakeholders and the public at large. The Ministry currently reports the results of each inspection performed at a specific point in time. While it is useful to know what issues were found at a home during an inspection, it would be more useful if the Ministry also reported and summarized whether instances of non-compliance were later rectified, or how a home was performing compared to other homes in the province.

4.9.1 Reports Are Not Easy to Understand

Stakeholders told us that they found inspection reports unclear and that it was difficult to determine from them how a home was performing. In our survey of family council representatives, about 60% of respondents indicated that inspection reports provided helpful information to current residents and their family members in understanding and assessing the quality of care at a home, while 30% of respondents disagreed and 10% did not know. Some respondents indicated that inspection reports were "very confusing and difficult to understand" and "need to be written…so the average person can comprehend them."

Ministry inspection reports include detailed descriptions of inspectors' activities and lengthy excerpts from sections of the Act. In comparison, the licensing inspection program for child care centres in Ontario provides easy-to-understand inspection results in a summarized format. The program's website clearly indicates whether any issues noted were resolved before the licence was re-issued, whether specific licensing requirements were complied with, and whether the overall compliance level was achieved.

4.9.2 Public Reporting Does Not Provide Complete Quality-of-Care Information on Long-term-care Homes

The Program's current style of public reporting does not provide a complete picture of the quality of care that a long-term-care home provides to its residents compared to other homes or against the provincial average. Arguably, this is the information that prospective and current residents, their families, and members of the public are very interested in knowing.

There are other organizations that report on various quality-of-care measures at long-term-care homes in Ontario. But, so far, no attempt has been made to consolidate this information with the Ministry's inspection results in order to provide the

public with useful, comprehensive information on the quality of each home as a whole. For example:

- Health Quality Ontario reports on a number of quality indicators for individual long-term-care homes, such as wait times, the percentage of residents with worsening bladder control, the percentage who had a recent fall, and the percentage who were physically restrained. In May 2015, it also reported on the use of antipsychotic drugs in long-term-care homes in response to a controversy surrounding the side effects of these drugs in treating behavioural symptoms of dementia. Health Quality Ontario reported a wide variation in the proportion of long-term-care home residents being given these drugs in 2013, from no residents in some homes to more than 60% in others; the provincial average it reported slightly decreased, from 32% in 2010 to 29% in 2013.
- The Canadian Institute for Health Information published a report in June 2015 (covering the 2013/14 fiscal year) that ranked long-term-care homes using various criteria, such as the percentage of residents put in daily restraints (an average of 9%, ranging from 3% in one LHIN area to 14% in another), the percentage who were experiencing pain (an average of 8%, ranging from 4% to 18%), and the percentage with a worsening depressive mood (an average of 26%, ranging from 19% to 30%) or worsening physical function (an average of 36%, ranging from 29% to 41%).
- Community Care Access Centres publish monthly wait times for each long-term-care home in the province, including the number of people on the wait list for each type of bed (basic, semi-private or private).

Ontario could look to other jurisdictions that use reporting indicators to help the public determine how well a particular home is performing relative to others. In the United Kingdom, for example, inspection results are summarized into ratings for each home, from inadequate to outstanding in five general categories: treating people with respect; providing care that meets people's needs; safety; staffing; and quality of management. The categories are designed to focus on the areas that most matter to people. In the United States, the federal government uses a five-star rating system that combines its health inspection reporting on nursing homes with staffing ratios and quality measures that are similar to the indicators Health Quality Ontario uses, such as the percentage of residents who have had falls and the percentage who were physically restrained. The rating system allows people to compare information about nursing homes across the country.

RECOMMENDATION 10

To provide the public with better information for decision-making on long-term-care homes, the Ministry of Health and Long-Term Care should:

- summarize and report the number of instances identified of non-compliance, for individual homes and on a provincial basis, and when they were rectified;
- consolidate its inspection results together with quality-of-care information from other entities, such as Health Quality Ontario and the Community Care Access Centres, in order to provide a broader perspective on each home's performance, including the use of antipsychotic drugs, wait lists, staffing ratios and other quality-of-care indicators; and
- consult with other stakeholders and consider best practices from other jurisdictions to develop a reporting strategy that allows the public to compare and rank homes' level of compliance and other quality-of-care indicators against the provincial average.

