2020 - THE YEAR OF TRAGEDY IN LONG TERM CARE

It has been shocking for all of us to see the tragedy take place in these homes – the majority of deaths from COVID have taken place in our long-term care (LTC) homes. Why has it taken all these deaths to get the broader public and the government to listen? We are hopeful that the long overdue corrections in the system will take place, that Ontarians do care about our elderly and their right to live out the end of their lives peacefully with good care.

Concerned Friends thanks all staff and family members who have worked so hard to protect the lives of the residents living out their lives in LTC. We thank you all. We have been pleased to see other groups raise the issues taking place in the homes and pressuring the Government to respond.

This year-end report focuses on our reviews of all the 2020 inspections of LTC homes in Ontario. We will not repeat all the stories the media has reported on – the tragic rate of deaths, neglect, staff shortages, the struggles of families and staff. This note will focus on specific issues of concern arising from the inspection reports.

1. We have strong evidence of the error committed by the Government when it cancelled the Resident Quality Inspections (RQI) inspections. These were thorough annual inspections of every home. Resident Quality Inspections covered every aspect of the home's work and management. The inspectors were able to see deficiencies early and require their correction within a fixed time frame. This was a proactive approach to prevent trouble in the homes in addition to the reactive inspections following Critical Incidents or Complaints.

2. When COVID hit Ontario all inspections of LTC homes became more complicated and in fact essentially stopped or took place talking to staff online without entering the home. This occurred during the first peak of the COVID infection in Spring and Summer of 2020 and led to the total number of in-home inspection reports in 2020 being lower than in previous years.

3. The vast majority of inspections were in response to Critical Incidents and Complaints. Unlike the RQIs, these inspections do not look at all aspects of the homes. They are more narrowly focused. As the second wave of COVID grew in the homes, we began to see many reports that detailed problems with infection control, staffing, neglect or abuse of residents, and management & quality assurance. Our charts identify these areas and the regions of the province where they occurred in significant numbers. In some homes overwhelmed with COVID infections, deaths and staff shortages, the Province sent in neighbouring hospitals to take charge of the homes. These are listed as Director Orders.

We urge Ontarians to ensure that our Elders matter, that their right to live out their lives peacefully and with good care is respected. Families cannot do this alone. In most cases, they need help from all of us. The Province has the responsibility to carry this out. There are a number of models of care that we can emulate, one of which is in Denmark. Let us ensure that this tragedy of neglect never happens again!

2020 Inspections by Service Area

Service Area	Number of Homes	Resident Quality Inspection	Critical Incidents	Complaints	Follow-up	Other	Total 2020	Total 2019
Hamilton	92	0	130	91	31	1	253	408
London	89	0	106	67	7	11	191	481
Ottawa	94	0	161	124	16	2	303	452
Sudbury	88	0	136	80	52	19	287	383
Toronto	88	0	134	109	11	3	257	367
C East	88	0	158	100	16	2	276	263
C West	88	**0**	175	88	37	10	310	297
Totals	**627**	**0**	**1000**	**659**	**170**	**48**	**1877**	**2651**

Note:
There were 774 fewer inspections done in 2020 as compared with 2019.
No RQIs were done in 2020, compared to 8 in 2019, and 347 in 2018.

The 2020 Summary of Compliance Orders (CO) & Director Referrals (DR) is broken down into 9 categories as defined below:

1. **Nursing and Personal Care** includes general nursing care, continence care, **falls prevention care**, wound care, weight care management and pain management.
2. **Care Plans** includes assessment & reassessment of resident needs, implementation of plan, accessibility to care staff, reviews and revisions as necessary, interdisciplinary care conferences which include resident and family, and complete, accurate documentation.
3. **Resident Rights** includes the right to dignity, privacy, respect, individuality, and freedom from abuse (except for #9 below), **including resident to resident abuse and responsive behaviours**; consent to treatment; appropriate resident activities and programming; bathing/grooming. Also Restraint Use issues such as resident/family consent, doctor's order, repositioning, and required documentation. Also Resident/Family Council issues such as timely, written response to concerns, supporting & consulting with councils as required.
4. **Medication** includes orders signed for by appropriate personnel, storing, documenting, dispensing, and evaluation of medication use.
5. **Dietary** includes all issues related to nutrition, hydration and meal service.
6. **Safety/Hazards** includes **infection control** and any practice that could contribute to risk or injury, such as **unsafe transfers**, bed rails, water temperature safety, poor disaster plans, unlocked doors, call bells, labelling personal hygiene items.
7. **Maintenance Issues** includes maintenance, housekeeping issues and general cleanliness as well as unclean or inadequate linen and supplies.
8. **Facility Management** includes staffing issues, information provided to residents, and critical incident reporting, handling complaints, staff training. Also Quality Assurance such as policy & program development, implementation and evaluation, including abuse policies.
9. **Staff Abuse and Neglect of Residents** a new category – previously included under Resident Rights.

