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Wednesday, June 28, 2017

The care our parents deserve: Horwath calls for full seniors care inquiry

- Phase 1 of the public inquiry, under the *Public Inquiries Act*, must investigate systemic failures associated with the Wettlaufer case.
- Phase 2 of the public inquiry must investigate the systemic problems in long-term care with particular attention to the:
    - Safety of residents and staff
    - Quality of care
    - Funding levels
    - Staffing levels and staffing practices
    - Regulation, enforcement, and inspections
    - Capacity, availability, and accessibility in all regions
    - The impact of for-profit privatization on care
    - Government action and inaction on previous recommendations to improve the long-term care system
- If the Wynne government fails to set the appropriate scope for this public inquiry, New Democrats will expand the scope of the public inquiry to include the systemic problems in long-term care, within 100 days of taking office.
- The terms of reference will be established in full consultation with the long-term care sector.
- There is precedent for important public inquiries to be conducted in two phases and to examine systemic problems in order to help ensure the safety of Ontarians. In the Walkerton Inquiry (2000-2002), Justice Dennis O'Connor divided his mandate into two parts, writing, "The first, which I refer to as Part 1, relates only to the events in Walkerton. It directs me to inquire into the circumstances that caused the outbreak – including, very importantly, the effect, if any, of government policies, procedures, and practices. The second, Part 2, goes beyond the events in Walkerton, directing me to look into other matters I consider necessary to ensure the safety of Ontario's drinking water. The overarching purpose of both parts of the Inquiry is to make findings and recommendations to ensure the safety of the water supply system in Ontario."[1]

[1] http://www.archives.gov.on.ca/en/e_records/walkerton/report1/pdf/WI_Chapter_01.pdf

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Key Facts:

- Today, there are approximately 78,000 long-term care beds in Ontario, but more than 30,000 people waiting on the wait list for long-term care.[2]
- Wait times for people who urgently need long-term care and are waiting in hospital have increased by 270 per cent since the Liberals came to office, to a median to up to 68 days, up from a median 18 days.[3]
- The number of homicides in long-term care being investigated by the Coroner each year is increasing:
    - In 2012, the Coroner investigated 3 homicides;[4]
    - In 2013, the Coroner investigated 5 homicides;[5]
    - In 2014, the Coroner investigated 8 homicides;[6] and
    - In 2015, the Coroner investigated 9 homicides.[7]
- In 2014, long-term care homes reported more than 12,900 "critical incidents" to the Ministry.[8]
- In the past twelve years, the government has received the following reports, amongst others, yet recommendations have been ignored:
    - 2005 – Casa Verde Coroner's Inquest
    - 2008 – Sharkey Report – *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes*
    - 2010 – Ombudsman's Report on the Monitoring of Long-Term Care Facilities
    - 2015 – Auditor General's Report on Long-Term Care Homes Quality Inspection Program
    - Annual Reports from the Coroner's Geriatric and Long-Term Care Deaths Review Committee

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[2] Ministry of Health and Long-Term Care, *Long-Term Care Home System Report from New CPRO*, March 2017, published June 1, 2017.
[3] Health Quality Ontario, *Common Quality Agenda 2016*, p. 85.
[4] Geriatric and Long-Term Care Review Committee 2012 Annual Report, December 2013, p. 2.
[5] Geriatric and Long-Term Care Review Committee 2013-14 Annual Report, October 2015, p. iii.
[6] Geriatric and Long-Term Care Review Committee 2013-14 Annual Report, October 2015, p. iii.
[7] Geriatric and Long-Term Care Review Committee 2015 Annual Report, October 2016, p. iv.
[8] Auditor General 2015, p. 365.

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- Casa Verde Coroner's Inquest (2005) recommended:
    - "That the Ministry of Health and Long-Term Care (MOHLTC) should give increased priority to the health care needs of the elderly and, in particular, the serious challenges faced in treating elderly cognitively impaired residents" (Recommendation 1)
    - "That the MOHLTC, once the updated evidence based study is received, should set out standards based on this information, for all Ontario LTC facilities to ensure that Ontario LTC facility residents are given appropriate nursing and other staff hours. At a minimum the staff hours must be comparable to other similar jurisdictions and are sufficient to meet the needs of present and future Ontario LTC facility residents" (Recommendation 30)
    - "MOHLTC should take immediate steps to enhance the working conditions in LTC facilities including" (Recommendation 34).
    - "MOHLTC should… Develop standards for staffing in LTC facilities… [and] Track staff to resident ratios" (Recommendation 37).
- Sharkey Report (2008) recommended the following:[9]
    - "Based on our assessment of this evidence, we are recommending that provincial guidelines be established to support decisions on funding enhancements to provide to residents a comprehensive range of nursing, personal care, programs and support services; and to provide to staff opportunities for professional development and team collaboration. The provincial guidelines are designed to achieve up to four hours of care per resident per day over the next four years" (p. 10)
    - "Establish provincial guidelines to support annual funding for enhanced capacity for resident care to achieve (at this time, pending the results from the annual evaluations and learnings) a provincial average of up to 4 hours of care per resident per day over the next four years, including:
        - a. Up to 2.5 hours to be provided by PSWs;
        - b. Up to 1 hour to be provided by licensed nurses (RNs and RPNs);
        - c. Up to 0.5 hours to be provided by therapists, dieticians/nutritionists, social workers and other allied health professionals" (p. 16)
    - To date, the government still has not acted on these recommendations.
- The Auditor General's 2015 report on the Long-Term Care Homes Quality Inspection Program found numerous failures and concluded:

[9] http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=5987&cf_id=68&lang=en

- "Complaint and Critical-Incident Inspection delays place residents at risk" (p. 369)
- "Situations placing residents at risk are not followed up by the Ministry in a timely manner to ensure resolution" (p. 370)
- "The Ministry's actions are not sufficient to address the repeated non-compliance in certain long-term-care homes" (p. 371)
- "Inspection timeliness and effectiveness varies across the province" (p. 371)
- "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." (p. 371)

- The Office of the Chief Coroner of Ontario's Annual Report 2015 from the Geriatric and Long-Term Care Home Deaths Review Committee states:
  - "The Office of the Chief Coroner should consider producing a comprehensive report covering all the cases of resident-related homicide in LTC facilities in Ontario in the past 15 years. This summary report should be shared publicly and particularly with the MOHLTC… to provide added perspective regarding the magnitude and urgency of the problem" (p. 23)
  - "MOHLTC should develop a concrete action plan to address resident-to-resident violence in LTC facilities. The current investments in Behavioural Support Teams and training are not a replacement for sufficient numbers of caring staff who have time to spend with residents" (p. 23)
  - "The issue of resident-to-resident violence in LTC homes is an urgent and persistent issue. The Committee is regularly asked to review homicides in LTC homes, where one resident causes the death of another" (p. 25)