ATTACHMENT 3

Long-Term Care Home Audit Report Community and Health Services, Paramedic and Seniors Services

May 2024

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1.0 Management Summary

Audit Services has completed an audit of Long-Term Care Homes (LTC) under the Paramedic and Seniors Services Branch, within the Community and Health Services Department. The objectives of the review were to provide assurance on the adequacy and effectiveness of internal controls in place to properly manage the operations of the LTC homes, including compliance with legislative requirements and internal policies and procedures and measures in place to support resident and staff overall wellbeing.

The audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing.*

Based on the work performed, opportunities were identified to improve on existing internal controls and process areas within the administration and management of the LTC Homes. These internal control and process improvements have been noted and discussed in the body of this report. These opportunities fall within three areas: people, process and financial.

During the audit we noted key strengths within the LTC Homes program. Management appears highly motivated and focused on identifying and implementing positive change initiatives to better support staff and the overall success of the LTC Homes, given the significant legislative changes underway within the long-term care sector, and impact of the COVID-19 pandemic on the Homes' operating environment.

Proactive change initiatives noted during the audit include the Transformation Project, which includes four key priority areas: scheduling and staffing, leadership and learning, ways we work, and culture and well-being. Goals of the project include increasing the percentage of full time to part time staff, addressing precarity in the workplace, preparing for increasing sector pressures, and to reach the goal of providing four hours of care per day to the residents by March 2025.

In addition to the above, the Region was successful in obtaining the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in June 2023 by achieving the highest level of standards of quality in health and human services. The accreditation is valid for three years and provides recognition of management and staff's continued efforts and commitment to continuous improvement within the LTC Homes programs and service delivery.

Should the reader have any questions or require a more detailed understanding of the risk assessment and sampling decisions made during this audit, please contact the Director, Audit Services.

Audit Services would like to thank Region LTC Home staff and management for their co-operation and assistance provided during the audit.

2.0 Introduction

On April 11, 2022, the Fixing Long-Term Care Act, 2021 ("Act") and Ontario Regulation 246/22 replaced the previous Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation 79/10 as the governing legislation for LTC in Ontario. The new Act was implemented as a plan to fix long-term care and to ensure Ontario's seniors and other LTC residents get the quality of care they need and deserve. The Act was built on three pillars: staffing and care; accountability, enforcement, and transparency; and building modern, safe, comfortable homes for seniors.

LTC homes are facilities designed to provide specialized care and support for individuals who can no longer live independently due to aging, disability, illness, or other factors. These homes offer 24-hour supervision, assistance with activities of daily living (such as bathing, dressing, and medication management), nursing care, social activities, and meals. They are particularly intended for seniors and individuals with complex medical needs who require ongoing assistance and support that cannot be provided in their own homes or other community settings. The goal of long-term care homes is to ensure that residents receive the necessary care and support to maintain their quality of life and dignity.

The Region operates two LTC Homes: the Newmarket Health Centre and the Maple Health Centre for those 18 years of age or older. Both homes provide short stay beds for respite and convalescent care with a total of 132 and 100 licensed beds respectively.

The Region's "2024-2027 Plan to Support Seniors" identifies priority areas, objectives and related actions and advocacy the Region will take to enhance the health and well-being of our growing and diverse seniors' population. The plan focuses on supporting seniors to "age in the right place" based on their preferences, circumstances and care needs.

3.0 Objectives, Scope and Methodology

AUDIT OBJECTIVES

The main objectives of this engagement were to assess:

- the adequacy and effectiveness of internal controls in place to properly manage the operations of the Long-Term Care Homes.
- compliance with internal policies and procedures, and applicable regulations, including the Fixing Long-Term Care Act and Personal Health Information Protection Act.
- the adequacy of measures in place to support resident and staff mental health and wellness.
- adequacy and effectiveness of processes in place to monitor achievement of objectives and desired outcomes.

AUDIT SCOPE & AUDIT METHODOLOGY

The audit included a review of operations, processes and documentation in effect as of January 2024.