MINISTRY RESPONSE

The Ministry supports this recommendation and currently publishes all inspection reports and orders on its public website, sorted according to homes. The Ministry is currently finalizing the

implementation of an upgrade to the website to allow the public to view compliance information per home as compared to provincial averages.

The Ministry is examining further improvements to the public website which will facilitate more comparability between LTC homes, based on available ministry information. This would allow the general public to compare LTC homes against provincial level averages on key indicators.

4.10 Allocation of Inspectors Needs Further Analysis

4.10.1 Inspectors Are Not Allocated According To Regional Needs

The Ministry has not collected the necessary information on a regular basis to assess whether its current allocation of inspectors is appropriate. It also has not done any analysis to substantiate that allocations are based on either workload or efficiency of inspectors across the province. Ineffective allocation of inspectors' workload could lead to inconsistent timelines in addressing residents' concerns.

Figure 15 shows that the number of inspector positions allocated by the Ministry does not correspond to the workload in some regions. For example, in 2014, the London region had the most homes requiring comprehensive inspections, close to 35% more complaints and critical incidents, and approximately 65% more compliance orders requiring inspections than the Ottawa region. Yet, both regions were allocated around the same number of inspectors. Similarly, the Toronto region was allocated a similar number of inspectors as the London region even though the number of complaint and critical incidents requiring inspection in the Toronto region was about 20% less than the London region.

4.10.2 Inspectors' Workloads Vary Across the Province

The Ministry does not use the information it has available to determine whether individual inspector's workloads are appropriate and whether inspections are being conducted efficiently from region to region. For example, it does not track and monitor how many inspections an inspector has done or how long it takes each inspector to perform an inspection.

After we showed the Ministry our analysis on inspector allocations and workload (shown in **Figure 15**), the Ministry did its own calculations and found similar differences in inspector workloads between regions. It also found regional variations depending on the type of inspection, which are shown in **Figure 16**. For example, each inspector conducted about 12 comprehensive inspections, on average, but this ranged from seven inspections in one region to 15 in another. Similarly, each inspector also conducted, on average, 16 complaint, critical-incident and follow-up inspections, but these ranged from nine per inspector in one region to 26 in another.

Figure 15: Key Workload Indicators and Number of Inspectors Allocated to Each Region, 2014

Source of data: Ministry of Health and Long-Term Care

Key Workload Indicators	Sudbury Region	Hamilton Region	London Region	Ottawa Region	Toronto Region	Average (Total)
# of Long-term-care Homes	70	125	150	145	140	**126 (630)**
# of Complaints And Critical Incidents Requiring Inspections	280	1,140	1,570	1,170	1,280	**1,088 (5,440)**
# of Compliance Orders Past Due Without a Follow-up Inspection	50	135	25	15	25	**50 (250)**
# of Inspectors Allocated*	**24**	**35**	**36**	**37**	**37**	**34 (169)**

* Includes the number of inspector positions approved by the Ministry not yet filled.

Figure 16: Average Number of Inspections Per Inspector,* by Region, 2014

Source of data: Ministry of Health and Long-Term Care

Type of Inspection	Sudbury Region	Hamilton Region	London Region	Ottawa Region	Toronto Region	Weighted Average*
Comprehensive (A)	7	14	12	15	9	**12**
Complaint, Critical-incident and Follow-up (B)	9	11	26	15	11	**16**
All Inspections (A+B)	**16**	**25**	**38**	**30**	**20**	**28**

* Based on weighted average, which incorporates the fluctuation of the number of inspectors throughout the year.

The average time inspectors took to complete an inspection also varied between regions. The comprehensive inspections in our sample took, on average, seven days to complete in one region and more than 10 days in another. And one region took, on average, just one day to complete complaint, critical-incident and follow-up inspections while another region took three days.

