BRIEFING SUMMARY AND ANALYSIS

TESTIMONY TO LONG TERM CARE COVID-19 COMMISSION
Ministry of Long Term Care Inspection Branch
Tuesday, September 15, 2020

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Preamble

On May 25, 2020, Seniors for Social Action Ontario (SSAO) called for a reinstatement of the tough inspection and prosecution policy that existed thirty five years ago before successive governments dismantled it.

Its News Release stated:

"Now what we see is repeated compliance orders issued, a reliance on written notices and voluntary correction plans, repeated Director's referrals, and Director's orders, and then it seems to all fall off a cliff and nothing further happens. Licenses are not revoked, even with repeated infractions."

"In examining what is currently occurring it became clear that only 9 actual Resident Quality Inspections (RQI's) of homes were done this past year. Residents have no protection whatsoever because inspections are now a completely critical incident and complaints-based system - nothing proactive at all to prevent issues like what happened during this pandemic. And what about those residents who have no one visit who would complain. **"No wonder we have these high infection and death rates. Successive governments have abandoned their responsibilities to protect residents in these facilities. They had better protections 35 years ago than they do now"**.

SSAO called for:

- Immediate reinstatement of yearly Resident Quality Inspections (RQI's) as recommended by the Auditor General – comprehensive yearly inspections involving a team of nursing, dietary, and environmental inspectors, among others;
- Re-introduction of a prosecution policy in conjunction with a Crown Attorney cross appointed to the inspection branch by the Deputy Attorney General;
- Re-introduction of more effective sanctions (cease intake, fines, charges, license revocation etc) to ensure compliance with the Act;
- Access to forensic accountants to determine why some facilities are short-staffed and do not have adequate linens and other supplies;

- Mandatory reporting to police of any suspicions of criminal activity by inspectors;
- Location of the inspection branch in the Ministry of Health so that the Director can order in clinical teams from hospitals to protect residents if any long term care facilities appear to be placing them at risk;
- Take-over by the Minister of Health under the Health Facilities Special Orders Act if any facility endangers residents;
- Imposition of non-profit management through municipalities or non-profit seniors' agencies if any commercial home has its license revoked and is taken over by the Ministry.

It is even clearer now, in light of testimony from the Ministry of Long Term Care Inspection Branch how critical these recommendations are.

What follows are highlights of testimony by senior managers of this Branch in their own words, followed by an analysis of how the Branch's action or lack thereof undermined its own mandate failing to prevent harm to residents of long term care institutions in Ontario.

Summary and Analysis of Testimony

On September 15, 2020 two senior managers, Pamela Chou and Lynne Haves of the Long Term Care Inspection Branch made a presentation to the Commission.

This was their testimony:

MANDATE OF THE INSPECTION BRANCH

"Our mandate is to be responsive and dedicated to promote the rights and quality of life for the residents in the long-term care homes, and we do this by ensuring that the homes are following the Long-Term Care Homes Act and the regulation." (Pg. 10/11)

"…all of our inspections are unannounced." (Pg. 10).
"So you can think of compliance as the inquiries and the inspections that's conducted based on all the issues that are coming in. And there's lots of issues coming in to our program area based on areas that we see through public complaint or critical incidents… So compliance is really the actions that we take as the basic actions through inquiries or inspections." (Pg. 11)

<u>Analysis</u>

The stated mandate of the Inspection Branch is to be responsive an dedicated in promoting the rights and quality of life of residents in long term care facilities and to ensure that the facilities are functioning in accordance with the Long Term Care Homes Act and Regulation. But here the statement is that inspection are complaint and critical incident driven – based on issues coming in to the Branch – not on proactive action taken by the Branch to ensure that facilities are in compliance with the law.