The audit objectives were accomplished through:

- Detailed review of Long-Term Care Home regulatory requirements and internal policies and procedures
- Detailed testing of specific operational processes including but not limited to safety and security, resident and staff wellness, and staff training and capacity
- On site visits at the LTC Homes
- Interviews with appropriate management and staff

4.0 Detailed Observations

4.1 Culture

Culture challenges were noted as negatively impacting employees' wellbeing.

Several staff noted concerns around overall culture within the homes and specifically regarding an absence of support from upper management. A recurrent theme throughout the audit was that staff lack security in their job and feel unsupported when difficult or challenging situations arise.

Staff also commented that staffing changes in management positions, including lengthy acting assignments, have contributed to a general feeling of uncertainty.

Culture concerns can negatively impact staff mental health, reduce employee performance and engagement, and lead to an increase in staff absenteeism and turnover, which may result in reduced levels of care provided to residents.

Recommendations

4.1.1 Management should consider completing an independent culture review within the long-term care homes to better identify specific areas for focus to help improve the overall culture and wellbeing of staff.

Management Response

Management is aware of these challenges, which are a key reason for development of the Seniors Services Transformation Project, a comprehensive, multi-phase initiative launched in 2022 and scheduled for completion in 2026. A primary objective of this project is to enhance the organizational culture, promote well-being, and create an inclusive environment in the Region's homes.

4.1.1 Action Plan:

- Implement Transformation Project Key Priority Areas
    - Scheduling and staffing
    - Leadership and Learning
    - Ways we Work
    - Culture and Wellbeing
- Increase visibility of management within the Homes to staff and residents.
- In partnership with People Equity and Culture establish a Wellbeing unit dedicated to Seniors Services staff.

- Implement new schedule to create more full-time frontline positions, stabilize the workforce, enhance the quality of resident care, and meet the legislated system average of 4 hours of direct care per resident per day.
- Consolidate the management structure of the homes under one Administrator and two Associate Administrators to enhance efficiency in decision-making and oversight, optimize resource allocation, foster collaboration, and ensure seamless coordination between both homes.
- Complete a culture assessment.

Owner:
Director, Seniors Services

Target Completion Date: (Q/Y)
Q4 2026

4.2 Volunteer Program

Opportunities exist to enhance the volunteer program within the homes.

Both LTC homes have a volunteer program that is managed by the Recreation & Programming area within LTC. Volunteers provide additional mental health supports to help improve residents' health and wellbeing.

Based on discussions with staff and a review of the volunteer program, there have been lost opportunities to provide residents with additional quality mental health supports through the volunteer program as a result of what are perceived to be very restrictive requirements.

Restrictions that are seen to have negatively impacted the retention of individual volunteers and the development of new organizational volunteer partnerships include the level of insurance required for partnership agreements, the length of time to finalize agreements, and the requirement for volunteers to have received 3 COVID vaccines.

By imposing restrictions on individual volunteers and partnership volunteer agreements, the Region may continue to experience reduced participation which may impact its mission to enhance resident wellbeing by prioritizing quality programs.

Recommendations

4.2.1 Management should consider reviewing the LTC homes volunteer program in its entirety and developing a strategic plan that prioritizes the health and wellbeing of residents. Expert advice may be sought to help ensure that volunteer opportunities are optimized while effectively managing risk.

Management Response

Management is rebuilding this program post pandemic and acknowledges the necessity of a comprehensive review of the volunteer program. Volunteers help to enhance our LTC Homes programs and services. Unlike Fee for Service programs and Educational Institutions, volunteers are not required to have a formal contract through procurement or insurance within the LTC Homes.

4.2.1 Action Plan:

- Management will engage with subject matter experts, conduct a review of the volunteer program. This will include an environmental scan of best practices, and assessment of the mandatory COVID-19 vaccination policy.
- Management will review the volunteer program. Based on this review, management will develop strategic actions with measurable outcomes aimed at enhancing the program.

Owner:
Administrator

Target Completion Date: (Q/Y)
Q4 2025

4.3 Training

Training requirements were not always completed on time.

LTC home staff are required to complete specific training, as defined by the Act, to ensure they have the necessary skills and knowledge to provide high-quality care to residents. The training requirements vary depending on the role and responsibilities of the staff member.