Although each type of inspection and each inspector's level of experience are different, collecting this information would help the Ministry establish a target for workload and efficiency. The Ministry has not done any further analysis to determine the reasons for the variations identified, but it informed us that it might be due to difficulties in recruiting and retaining new inspectors from region to region. For example, from June 2013 to March 2014, the Ministry hired 86 new inspectors, but eight of those resigned within the same year and another ten resigned the following year. An additional 29 inspectors were hired from April 2014 to March 2015.

RECOMMENDATION 11

To ensure residents' concerns are addressed equitably across the province, the Ministry of Health and Long-Term Care should periodically review and assess inspectors' workload and efficiency among the regions, and take necessary actions to address any unexpected variations.

MINISTRY RESPONSE

The Ministry supports this recommendation and will conduct an analysis of the current organizational structure for the Program. This will include an analysis of staff and management complements and workload, intake functions, administrative functions, specialized resources and operating budgets, as well as strengths, opportunities and risks of the current program structure.

4.11 The Ministry Does Not Effectively Ensure the Quality of Inspectors' Work

4.11.1 Inspection Reports Need More Review

Although the Ministry has policies in place for regional managers and/or inspector team leads to review and approve inspection reports before they are finalized, it does not track whether these reviews are actually done. Regional managers informed us that they did not review every report. For example, regional managers did not review reports that had been completed by more experienced inspectors with findings of only minor instances of non-compliance and where no orders were issued. But, given that almost 90% (8,500 of 9,500 as shown in **Figure 4**) of the instances of non-compliance identified are considered "minor," the Ministry cannot confirm if these non-compliances—such as infection prevention and control, and skin

and wound care—are indeed minor if it is reviewing reports that only deal with instances of serious non-compliance. Also, the Ministry cannot be assured that sufficient and appropriate work was performed in those inspections.

4.11.2 The Ministry Cannot Explain the Regional Variances in the Number of Compliance Orders Issued

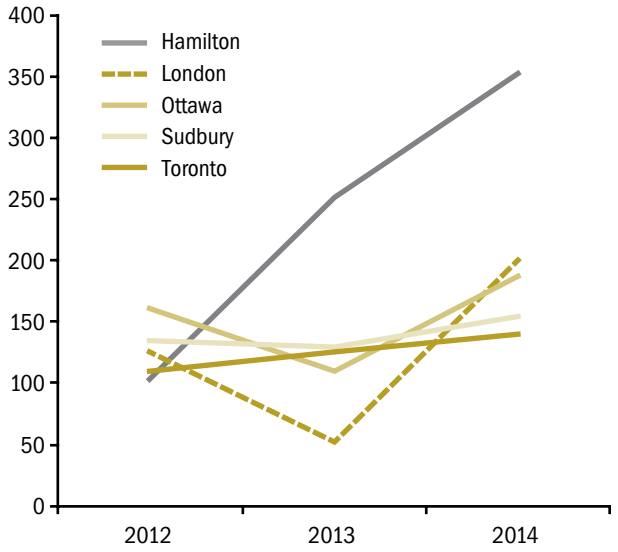
Figure 17 shows the significant variation in number of compliance orders issued by region over a three-year period. In 2014, inspectors in the Hamilton region issued, on average, nine compliance orders for every 10 inspections conducted, whereas the London region issued, on average, two compliance orders for every 10 inspections conducted. From 2012 to 2014, the number of compliance orders issued had increased in all regions primarily due to an increase in comprehensive inspections conducted in 2014. Despite performing a similar number of comprehensive inspections in 2014, the Hamilton region issued at least 75% more compliance orders than any other region. The Ministry did not know if this was because homes in the region were less compliant or because inspectors in the region were more willing to issue orders. However, we noted that, based on the 2013/14 information reported by the Canadian Institute for Health Information, the homes in the Hamilton region scored relatively close to the provincial averages for the nine quality-of-care indicators. In comparison, the homes in the London region scored worse in eight out of nine quality-of-care indicators than the provincial average.

Several stakeholders informed us that inspection results are not consistent from one region to another or even from one home to another within the same region. This opinion was echoed by almost 60% of the home administrators we surveyed.