ENFORCEMENT

"you can think of enforcement as escalated actions that a director, under the act can take to further help bring the home back into compliance… So these enforcement activities are usually used when we see higher-risk issues in the homes. So as an example, if you have a home that's continuously in non-compliance, they're just not fixing their issue, or they're presenting significant care or operational concerns that can be fixed, and it's really posing a risk on the residents' safety, then our director can take additional actions. And some of these actions that's possible to take through enforcement are things like an inspector can make a referral to the director. So after the inspector has looked through the issue through inspections, maybe they felt the issue is really, really high-risk, and they want to make a referral to the director. That's considered an enforcement action….a director can also issue an interim manager to take over the home on a temporary basis. In more serious situations, a director may even cease the admission of the home until she feels that the home is ready to bring back residents and resume normal operations -- then, she can lift that cease of admission -- or in very, very serious cases, we can also revoke the licence of that particular licensee." (Pg. 10/11)

Analysis

So essentially resident care must be in enormous jeopardy and there is a risk to residents' safety before the Director takes additional actions such as having an interim manager take over a facility or cease admissions – considered a more serious situation possibly because it reduces revenues for the facility.

The most serious issue results in license revocation, except that only one license has been revoked in the past several years in spite of extremely serious issues detailed in inspection reports and in the military report.

It should be noted that in the case of Orchard Villa with the highest death rate in the province during the pandemic and a devastating report by the military as well as years of alarming inspection reports, there was never a Cease Admissions notice given. A Director's Order was issued on March 17, 2017. It was the Durham Region Medical Officer of Health who stepped in and ordered in hospital teams.

It should be noted that the manager says all inspection results are made public, however that is not exactly true. Director's referrals are not made public and these must be obtained through Freedom of Information which can be a long and costly process for members of the public.

It should also be noted that facilities can appeal any findings by inspectors to the Director, and appeal again to the Health Services Review Board (HSRB) if a facility disagrees with a Director's finding. The testimony was that follow up inspections can be delayed by 3-4 months by this process pending a decision by the HSRB (Pg.17).

Non-compliances are only issued under the Act and Regulations and do not pertain to internal policies of the Ministry (Pg 17). This raises the question of whether facilities are simply ignoring Ministry guidelines and policies as they did when they extended the time that essential family visitors were not allowed into facilities to see their loved ones. The caveat was later provided that ***"specifics are not necessarily laid out in the act or the legislation itself, but the legislation does indicate that you have to follow the Ministry's or the director's policies and procedures"*** **(Pg. 25).**
"So we have many teams with many inspectors, and the more people you get, we need to ensure that there's consistency of practice across the board. And that's why we have a team that helps develop our policies and educations and training materials to support our frontline staff."**(Pg. 23)**

This speaks to a reliance on policies and training to ensure consistency in inspections, but makes no reference to supervision of inspectors to ensure consistency. Given the lack of apparent consistency of when Director's Referrals are made and Compliance Orders issued, it raises questions about whether or not this is the best system to ensure cross system consistency and accountability.

DUPLICATION OF ROLE OF OLTCA

"whenever we do identify a good practice that we like to share, we have a portal that's for the long-term care homes, and we share those informations through memos and, for example, our inspection protocol, which we consider as best practice." **(Pg. 33)**

Analysis

It is generally the role of the provincial organization representing local service providers to share best practices and new information. There appears to be a bit of role confusion here, where the Inspection Branch sees part of its role as consultation rather than inspection and enforcement. It is up to service providers to seek information on best practices and should not be up to inspectors to provide this information to those being inspected.

NUMBER OF INTAKES AND INQUIRIES VS INSPECTIONS

"our program is made up of four main inspection types, and these are complaint inspections, critical incidents, follow-up inspections, and proactive inspections….there are over 2,000 issues or intakes coming in per month into the program [complaint and critical incidents] So that is a huge 5volume that we have to manage on a daily and 6monthly basis to triage that information (Pg. 35).

"We do have policies around how we assign risk to every individual issue or matter that's coming in, so whether it's a complaint or a critical incident, if the issue we see at hand is a high-risk concern -- it doesn't matter if it's a complaint or a critical incident -- we will deal with it accordingly based on the risk level that we assign to it." **(Pg. 36/37)**

"a follow-up inspection coming into the Ministry because follow-up inspections is a response to a compliance order that the inspector had previously issued. And a proactive inspection is something that's initiated by the service area……   Complaints are public, and it comes through any means through the public, and critical incidents are the mandatory stuff that homes has to report." (Pg. 38)

Analysis

So essentially the Inspection system is complaint and critical incident driven with follow-up inspections done to determine if there has been actual compliance with compliance orders issued by inspectors. "***So when the compliance due date is expired, we have to conduct a follow-up inspection to determine if that non-compliance was corrected."*** **(Pg. 42).**

