



## Pandemic Readiness and Response in Long-Term Care 2021 Special Report

### Why We Did This Audit

- Many past reports, including those of our Office have identified issues and provided recommendations on improvements needed to improve Ontario's outbreak preparedness and address the systemic problematic issues in the long-term care sector.
- We initiated the audit to assess whether the Ministry of Long-Term Care and the long-term-care homes were sufficiently positioned, prepared and equipped to respond to the issues created by the pandemic in an effective and expedient way.

### Why It Matters

- The importance of improving the care and safety for long-term-care residents comes at a time not only of an unprecedented medical crisis, but also when Ontario's elderly population continues to grow, with residents frailer and in need of even greater health-care support.
- As of December 31, 2020, 2,800 residents and eight staff in Ontario's long-term-care homes had died as a result of COVID-19, and a total of 11,143 residents and 4,329 staff had contracted the virus.

### What We Found

- The tragic impact of COVID-19 on the residents and staff of long-term-care homes in 2020 is unprecedented. The pandemic starkly highlighted the underlying long-standing problems of the long-term-care sector, which has typically operated separately from other sectors, such as hospitals, in the health-care system.
- Although current Ministry bedroom standards are intended to limit the number of residents sharing one room to two people, our analysis of self-reported COVID-19 data from homes from March 19 to August 31, 2020—the initial wave of the pandemic—found that, of all the homes where at least 30% of the home's residents became infected at the same time, almost two-thirds primarily had bedroom designs that housed up to four residents in one room. The Ministry and the Local Health Integration Networks, which are responsible for placing residents in long-term-care homes, did not know how many residents were actually housed in three- or four-bed wards when the pandemic hit.
- The transfer of patients designated as alternate level of care (ALC) from hospitals to long-term-care homes contributed to crowding in homes. For example, in the month of March 2020, 761 transfers of patients designated as ALC were made from hospitals to long-term-care homes, 50% more than the average of 508 patients transferred per month throughout 2019. Given that homes were, on average, at 98% capacity prior to the pandemic according to the Ministry's occupancy data, these transfers of patients designated as ALC added more pressure to the homes, some of which were already struggling to contain the spread of COVID-19.
- On March 30, 2020, Ontario's Chief Medical Officer of Health issued a directive that limited visitors to long-term-care homes to only essential visitors. The measure was intended to control COVID-19 outbreaks by limiting the number of people going into homes. However, this lack of contact took an enormous emotional and physical toll on residents and their families, in many cases resulting in a deterioration in residents' physical and mental condition.
- Infection prevention and control (IPAC) were not consistently practiced and well understood in long-term-care homes even prior to the COVID-19 pandemic. Our analysis of the results of Ministry inspections between January 2015 and December 2019 found that about two-thirds (413) of all 626 homes were cited for a total of 765 instances of non-compliance with IPAC requirements.
- Long-term-care homes had insufficient staff and staff training to provide appropriate care.
- Long-term-care homes were initially not partnered with hospitals or public health units so as to benefit from their expertise in infectious disease outbreaks. Given the limited IPAC specialists in long-term-care homes, many homes did not have the capacity to manage the COVID-19 outbreaks without external support, such as from hospitals.
- A problematic enforcement practice culminated with the Ministry completely discontinuing, in fall 2018, its proactive comprehensive inspections of homes to focus on clearing a growing backlog of critical incidents and complaints. This occurred despite the fact that the annual comprehensive inspections identified areas of significant non-compliance, including IPAC non-compliance.
- Ministry inspectors are responsible for inspecting IPAC practices at long-term-care homes, but IPAC expertise resides with public health units. Only three staff in the Ministry's Inspection Branch have extensive IPAC expertise.

- The Chief Medical Officer of Health issued his first mandatory instruction to long-term-care homes on March 22, 2020, directing homes not to permit residents to leave the home for short-stay absences and limit, *where possible* [emphasis added], the number of homes that employees were working at. When requirements were eventually issued to the long-term-care home operators, they were often unclear, ambiguous and open to interpretation. For example, temporary staff from agencies were allowed to work in multiple homes, which appeared inconsistent with the order to restrict homes' employees from working at multiples sites.

## **Conclusions**

- Despite concerns about the care and safety of long-term-care home residents raised over several years by our Office and others prior to the pandemic, the Ministry of Long-Term Care and the long-term-care homes were not sufficiently prepared or equipped to respond to the issues created by the pandemic in an effective and expedient manner.
- Beginning in February 2020, the province implemented a number of measures to deal with the impact of COVID-19 in long-term-care homes and minimize its spread. However, these measures had unintended consequences on the homes' residents and staff by further contributing to crowding and staffing shortages.

Read the report at [www.auditor.on.ca](http://www.auditor.on.ca)