Based on our review of a select sample of staff training records, 25% of the staff sampled did not complete one or more of the training requirements by December 31, 2023. Most of the staff have since completed the overdue training in 2024.

Failure to ensure that staff complete required training on time may result in non-compliance with legislation leading to potential penalties and may compromise the level of care and safety of residents and staff.

Recommendations

4.3.1 Management should implement a monitoring and oversight process to identify approaching due dates for all staff within a pre-determined timeframe (i.e., three months) to ensure timely reminders to staff and management are provided and sufficient time is allotted to complete the required training.

Management Response

Management recognizes the need for improved monitoring and enforcement of staff compliance with annual training requirements.

Action Plan: 4.3.1

- Management will develop a monitoring process with clear timelines and communication methods, including reminders.
- Currently staff failing to complete mandatory training by December 31 annually are not able to work until requirements are fulfilled.

Owner:
Director, Seniors Services

Target Completion Date: (Q/Y)
Q3 2025

4.4 Vulnerable Sector Screening

Evidence of vulnerable sector screening of employees were not always on file.

LTC home staff are required to provide a vulnerable sector screening (VSS) upon hire. VSS is a security check to protect the vulnerable from individuals who may present a

direct threat to their safety and well-being. Talent Acquisition, within PEC, is responsible for collecting the VSS as part of the LTC hiring process.

Based on a sample test of VSS, several security checks were not present in the employee file. Based on discussions with PEC staff, there is a backlog in VSS collections due to the delay of processing during the pandemic period. Efforts have been made to help tighten the process, however there is still work to be done.

Recommendations

Management should ensure all staff have a valid vulnerable sector screening on file.

LTC home management should work with PEC to develop a standard operating procedure for the collection and storage of VSS's.

Management Response

Long Term Care Management and People, Equity and Culture are committed to complying with the Fixing Long Term Care Act., 2021 to ensure that all staff have a Vulnerable Sector Screening in the employee file and readily accessible.

Action Plan: 4.4.1

- Long Term Care and People, Equity and Culture will review current process of receiving and storing Vulnerable Sector Screenings.
- A plan will be developed in collaboration with Long Term Care Management and People, Equity and Culture to ensure all staff files contain the required documentation by Q4 2025.

Owner:
Director, Seniors Services

Target Completion Date: (Q/Y)
Q3 2025

4.5 Fire Drills – Roles & Responsibilities

Opportunities exist to clarify roles and responsibilities for completion of monthly fire drills.

The Fire Safety Plan requires that three (3) fire drills are completed each month (one per shift) at both homes. According to the Emergency Response Training & Exercise Plan 2022, maintenance staff conduct the monthly fire drills, and the Emergency Management (EM) Specialist observes and supports at least one of the monthly drills.

Based on discussions with EM staff and LTC Home maintenance and management staff, there is confusion around who is responsible to formally plan, organize and run the three monthly fire drills per home.

Providing clarity around responsibilities and expectations with staff and management in both areas may help reduce the risk of non-compliance by the Region and help ensure the continued safety of residents and staff.

Recommendation

4.5.1 Management should meet with staff and provide clear direction on the responsibilities regarding monthly fire drills.

4.5.2 Management should consider retraining responsible staff on the Fire Safety Plan and Emergency Response Training & Exercise Plan requirements to ensure responsibilities are clearly understood.

Management Response

Management is fully committed to complying with the monthly drill requirements of the Fire Safety Plan and Emergency Preparedness & Response Exercise Plan.

Action Plan: 4.5.1
An annual training plan has been developed for 2024 to deliver in-person training on Fire Safety Plan and Emergency Response Training & Exercise Plan requirements as per the Fixing Long Term Care Act, and Accreditation Standards.

Action Plan: 4.5.2
The Administrator will audit the annual Fire Safety Plan and Emergency Response Training & Exercise Plan quarterly to ensure a retraining plan is in place for identified areas for improvement.