What is notable here is that complaints come from the public – presumably those being served, their families, or possibly advocates – whereas critical incidents are reported by the facilities – when they are reported. There are numerous instances identified in inspection reports that have been picked up either during a complaint inspection or during a Resident Quality Inspection, which is now rare, where facilities have not reported critical incidents, even those causing injury to residents, to the Director. The testimony is that critical incidents are often filed because of ***"missing residents, emergencies, disease outbreak, unexpected death"*** **(Pg. 42)*.***

All of these inspections are noted to be "reactive" in nature. (Pg. 42), whereas Resident Quality Inspections are noted to be proactive – '***a service area initiated inspection, and then we have resident quality inspections, which we call the RQ's."*** **(Pg. 43).**

What is also notable is the high volume of complaints and critical incidents reported – almost 2000 per month on average.

NO COMPREHENSIVE REVIEW OF WHETHER RESOURCES MATCH NEED

The testimony is that no "fulsome" analysis has been done to determine whether or not the Branch has ***"the required resources to manage the incoming volume and sustain it."*** **(Pg. 45)** and that this is a work in progress.

CONSEQUENCES FOR HOMES WITHOUT COMPLAINTS/HOMES WITH PROBLEMS GET NO COMPREHENSIVE INSPECTIONS

"all long-term care homes need to receive at least one inspection a year… ***we have seen cases where a long-term care home has not -- we have not received a complaint or a critical incident for a long-term care home. And so in those situations, we might decide to do a proactive inspection just to get into the homes and look at their overall aspect through the***

different care areas that we have outlined. So that's one reason why we may do a proactive inspection."**(Pg. 46)**

"Our service area managers are in collaboration and discussions frequently with the LHIN, Ontario Health, or Public Health, for example. And perhaps through that, there may have been issues that have surfaced or identified or we have heard that may trigger us to say that, hmm, even though we haven't really seen a complaint about this that it might be worthwhile to check in on the homes through a proactive inspection." **(Pg. 47)**

"So if we did do a proactive inspection, we would most likely look at their IPAC, and I want to say emergency plans as well, but I am not 100 percent certain. I would have to check our own policies to see what the mandatory areas are for those proactive areas. So your question, if it will come out through a proactive inspection, if we did do one, it would likely come out through that." **(Pg. 48)**

"So all of the reactive inspections is focused on the issue, and we do try to teach our inspectors to maintain focus on their inspection because otherwise you could spend days in the long-term care home to look at various, various issues. So the reactive inspections are specific to the issue that has been presented." **(Pg. 49).**

"It's any inspection. So if they had one complaint inspection that they -- so they have had one inspection a year." **(Pg. 50)**

"COMMISSIONER JACK KITTS: So you could go -- a home could go years if they have enough complaints, I suppose, without having a full proactive inspection?

PAMELA CHOU: Yeah, that's -- it could happen. Now, we have in recent years, usually there are -- we do conduct multiple inspections for the different long-term care homes. It's a very -- it's very minimal that we see a long-term care home really have no issues at all. So I would say that, on average, from inspection data perspective, you would have long-term care homes that has had multiple complaint inspections done or critical incidents done. So there are different areas that could be looked at through different inspections, but it's not to say that all long-term care homes has to receive one proactive inspection a year." (**Pg. 50/51)**

Analysis

This is a very disturbing component of Ms. Chou's testimony. She is essentially saying that they are required to do one inspection of each long term care home per year, but that a very narrowly focused complaint or critical incident inspection counts as the yearly inspection having been done.

She also says that where no complaints or critical incident reports have been received, a home would be pretty much guaranteed to have a proactive inspection triggered. This is of extreme concern because essentially it means that facilities that have not had complaints made against

them and have not had critical incidents that they were required to report are more likely to be inspected in a comprehensive proactive inspection than facilities that have had numerous complaints and critical incidents.