2020 Summary of Compliance Orders (CO) & Director Referrals (DR) by Problem Category
Issued in all Ministry of Long-Term Care Inspections

	Number of Orders by Problem Category							Total 2020	Total 2019
	Hamilton	London	Ottawa	Sudbury	Toronto	Central East	Central West		
Total # CO/DR	**64/4**	**77/1**	**46/2**	**134/4**	**84/4**	**75/1**	**100/14**	**580/30**	**654/39**
Nursing and Personal Care	8/DR1	16	2	20/DR1	7	10	20/DR5	83/7	106/8
Care Plans	15	8	3	9	11	9	14/DR1	69/1	117/10
Resident Rights	6/DR1	4	5	18	5	9	14/DR1	61/2	156/5
Medication Issues	5	4	7/DR1	8	4	1	13/DR1	42/2	72/5
Dietary	5	2	10	8	6	13/DR1	1	45/1	26/2
Safety/Hazards	9/DR2	9	9	19	28/DR2	18	14	106/4	79/7
Maintenance Issues	3	4	2	3	3	0	1/DR1	16/1	26/0
Facility Management Quality Assurance	5	16	5	35/DR2	10/DR1	7	20/DR5	98/8	72/2
Staff Abuse or Neglect	8	14/DR1	3/DR1	14/DR1	10/DR1	8	3	60/4	Included in Residents Rights

Comments: The significant increase in COs in the Safety category were largely due to infection control issues. It is encouraging to see the drop in COs regarding Resident Rights.

ORDERS BY THE DIRECTOR OF COMPLIANCE DURING THE PANDEMIC

In 2020, Concerned Friends Reviewers noted an increase in Orders by the Director of Compliance (DOs). There were at least seven Orders by the Director, for Mandatory Management of a Home.

In 2020 compliance inspections were focused on critical incidents and complaints as they had been in 2019. Actions or sanctions by an inspector start with a Written Notice (WN). When more action is needed the inspector requires a Plan of Correction to be implemented voluntarily (VPC). For more serious infractions, the inspector issues a Compliance Order (CO). In addition, the inspector can also make a referral to the Director when the severity of the non-compliance, or the required sanction, is beyond the inspector's scope.

Our Reviewers have regularly seen Referrals to the Director (DRs) usually tied to a specific non-compliance and signifying serious or repeated non-compliance. Usually, it is not clear what action is taken by the Director of Compliance, but we can assume that the issue will now receive close attention by the owner of the Home.

In 2020, we saw a significant number of Orders by the Director (DOs). The Director may issue the following orders:

- Amend or impose Conditions on Licence Order
- Renovation of Municipal Home Order
- Return of Funding Order
- **Mandatory Management Order**
- Revocation of Licence Order
- Interim Manager Order

According to the Government of Ontario website, where the Ministry of Long-Term Care (LTC) identifies a home in need of support, the Home may agree to bring in a third party, such as a hospital or management company, to provide assistance under a Voluntary Management Contract (VMC). In other cases, the Ministry may issue a Mandatory Management Order (MMO) that requires the LTC Home to retain a hospital or management company.

Once a VMC or MMO has been approved, the Ministry continues to work with the LTC Home licensee to ensure that an operating plan is developed and implemented to help the Home return to normal operations as soon as possible. The management agreements are in place for 90 days minimum with opportunity for extension if required.

Near the completion of the management contract the Ministry will work with the licensee and hospital or other appropriate organizations to implement a plan to transition operations back to the licensee. (Please note that the names of affected Homes are listed on the Government of Ontario website.

We know of at least seven Homes that received an Order by the Director for mandatory management, usually in response to a large number of deaths and/or a complaint by a physician or the armed services. These Director's Orders are posted as a separate document on the Ministry of Long-Term Care website, with many pages of supporting documentation of the concerns about the Home.

In addition, at least 28 Homes arranged voluntary Management Agreements usually with local hospitals. Presumably, without these voluntary agreements, these Homes could have received an order by the Director for mandatory management.

Additional Resources: Glossary of Terms MOHLTC – Ministry of Health and Long-Term Care