Owner:
Administrator

Target Completion Date: (Q/Y)
Q4 2024

4.6 Fire Drills – Monthly Testing

Monthly fire drills were not always completed in line with the Act, Fire Safety Plan, and the Emergency Preparedness & Response Exercise Plan.

Ontario Regulation 246/22 under the Fixing Long-Term Care Act, 2021, requires fire drills to be completed once per month at each home.

The LTC Homes Fire Safety Plan, as required under the Ontario Fire Code, *section FS-7.1 Method & Frequency of Fire Drills, "requires that fire drills are held three (3) per month (one per shift)*" and defines the Administrators as the "building owner" who are responsible to ensure fire drills occur according to legislative requirements as approved by the local fire services as outlined within the Fire Safety Plan Section FS-7.

The LTC Homes Emergency Preparedness Plan also requires fire drills to be completed three times per month at each home (1 per shift). The higher level of testing frequency required under the Fire Plan and Emergency Preparedness Plan was implemented by the LTC Homes to meet CARF accreditation.

During our detailed testing of 2023 fire drill records, we noted the following exceptions:

- Maple Health Centre was non-compliant with applicable legislative requirements and/or Fire Safety Plan 8 months out of 12; completing 2 fire drills 2 out of 12 months, 1 fire drill 3 out of 12 months, and zero fire drills 3 months out of 12.

- Newmarket Health Centre was non-compliant with applicable legislative requirements and/or Fire Safety Plan 12 months out of 12; completing 2 fire drills 5 out of 12 months, 1 fire drill 4 out of 12 months, and zero fire drills 3 out of 12 months.

Noncompliance with the Act and Fire Safety Plan could result in violation of the Fire Code and lead to fines and penalties and put the safety of residents and staff at risk.

Recommendations

4.6.1 Management should ensure annual fire drill schedules are created and adhered to through management oversight and review.

4.6.2 Retraining of staff should occur, where applicable, to ensure compliance is clearly understood and maintained.

Management Response
Management is fully committed to complying with the monthly drill requirements of the Fire Safety Plan and Emergency Preparedness & Response Exercise Plan.

Action Plan: 4.6.1
An annual training plan has been developed for 2024 to deliver in-person training on Fire Safety Plan and Emergency Response Training & Exercise Plan requirements as per the Fixing Long Term Care Act, and Accreditation Standards.

Action Plan: 4.6.2
The Administrator will audit the annual Fire Safety Plan and Emergency Response Training & Exercise Plan quarterly to ensure a retraining plan is in place for identified areas for improvement.

Owner:
Administrator

Target Completion Date: (Q/Y)
Q4 2024

4.7 After Action Reviews

After Action Reviews (AAR) are not always completed within the required timeline.

Ontario Regulation 246/22 under the Fixing Long-Term Care Act, 2021, subsection 90 (1), states "*the licensee shall ensure that the emergency plans for the home are evaluated and updated within 30 days of the emergency being declared over, after each instance that an emergency plan is activated*".

Based on results of detailed testing and discussions with staff, four (4) of the 2023 emergency code AARs were not completed and signed off within the 30-day requirement. Three (3) of the four were required tests of the emergency codes and one (1) was a real event activation of the code.

Based on discussions with EM staff, it is extremely difficult to complete the AARs including management input within the 30-day timeline given. Limitations in resources and coordination with LTC home staff are considered contributing factors to the delays.

Recommendations

4.7.1 Emergency Management and LTC home management should develop a Standard Operating Procedure for completing AARs that includes responsibilities, accountabilities, flow of information, timelines and oversight.

4.7.2 Management should consider implementing a digital tool to help streamline and manage the AAR review and approval process.

Management Response

Management agrees timely completion after-action reviews should be prioritized because they provide valuable insights for management, enhance educational delivery, and identify opportunities for growth.

Action Plan: 4.7.1
Management will collaborate with the Emergency Management team to develop Standards Operating Procedures (SOPs) for completing After-Action Reviews. These SOPs will outline responsibilities, accountabilities, timelines, information flow, and oversight.

Action Plan 4.7.2

A new digital tool for an escalation process for After Action Report approvals was implemented in Q2 2024. This system uses Microsoft Teams and a one-click approval and automated reminders.