This demonstrates that the entire inspection process is illogical and does not focus on the facilities most likely to need inspections to protect residents, thereby fulfilling the Branch's mandate. The admission that facilities with lots of complaints and critical incidents would not have a proactive, comprehensive inspection triggered is shocking and frankly alarming. Essentially those facilities are given a pass on a more comprehensive inspection, while facilities that likely have fewer problems are more likely to be inspected proactively.
There also appears to be a built in bias here where presumably resident and family complaints are less likely to result in a proactive, comprehensive inspection irrespective of how often they complain, whereas if say a LHIN or Public Health Unit complains, it is more likely to trigger a proactive inspection. Families and residents would be well advised to complain to one of these bodies then rather than the Inspection Branch, since to do so is more likely to result in a comprehensive inspection.

IF a proactive inspection is done, it is more likely to identify problems with infection control. But the worst facilities appear not to be subject to proactive inspections according to this testimony, therefore it is less likely that infection control problems would be identified because of complaints or critical incidents.

This is of extreme concern, since it was facilities with many complaint and critical incident inspections like Orchard Villa that did not receive proactive inspections that might have picked up infection control problems leading to their high death rates. This particular facility was filthy and was subject to weeks of deep cleaning after a hospital team went in. This should have been identified and compliance orders issues much sooner. Had that been done it is possible that infection would not have spread like wildfire through this facility.

TOP COMPLAINT: PLAN OF CARE ISSUES

***"What I do want to say, from the top of what I could remember, plan of care is one of the top non-compliance areas that comes through our complaints systems, and I want to say safe and secure home may be another."* (Pg. 51).**

<u>Analysis</u>

This statement is also of extreme concern. If care related and safety concerns come up most frequently and the Branch receives close to 2000 complains a month, then this is a strong indicator of exactly how much trouble these facilities are in. It raises the question – why is government paying facilities that are not meeting the most basic needs of their residents? And why are Cease Admission orders not issued more frequently when it is clear that care and safety related issues top the complaints and critical incident reports that the Branch is receiving?

INFECTION CONTROL AND PANDEMIC READINES NOT CAUGHT IN REACTIVE INSPECTIONS

"For the 2019 analysis of the top ten non-compliance areas, IPAC and emergency plans were not part of the top ten that presented as top non-compliance issues."

***COMMISSIONER JACK KITTS: Can I follow up on that? So back to my question. So if you've been inspecting homes for abuse and other things over the past year and you haven't done a proactive inspection which covers the whole gamut, you wouldn't necessarily ask about pandemic preparedness or IPAC compliance because that's probably part of the proactive inspection but not the targeted inspection that you seem to be doing a lot more of; is that correct? (*Pg. 52)**
PAMELA CHOU: That is correct."

Analysis

This is extremely alarming testimony. Essentially a senior manager of the government's Inspection Branch is admitting here that the inspections being conducted are unlikely to pick up whether or not a facility is prepared for a pandemic, specifically with appropriate infection control protocols.

It is also clear that proactive inspections that would have examined infection control protocols and pandemic preparedness were not conducted even once infection and death tolls were rising in these facilities.

It is difficult to imagine what would have moved the senior managers of the Inspection Branch to trigger proactive inspections if not high infection and death rates in the facilities, especially those with high rates of complaints and critical incident reports like Orchard Villa?

It is clear that the Inspection Branch lacks any sort of critical incident response itself.

PHONE CALLS VERSUS INSPECTIONS

COMMISSIONER JACK KITTS: And one last question that's kind of bugging me at the bottom there. Inquiries are conducted for lower-risk complaints. I'm assuming inquiries are calls, phone calls, or they're less in-depth than an inspection?

PAMELA CHOU: Yes. So, absolutely right. So majority, I would say most of our inquiries are done via phone calls. (Pg. 52)

Analysis

If complaints come in that the Inspection Branch designates as low risk, only a phone call follow up is done. This raises the question about families who many not be able to phrase their concerns in a way that meets the Inspection Branch's criteria for a more serious "matter" or

"issue". How many actual complaints with serious implications are missed this way? Clearly whoever is raising an issue with the Inspection Branch considers it serious enough to do so.

MAJORITY OF INSPECTIONS NOW COMPLAINT AND CRITICAL INCIDENT BASED

"..critical incidents actually make up almost half, almost at 50 percent. It's at 49 percent of the inspection types that we do, and following that is the complaint volumes that's at 37 percent. So we are programmed, really -- because of the volume that's coming in, our program sees a lot of inspections are related to critical incidents and complaints…..you'll see that for 2019, there were, on average, 313 complaints/issues that's coming in per month and 1,366 critical incident issues coming in per month. So if you actually add that up, it's close to 1,700….