Between 2010 and 2014, 29 long-term-care homes requested the Program Director, through the appeal process, to review 52 compliance orders that had been issued by inspectors. In about 20% of these cases, the Director rescinded the orders. Furthermore, we reviewed a sample of the orders altered by the Director and found that the revision was made due to insufficient evidence gathered by the inspectors for 40% of these orders.

Figure 17: Number of Compliance Orders Issued, by Region, 2012–2014*

Source of data: Ministry of Health and Long-Term Care



* Based on calendar year. Data prior to 2012 is either incomplete or not available.

4.11.3 Quality Assurance Procedures Have Been Put On Hold Since 2013

The Ministry developed quality assurance procedures in January 2013, including peer reviews and post-inspection audit checklists, to determine whether policies and procedures had been followed during inspections and to identify training needs. However, these measures were not implemented as the Ministry was focused on meeting the Minister's commitment to complete comprehensive inspections of every long-term-care home in the province by the end of 2014.

RECOMMENDATION 12

To ensure the high quality and consistency of inspectors' work across the province, the Ministry of Health and Long-Term Care should:

- revisit the quality assurance procedures, including peer reviews and the use of post-inspection audit checklists, that were put on hold and evaluate their relevance and usefulness;
- perform management reviews of inspectors' work on a regular basis and document the results; and
- consolidate and evaluate results from quality reviews and use them for training purposes.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will review the Terms of Reference of both the Governance Committee and the Quality Improvement Advisory Committee.

A complete transitioning of the current management structure to the committee structure is targeted for the fall of 2015.

The Ministry will evaluate this recommendation as part of the organizational review of the Program.

4.12 The Ministry is Not Measuring Program Performance

Collecting, reviewing and reporting performance indicators are crucial to determining a Program's efficiency and effectiveness. Doing so may help identify areas for improvement, and encourage accountability and transparency. A recurring theme in this audit has been that the Ministry has no clearly defined and expected outcomes or established targets against which it can assess how the Long-Term Care Homes Quality Inspection Program is performing. For example, as mentioned earlier, the Ministry has an informal target to follow up on orders within 30 days of the order due date, but it does not monitor the number of orders that comply with that goal. Without tracking this type of information, the Ministry has no way of establishing benchmarks to assess the Program's performance, such as an appropriate time frame to follow up on orders issued.

Furthermore, without established benchmarks, the Ministry has no way of assessing whether regional variations in areas, such as timelines for completing inspections, following up on compliance orders and publicly reporting inspection results, indicate that some are operating more or less efficiently than others, or if something else is causing the differences.

The Ministry developed a performance measurement framework in 2008 and attempted to establish the Continuous Quality Improvement Advisory Committee in June 2013. However, the Ministry is still in the process of implementing the framework and put the establishment of the committee on hold while it focused on meeting the Minister's commitment to complete comprehensive inspections of all long-term-care homes by the end of 2014. Currently, the Ministry lacks the key information it needs to ensure that the Program is achieving its mandate, meeting its targets and improving the quality of care for residents in long-term-care homes. The Ministry currently reports publicly on only one performance measure: the number of comprehensive inspections completed throughout the year. The number of complaints or critical incidents that are inspected within the expected time frame is not publicly reported.

When we completed our audit work, the Ministry was still in the process of determining what information can and should be collected to monitor and track performance. The Ministry was also determining what targets should be established in areas such as inspector workload and the timeliness of inspections, inspection reports and follow-ups on compliance orders.

RECOMMENDATION 13

To ensure the mandate of the Long-Term Care Homes Quality Inspection Program is met and its performance is transparent to the public, the Ministry of Health and Long-Term Care should:

- identify key performance indicators and establish reasonable targets for each and to periodically review all targets to ensure they are appropriate;
- monitor and evaluate actual results against all targets established and take corrective action when any targets are not met; and
- regularly publish actual results against targets.

MINISTRY RESPONSE

The Ministry accepts this recommendation. Enabled by the IQS (Inspectors' Quality Solution) inspection application, a wide variety of performance tracking measures and reports are in place in areas such as: complaints and critical incidents received and inspected; annual comprehensive inspections; and follow-up inspections.

