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ATTENTION NEWS EDITORS: For immediate release

Ombudsman finds delays, inconsistencies and lack of transparency in monitoring of long-term care homes

Ministry effort to address problems "a work in progress"

TORONTO (December 21, 2010) – Ontario Ombudsman André Marin today released his findings in his investigation of the province's monitoring of long-term care homes. The probe identified several serious systemic problems that the Ministry of Health and Long-Term Care is working to correct, Mr. Marin said.

Stating that he is "guardedly optimistic" that the Ministry is taking the problems seriously, Mr. Marin opted not to release a full, formal report. Instead, he tabled a summary of his findings with the Legislature, along with responses from the Ministry.

The Ministry co-operated fully with the investigation and has incorporated the Ombudsman's suggestions into its reform plan. It has agreed to report back to the Ombudsman regularly on its progress in fixing the problems he raised. The Ombudsman will monitor these changes and may still reopen the investigation and release a report if he feels it is warranted.

"I am guardedly optimistic that the proposed organizational reforms and new regulatory scheme will lead to more effective oversight by the Ministry… and ultimately, improvement in the living conditions and care experienced by long-term care home residents," Mr. Marin wrote in a November 26 letter to the Ministry that summarizes his findings. "However, this area continues to be a work in progress and I intend to monitor the Ministry's ongoing progress closely." The letter, along with responses and progress reports from the Ministry, was tabled and publicly released today.

The extensive investigation, conducted by the Special Ombudsman Response Team, was launched in July 2008 after the Ombudsman received more than 100 complaints (a further 450 complaints were received after the investigation was announced). During and after the investigation, "significant organizational transition" occurred in the Ministry with respect to the monitoring system, Mr. Marin noted. Among other things, it opted to adopt entirely new "quality indicator" methodology in early 2009, while regulations under the new *Long Term Care Homes Act, 2007* were being developed. The Act and regulations did not come into effect until July 1, 2010, and the Ministry's reform process is ongoing.

The Ombudsman identified four areas of concern in his letter:

1. The standards being used to monitor long-term care homes were inconsistently interpreted and applied. With 450 different criteria to check, ranging from minor to serious, the Ministry's compliance staff were often overwhelmed, the Ombudsman found. Largely due to inadequate and inconsistent training of staff, serious deficiencies tended to be lumped in with less serious ones and follow-up was spotty, as was enforcement. "Inconsistency in the application of standards can result in dangerous situations continuing unchecked," Mr. Marin warned the Ministry.

2. The Ministry failed to ensure the timely conduct of inspections. Some facilities went for 18 months without follow-up inspections after problems were identified, and, due to a lack of specialists such as environmental health or dietary advisors, several homes "had not seen a specialist advisor in more than 15 years," the Ombudsman reported.

3. The complaint investigation process lacked rigour and transparency. The call centre handling complaints about resident care provided sketchy and at times inaccurate information and the Ministry routinely referred complainants back to the homes, Ombudsman investigators were told. Residents and family members who complained about conditions or treatment in homes feared reprisals – some "were threatened with being banned from the home," Mr. Marin said. Investigations of complaints were often delayed, less than thorough, and complainants were given little information about the evidence gathered or the basis for any findings.

4. The public reporting of compliance findings was inadequate. The Ministry posted inspection data on its website, but it was incomplete, practically incomprehensible and grossly outdated, the Ombudsman said. "All that was available was a partial, incomplete and, at times, inaccurate snapshot of compliance." The results of specialty inspections were not even included, meaning "serious issues discovered during specialty reviews remain shielded from public knowledge," he wrote, noting that similar websites in other jurisdictions, such as those in Florida and the U.K., were far superior and more transparent.

Now that the new Act is in force, designating compliance staff as "inspectors," focusing on "high-risk areas" and refining the unwieldy compliance standards, the problems of inconsistent monitoring "should be mitigated to a certain degree" and assist in ensuring that serious complaints are responded to quickly, Mr. Marin said. "However, it is too early at this stage to assess what impact the new approach will have on resident welfare," he wrote, adding that it is also not clear how the Ministry will ensure all homes apply the new standards consistently.

The Ombudsman expressed similar concerns about the Ministry's new system of risk indicators, noting "there is no provincial strategy yet in place" for monitoring the data. He also called on the Ministry to consider the need for experienced complaint intake staff and well-trained investigators, and to "listen to concerns raised by the public" about the need for transparency in responding to complaints. Finally, he noted that the outdated website was "refreshed" in June 2010, but its format remained confusing. Ombudsman staff recently flagged several errors on the site for Ministry officials, who continue to revise it.

Letters from two different deputy ministers (from December 2009 and December 2010), also tabled today, detail the steps the Ministry has taken throughout the period of the investigation and acknowledge the Ombudsman's role in providing constructive input.

While the Ombudsman oversees the Ministry of Health and Long-Term Care, he does not (unlike ombudsmen in Alberta, Quebec, Nova Scotia, Yukon and Newfoundland and Labrador) have jurisdiction over long-term care homes themselves. The investigation was necessarily confined to the Ministry's actions and its monitoring system, not conditions within the facilities.

Not all Ombudsman investigations result in a formal report. Similar previous cases involved, among other things, the provision of mental health services for soldiers' children, the province's out-of-country cancer care program, the provision of PET scans, and coroner's inquest delays. For details on these and other investigations, see: http://www.ombudsman.on.ca/en/what-we-do/special-ombudsman-response-team/sort-investigations.aspx

-30-

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