COMMISSIONER FRANK MARROCCO (CHAIR):
critical incidents and complaints make up 86 percent of the pie, and then the follow-up amounts to 11 percent. Now, would the follow-up inspections be mostly in response to the reactive inspections?

PAMELA CHOU: Mostly. So I would say mostly but not exclusively. So it could be any inspection that an inspector decides to issue a compliance order. So a follow-up inspection is basically to check to see if the compliance order was brought back into compliance. So you could have a proactive inspection where the inspector issued a compliance order during a SAO-initiated inspection or an RQI, and in that case, that would be captured under follow-up inspection as well. So it's not exclusively complaint- and critical incident-related; it could also be proactive, but just -- and I say majority and mostly is reactive inspection-related just because of the sheer volume of the reactive inspections that we do." (Pg. 54/55/56)

Analysis

86% of the inspection that are now done in Ontario are "reactive" – complaints or critical incident based. This means that the remaining 14% are a combination of follow-up or Resident Quality Inspections. This indicates the low level of proactive actions taken by the Inspection Branch since the Ford government all but stopped comprehensive Resident Quality Inspections in 2019.

Critical Incident and Complaints inspection are narrowly defined as previous testimony showed. These are not comprehensive proactive inspections. Nor are they unannounced for the most part with almost half being critical incident based. Most facilities would be well aware that as soon as they file a critical incident they can expect a visit from Ministry inspectors.

This is confirmed with the testimony:

INSPECTIONS DONE OFF SITE

"COMMISSIONER FRANK MARROCCO (CHAIR): All right. And on the left side, then, of the 2,882 inspections, 77 of them were proactive; have I got that right? Am I reading that correctly?

PAMELA CHOU: Yes, yes." **(Pg. 56)**

"When I talk about what we did during COVID, we did have to adapt a little bit just so that we can maintain the safety of our inspectors, and so the inspections could be done offsite as well." (**Pg. 57)**

<u>Analysis</u>

This confirms that with the worst pandemic in the history of the province, while infection and death rates were rising in long term care facilities, and residents were left without food and water because of severe short staffing, inspectors were doing their visits off site for their own safety. Considering that their mission was to keep residents safe and ensure compliance with the law, this indicates a complete breakdown in their responsibility to conduct inspections on site that may well have contributed to residents being at risk. If front line workers were going into these facilities in full PPE, it raises a question about why Ministry inspectors were not doing the same.

INSPECTIONS VS NUMBER OF COMPLAINTS

"The formal name is called Compliance Smart Client, CSC, but internally, we refer that as our intake form or intake module, just for easier reference. So the first line of people or line of staff that receives this information coming in and creates an intake for it is our triage inspectors. So those are the inspectors; they are RPNs by professional designation. They triage the information that's coming in, and they log it and create an intake for it…..one intake doesn't necessarily mean one inspection So you could have one inspection that actually contains multiple intakes. It could be a repeated issue that the complainant continues calling in; maybe we've received three of the same complaints. We'll group that into one inspection…..So out of 8,116 intakes that was inspected individually -- sorry, individual intakes, that resulted in 2,882 inspections." (Pg. 59/60)

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. And so you would have a sense, for example, of whether a Level 3 inspection is actually taking place within 60 business days or not?

PAMELA CHOU: Yes, yes. And we do try, to our very best of our ability, try to keep within those target timelines. Now, there are situations where we may not meet the timelines for whatever reason, and it could be -- I'll just use maybe a Level 3 example. We needed to do an inspection, but that inspector that was assigned to do that inspection had to be called to

respond to an immediate jeopardy situation. So we're taking away that resource that should have met the timeline to do something more important. So there are areas where we may not meet the timeline 100 percent of the time, but we do try our very best to meet those target timelines. It is one of the principles that we try to stick to within our program." (Pg. 66/67).