Reporting on inspection outcomes of the "top ten" non-compliant homes has been in place since early 2011. After the completion of comprehensive inspections in all LTC homes in 2014, the findings were shared with the sector.

Key Performance Indicators are currently being finalized as part of the further expansion, refinement of program monitoring and quality management, with a completion target of fall 2015. The Ministry is finalizing these key performance indicators to also enable the creation of a Balanced Score Card with respect to inspection outcomes.

The Ministry has implemented performance measures for the Program which have been in place since 2010. These measures include the number of complaints and critical incidents received and requiring inspections, the number of inspections completed by type and by year, and the analysis of the top 10 non-compliances and orders issued.

The Ministry now also has the ability to establish benchmarks for internal performance including:

- Timeliness of follow-up inspections for orders issued, and
- Timeliness of inspection for high-risk issues.

The Ministry is currently working on identifying and reporting the data elements that will be valuable for reporting on and analysing the inspection program, its outputs, and identifying areas for improvement and enhancement. Implementation is targeted for spring 2016. An analysis of the indicators will be conducted to determine what information is helpful to stakeholders. As mentioned above, many of the indicators are already being shared with stakeholders through the publishing of inspection reports and the sharing of comprehensive inspection and other inspection-type analytics.

Appendix 1—Performance of Long-term-care Homes as Measured by the Canadian Institute for Health Information's Nine Quality Indicators

Source of data: Canadian Institute for Health Information

	Performance by Region,[1] 2013/14[2] (% of Residents)					Provincial Average, 2013/14 (%)	% Change Between 2010/11 and 2013/14
	Hamilton	London	Ottawa	Sudbury	Toronto		
Indicators For Which Provincial Performance Improved Between 2010/11 and 2013/14							
Restraint use[3]	9.2	10.7	12.0	11.7	5.2	8.9	–45
Potentially inappropriate use of antipsychotics[4]	30.3	31.4	30.3	29.1	31.2	30.6	–34
Experiencing pain[5]	7.4	8.7	8.9	12.5	5.7	7.9	–13
Experiencing worsened pain[6]	11.3	12.6	11.2	13.4	9.7	11.2	–6
Indicators For Which Provincial Performance Worsened Between 2010/11 and 2013/14							
Worsened pressure ulcer[7]	3.1	3.5	2.9	3.1	2.7	3.0	+7
Improved physical functioning[8]	29.7	34.0	31.5	32.2	28.6	31.1	–6
Worsened physical functioning[9]	35.7	37.6	35.5	34.9	35.4	35.8	+5
Falls in last 30 days[10]	14.1	15.1	14.3	14.8	13.3	14.2	+2
Worsened depressive mood[11]	26.3	27.7	27.7	28.5	21.9	25.9	+2