Analysis

What Ms Chou is acknowledging here is that out of over 8000 complaints coming in, a third or less may result in an actual inspection. She later acknowledges that there are only 10 triage inspectors handling this volume. (Pg. 62)

She also acknowledges that internal policies require that a complainant receive a response within 3 days. (Pg. 63)

She also mentions that complaints are considered legitimate if they involve non-compliance with the Act or Regulation. (Pg. 63) Triage inspectors then categorize which part of the Act or Regulations it falls under and then do a risk assessment level 1-5). (Pg. 64/65)

HUGE DELAY IN FOLLOW UP TO COMPLAINTS

Low level issues result in an inquiry – so not an on-site inspection – follow up within 90 days. Only complaints at risk level 3 (actual harm) or higher result in an actual inspection WITHIN 60 DAYS. More significant risk – WITHIN 30 DAYS (Pg. 65). Only immediate jeopardy – unexpected death, suicide, or very serious issue will trigger an inspector attending right away. (Pg 65/66)

The seriousness of this failure to protect residents is obvious. Unless someone has died, committed suicide, or there has been a very serious issue at a facility, inspectors will show up sometime between 6 weeks and over 3 months. That is a completely unacceptable response time especially for a Branch whose mandate is to protect residents. This implies that unless someone has died, committed suicide or is in immediate jeopardy no inspectors are likely to show up quickly.

SOME FACILITIES FAIL TO RESPOND TO INSPECTORS

"..something that we had to adapt during the pandemic as part of the broader government response is a support and monitoring role. So this is quite different from the normal compliance and enforcement role that our long-term care home inspectors would do. So these efforts include making outbreak -- sorry, making outgoing calls to the long-term care homes just to check in on them and see how they are doing. If they are in COVID outbreak, we ask for some stats around the COVID outbreak information, like number of active cases; was it resident or staff; do they have any COVID-related death. We also support them by asking questions if they are seeing any critical concerns with staffing or PPE shortages.

So that would be some of the activities that we would do under that bucket of support and monitoring.

COMMISSIONER FRANK MARROCCO (CHAIR): But when they answer, though, did they answer those questions in a timely manner?

PAMELA CHOU: So we did -- not every single home responded actively when we reached out to them. So some homes were struggling a little bit, and it wasn't a good time to speak with them. So we really had to -- the inspectors really had to use their judgment and not put extra pressure on the home. So some homes are more willing to speak to us, and some homes are, perhaps, occupied in other areas at that time when we tried to do our outreach to them. So it does vary across the board." **(Pg. 73)**

Analysis

What this exchange demonstrates again is an abundance of consideration for the long term care providers and little consideration of what might be happening to residents, especially in facilities which are "struggling". That is exactly when inspectors should be going in rather than allowing themselves to be ignored by the facilities. In fact, facilities that did not respond should have automatically had inspectors show up at their doors.

IS THE INSPECTION BRANCH IN THE WRONG MINISTRY?

"if we did hear that the home is struggling significantly with, for example, PPE or staffing, then there are proper channels that our inspectors could remind the homes on where to look, where to seek that information. And oftentimes, we recommend them, have you contacted your LHIN representative; have you used the online portal for staffing matching. So sometimes they don't even know what the information exists out there, and in very serious situations, the inspectors could escalate it to their manager, and their manager would escalate it, for example, to a senior manager. And we would connect with our internal partners at the Ministry of Health to try to get some escalated action for these homes that are critically struggling. **(pg. 74)**

Analysis

What this demonstrates is that the Inspection Branch needs, once again to be included in the Ministry of Health. There are far too many levels involved before there are interventions between the Health Ministry and long term care institutions.

What this also demonstrates is another blurring of inspector roles as they act as consultants and helpers to the facilities rather than inspectors.

And it points out that some facilities apparently have no clue about "what information exists". No one receiving almost $200.00 in per diems that holds a license from the province to provide

care to vulnerable people should ever be operating with this level of ignorance, especially during a crisis.

COVID outbreaks were seen as critical incidents likely to trigger an inspection – however, we also saw that these may not take place for quite some time, especially as inspectors responded to high risk situations. (Pg. 76)

The testimony was also that they had to obtain PPE for their inspectors and a senior manager of the Inspection Branch was unable to say in what timeline that was obtained but it was not immediately and it had to be obtained by the Ministry of Health underscoring the earlier point that the Inspection Branch needs to be reincorporated in that Ministry (Pg. 78).

Some comments raise the question of how much the Ministry of Long Term Care is essentially a puppet Ministry.