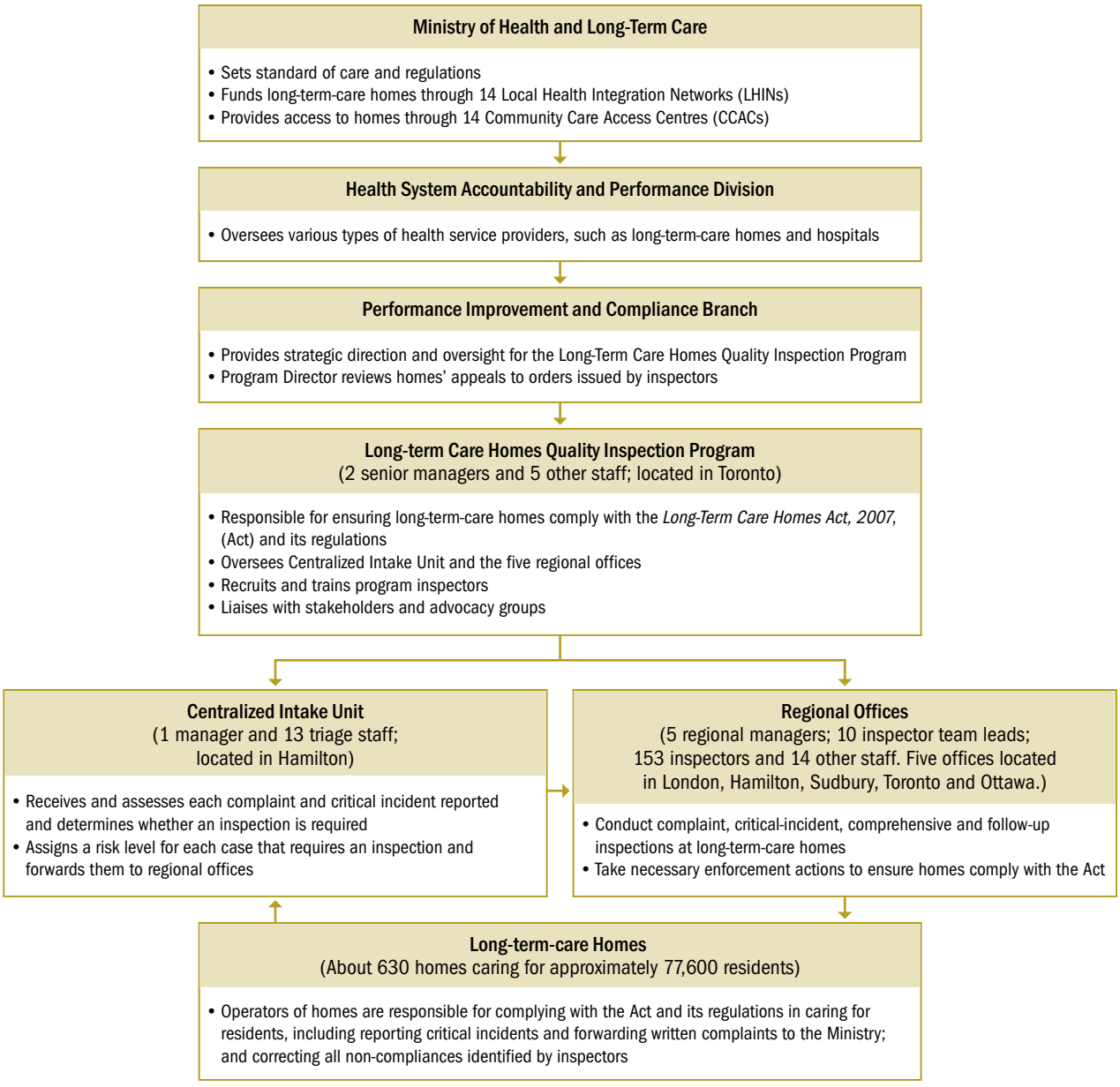
Boxes shaded in dark grey indicate the region with the worst performance for the indicator.

Boxes shaded in light grey indicate the region with the best performance for the indicator.

1. Long-term-care homes reported their results to the Canadian Institute for Health Information, which in turn published the results by 14 Local Health Integration Networks (LHINs). We mapped the data for the 14 LHINs to the Ministry's five regions, weighting the data according to the number of long-term-care beds in each LHIN as a proportion of the total number of long-term-care beds in each region.
2. 2013/14 is the latest year for which data is available publicly for individual long-term-care home performance on the nine quality indicators.
3. This indicator looks at how many long-term-care residents are in daily physical restraints. Restraints are sometimes used to manage behaviours or to prevent falls. There are many potential physical and psychological risks associated with applying physical restraints to older adults, and such use raises concerns about safety and quality of care.
4. This indicator looks at how many long-term-care residents are taking antipsychotic drugs without a diagnosis of psychosis. These drugs are sometimes used to manage behaviours in residents who have dementia. Careful monitoring is required, as such use raises concerns about safety and quality of care.
5. This indicator looks at how many long-term-care residents had moderate daily pain, or horrible or excruciating pain at any frequency. The consequences of pain include increased difficulty with activities of daily living, depression and lower quality of life. The prevalence of persistent pain increases with age, and proper treatment of pain is necessary to improve the health status of residents.
6. This indicator looks at how many long-term-care residents had worsened pain. Worsening pain can be related to a number of issues, including medication complications and/or improper management of medication. Careful monitoring of changes in pain can help identify appropriate treatment. Worsened pain raises concerns about the resident's health status and the quality of care received.
7. This indicator looks at the number of long-term-care residents whose stage two to four pressure ulcer had worsened since the previous assessment. Pressure ulcers can happen when a resident sits or lies in the same position for a long period of time. Immobility may be due to many physical and psychological factors, neurological diseases like Alzheimer's and improper nutrition or hydration. Careful monitoring is required to ensure good quality of care.
8. This indicator looks at how many long-term-care residents improved or remained independent in transferring on and off surfaces (such as beds, chairs and toilets), moving around in bed and walking around the home. Being independent or showing an improvement in these activities of daily living may indicate an improvement in overall health status and provide a sense of autonomy for the resident.
9. This indicator looks at how many long-term-care residents worsened or remained completely dependent in transferring on and off surfaces (such as beds, chairs and toilets), moving around in bed and walking around the home. An increased level of dependence on others to assist with transferring and locomotion may indicate deterioration in the overall health status of a resident.
10. This indicator looks at how many long-term-care residents fell in the 30 days leading up to the date of their quarterly clinical assessment. Falls are the leading cause of injury for seniors and contribute to a significant burden on the health care system. Residents are at a higher risk of falling if they have a history of falls or are taking certain medications. Preventing falls increases the safety and quality of care of residents.
11. This indicator looks at the number of long-term-care residents whose mood from symptoms of depression worsened. Depression affects quality of life and may also contribute to deterioration in activities of daily living and an increased sensitivity to pain.

Appendix 2—Key Roles, Responsibilities and Accountability Relationships in Long-term-care Home Oversight

Prepared by the Office of the Auditor General of Ontario



Appendix 3—Comprehensive Inspection Process and Inspection Protocols

Source of data: Ministry of Health and Long-Term Care

Stage One	Stage Two
Inspectors randomly select a sample of 40 residents. They interview the residents, observe them, and review their health records. After this, inspectors interview the home staff responsible for overseeing the care of the residents in the sample. They also interview family members of several of the residents in the sample.	Inspectors use an algorithm to analyze information collected from stage one to identify areas that require more in-depth inspection. Inspectors use standardized inspection protocols to conduct in-depth inspections and summarize their findings in a report.