"COMMISSIONER FRANK MARROCCO Why -- you maybe can't answer this, but why wouldn't that information, as it related to long-term care homes, anyway, and I don't know about retirement homes, but why wouldn't that information go to the Ministry of Long-Term Care for assessment? Why would it go to the Ministry of Health; do you know?

PAMELA CHOU: No, I don't have the answer to that" **(Pg. 84).**

"a focused meeting on inspector views on the pandemic, we didn't do that."(Pg 110)

The testimony was that it was the Health Ministry that assessed ratings to long term care facilities as to COVID risk, not the Ministry of Long Term Care or the Inspection Branch. (Pg 89/90).

The testimony was also that the Inspection Branch had no additional surge capacity during COVID and was not provided with additional resources and instead redeployed existing resources. (Pg. 98/99) And the resources being deployed, namely inspectors, had not had a meeting focused on the pandemic in order to obtain their views.

HIGH RISK FACILITIES NOT INSPECTED DURING THE PANDEMIC

"COMMISSIONER FRANK MARROCCO (CHAIR): But I guess what I was asking was -- another way of putting it, perhaps, is in terms of proactive inspections –
which would presumably include warning people that there was a problem on the way, were there proactive inspections of that nature prior to March or April? I mean, I'm talking about January or February.

PAMELA CHOU: My understanding is that there were not. It's one of the things that we can check in our data just to confirm." (Pg. 79/80)

Analysis

So essentially no proactive action was taken by the Inspection branch to inspect, particularly high risk facilities, to determine whether or not they were prepared for the pandemic that by late February or early March they should have known was coming. Inspections appear to have occurred but primarily in May. (Pg. 92)

Not only that but a daily COVID-19 report was begun on March 19th and shared with health care partners, so it was clear that by March 19th the Inspection Branch was aware of COVID outbreaks in long term care facilities. (Pg. 80). Under questioning by a Commissioner, there was an admission that it was the Inspection Branch that was providing COVID outbreak data to the Ministries of Health, Long Term Care and Ontario Health at that time. No inspections were taking place. Inspectors were calling facilities and inputting the information into a database that was being shared with the Branch's partners. Testimony also showed that the Inspection Branch was using a risk report produced by the Ministry of Health's Emergency Operations Centre that including COVID risk levels (Pg. 81/82/83).

She also mentions the role that Ontario Health plays in providing information about PPE and staffing levels. (Pg. 84). This is a critical point since these were the important issues that occurred and led to high levels of infection of residents and staff and death in these facilities. It should be noted here that Shelly Jamieson, a former President of Extendicare and Executive Director of the Nursing Home Association – the lobby group for for-profit nursing homes – sits on the Board of Ontario Health, as does Adelstein Brown – Former Assistant Deputy Minister for Strategy and Policy at the Ontario Ministry of Health and Long-term Care https://www.ontariohealth.ca/our-team/board-directors

The last exchange between Ms. Chou and a Commissioner may be the most telling.

COMPREHENSIVE INSPECTIONS SUSPENDED DUE TO LACK OF RESOURCES?

COMMISSIONER ANGELA COKE: Yeah, I just want to clarify something more general. So every home does not have a full proactive annual inspection, and is that due to taking a risk-based approach to lessen burden on the homes, or you simply wouldn't have the resources or capacity to do that? I think most people expect that every home is getting at least one inspection annually, but that doesn't sound as if that's really necessarily the case based on your earlier slides. So I just want to be clear on that and why that is.

PAMELA CHOU: Right. So every home does get an inspection once a year, but to answer your question around, is it proactive and was it a resource constraint, it was a real –

COMMISSIONER ANGELA COKE: A full inspection. Because if they're coming around, inspecting on one specific complaint, that doesn't tell you what's happening in the rest of the place.
PAMELA CHOU: No.

COMMISSIONER ANGELA COKE: So once a year is not a comprehensive systemic sort of review every year. I'm trying to be sure that's not what's happening.

PAMELA CHOU: Right. And <u>so I can't say that for those homes that didn't receive a proactive inspection if all of the care areas in the home was looked at</u>. So that's one. <u>The other thing is in terms of proactive inspection, resource availability was a concern. So that is a realistic concern that we have to consider.</u> Proactive inspections do take significant amount of resource time, and so we have to be able to manage the volume that's sitting there as risks that are coming in through those complaints and critical incidents. And so we had to find a balance that allows us to still address those Level 3 --especially those Level 3-pluses and any 4s, those higher-risk areas that may not have been done in a proactive inspection -- you're right -- but we had to manage all of that volume and respond to those risks; otherwise, it's risk sitting there. <u>So as a program, we had to make the decision to go risk-based, and -- so our program is risk-based</u>. And so that is why we focus on the risk that's coming in the door, and then we also do the proactive inspections. But as part of the response on how we can actually get all of those risks addressed is to ensure that we actually do those reactive inspections first.

COMMISSIONER ANGELA COKE: Did you used to do annual inspections in the way I'm describing?

PAMELA CHOU: You mean annual proactive inspections?

COMMISSIONER ANGELA COKE: Yeah, in the past.

PAMELA CHOU: Yes. To answer your question, yes, we did do that in the past.

COMMISSIONER ANGELA COKE: Okay. And so is it just responding to the increase in volume that made you have to switch to this risk-based approach?

PAMELA CHOU: Yeah. So it was in 2018,in the fall of 2018, that our program switched to a risk-focused approach, and part of the significant rationale behind it is the significant volume that was sitting there and the complaint and critical incidents. So those are unknown risks that if we don't inspect on it, we don't know the outcome. So we needed to address those risks. So also through our Auditor General's recommendation, and they did a report on this in 2015, so out of that recommendation was a recommendation for the program to also be risk-focused. So throughout the years, we've had to make adjustments, and we've had to turn to a risk-based approach. In addition to that, the broader OPS direction in terms of compliance is taking on a more risk-focused approach as well to compliance in general, so we wanted to also adhere to the principles behind that. So there was a number of factors that allowed our program to make the decision to be more risk-focused in our approach in 2018.

Analysis

It is clear here that comprehensive annual Resident Quality Inspections that were proactive were abandoned in 2018 in favor of risk based inspections – inspections that occurred only once harm was done. This undermines completely the mandate of the Inspection branch to keep residents safe. However it is also part of a broader OPS direction as Ms. Chou points out to cut costs across the civil service by going to risk-focused approaches. What this means is that this new approach to save resources is not confined to just the Inspection Branch.

SUMMARY

In summary, what was learned from the Inspection Branch testimony is that:

- Resident care must be in enormous jeopardy and there is a risk to residents' safety before the Director takes additional actions such as having an interim manager take over a facility or cease admissions – considered a more serious situation possibly because it reduces revenues for the facility;
- There is a reliance on policies and training to ensure consistency in inspections, but no reference is made to supervision of inspectors to ensure consistency;
- The Inspection system is complaint and critical incident driven (86% of inspections), hence reactive with follow-up inspections done to determine if there has been actual compliance with compliance orders issued by inspectors. Proactive Resident Quality Inspection happen infrequently.
- No fulsome analysis has been done to ensure that the Branch has the required resources to meet its responsibilities under the Act, and it appears that RQI's were abandoned in 2018 because of inadequate resources.
- **Since any inspection is considered a yearly inspection those facilities that have not had a complaint or critical incident are more likely to receive a comprehensive Resident Quality Inspection than facilities that have had numerous complaint and critical incident inspections (which are narrowly focused) during the year. It is during a comprehensive inspection that infection control issues are more likely to be identified.**
- Care related and safety concerns come up most frequently and the Branch receives close to 2000 complaints a month. This is a strong indicator of exactly how much trouble these facilities are in and it raises the question – why is government paying facilities that are not meeting the most basic needs of their residents? Why are Cease Admission orders not issued more frequently, why are there not more frequent Director's Orders and license revocations?
- During COVID concerns about inspector safety trumped resident safety as inspectors were more likely to do inspections off site.
- **Unless complaints or critical incidents indicated that residents were in extreme jeopardy, in which case inspectors would go in right away, they went in anywhere from 6 weeks to over 3 months after complaints were received**.

- The testimony also indicated that information was shared with the Health Ministry but not the Ministry of Long Term Care by the Inspection Branch as a matter of course, raising the question of why the Branch is not still located within the Ministry of Health.