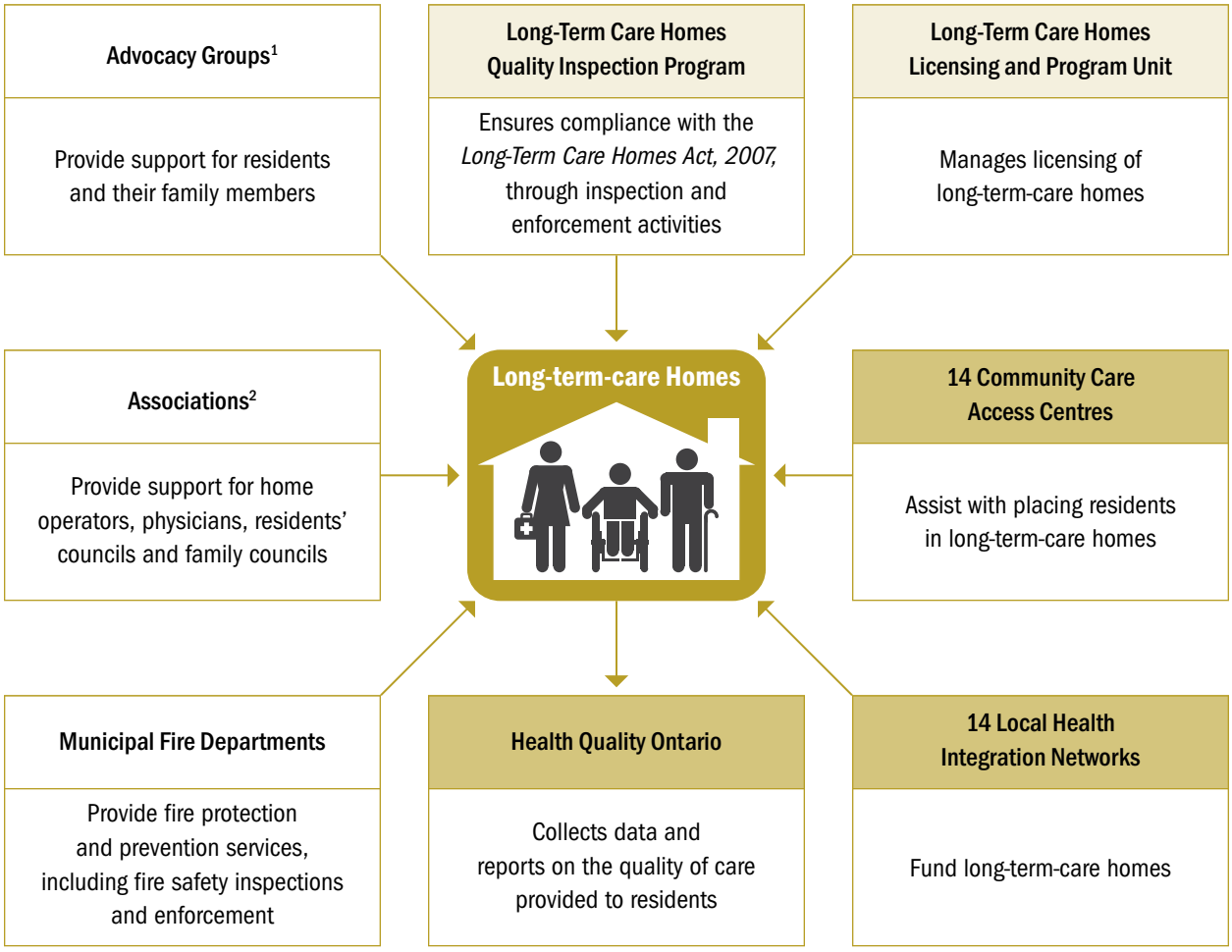
Mandatory Inspection Protocols
The following five protocols must be examined in stage one or two in every comprehensive inspection:
1. Medication
2. Infection prevention and control
3. Residents' council interview
4. Family council interview
5. Dining observation

Other Inspection Protocols	
Inspectors examine at one or more of the following protocols in stage two of an inspection if it is called for (i.e., triggered by records review, their observations, and/or interviews):	
Category	**Inspection Protocols**
Inspector-initiated	6. Admission and discharge 7. Quality improvement 8. Resident charges[1] 9. Training and orientation
Home-related	10. Accommodation services: housekeeping 11. Accommodation services: laundry 12. Accommodation services: maintenance 13. Critical incident response 14. Food quality 15. Reporting and complaints 16. Safe and secure home 17. Snack observation 18. Sufficient staffing 19. Trust accounts[2]
Resident-related	20. Prevention of abuse, neglect and retaliation 21. Recreation and social activities 22. Responsive behaviours 23. Skin and wound care 24. Continence care and bowel management 25. Dignity, choice and privacy 26. Falls prevention 27. Hospitalization and change in condition 28. Minimizing of restraining 29. Nutrition and hydration 30. Pain 31. Personal support services

1. Resident charges—Charges to residents for goods and services, such as haircuts, cable TV, phone line, received in the homes that are not covered by government funding.
2. Trust accounts—A bank account in which the home operator shall deposit all money entrusted to his/her care on behalf of a resident.

Appendix 4—Selected Key Players in the Long-term-care Home Sector

Source of data: Ministry of Health and Long-Term Care



1. Advocacy groups include organizations such as the Advocacy Centre for the Elderly and Concerned Friends.
2. Associations include organizations such as the Ontario Long Term Care Association, Ontario Association of Non-profit Homes and Services For Seniors, Ontario Long Term Care Physicians, Ontario Association of Residents' Councils, and the Family Councils' Program.