Owner:
Administrator

Target Completion Date: (Q/Y)
Q4 2024

4.8 Emergency Code Testing

Testing of the emergency codes were not always completed as required.

Emergency code testing exercises can promote preparedness, clarify roles and responsibilities, and identify potential gaps in skill or planning.

Under section 268(10) of Regulation 246/22 of the Act, emergency plans are required to be tested on a set schedule either annually or every three (3) years at each home depending on the emergency code.

The Emergency Preparedness & Response Training Exercise Plan was developed to ensure compliance with the Act and requires the annual codes to be tested three (3) times per year (one per shift) in each home.

Based on our review of the 2023 annual emergency code testing and the three-year cycle code testing, the following was noted:

- Code Orange and Code Grey testing occurred once (1) in 2023, not the three (3) times, (1 per shift), as required under the Emergency Plan.
- Code Blue testing occurred once (1) in 2023, not the three (3) times, (1 per shift), as required under the Emergency Plan.
- Code Green testing did not occur at Newmarket Heath Centre within the past three (3) years as required under the Act and Emergency Plan. Based on discussions with staff, this testing did not occur in 2022 as planned due to an outbreak at that time. This test has not been rescheduled as of audit fieldwork completion date.

Completing emergency code testing as required under the Act and the Emergency Preparedness Plan may help reduce the risk of serious injury to staff and residents.

Recommendation

4.8.1 Management should ensure emergency code testing is completed in line with the Act and Emergency Plan.

Management Response

Management acknowledges the importance of emergency code testing exercises and will ensure compliance with legislation requirements.

Action Plan: 4.8.1
The Administrator will audit the annual Emergency Code Exercise quarterly to ensure completion of required code testing in alignment with the Fixing Long Term Care Act and Accreditation Standards.
Code Green training for the Newmarket Health is scheduled in Q3 2024.

Owner:
Administrator

Target Completion Date: (Q/Y)
Q4 2024

4.9 Critical Incident & Complaint Tracking

Opportunity exists to improve the internal tracking of complaints and critical incidents.

The Act requires LTC homes to document, manage and report critical incidents and other complaints.

Based on our review of the "complaint trackers" for both homes, the following was noted:

- There are inconsistencies between the complaint trackers used by the homes in terms of information being tracked and details.
- The complaint trackers in both homes had several blank fields for the following columns: "final resolution remarks", "resolved y/n", and "complainants' response".

- There are a few complaints on both trackers that appear to have met the definition of a critical incident, however were not reported as such to the MOLTC as required under the Act.

Different templates may lead to inconsistencies in how complaints are documented and categorized by the two homes, which may cause challenges when comparing and analyzing incident data between the two homes.

Failure to complete all the fields within the complaint tracker could result in noncompliance with the Act and potentially lead to penalties/fines.

Recommendations

4.9.1 Management should review the complaint tracker process and consider implementing a review/oversight process to ensure all information and fields are completed and resolved within the required timelines.

4.9.2 Management should consider implementing a standardized format to be used by both homes to help ensure consistency in the collection of information.

Management Responses

Management is aware of these inconsistencies and have made improvements to our internal tracking system to improve this process.

Action Plan: 4.9.1

- A review of complaint tracker content was completed in Q2 2024 to ensure alignment in format between both Long-Term Care Homes.
- In Q2 2024 the complaint tracker process, roles, and responsibilities were reviewed with responsible persons.
- Beginning in Q1 2025 the Administrator will implement a quarterly review of the tracker.

Action Plan: 4.9.2

- Management conducted a review of the complaint tracker in Q2 2024 to ensure a standardized format is in place for both Long Term Care Homes.

Owner:
Administrator

Target Completion Date: (Q/Y)

Q4 2024

4.10 Maintenance Tracker

There is not a formal maintenance tracker used by the homes.

Based on discussions with staff and detailed testing of maintenance records, there is an opportunity to strengthen the oversight and tracking of preventative and regulated maintenance activities.

Regular maintenance is essential for ensuring the safety and functionality of the homes' equipment including heating and air conditioning, refrigeration, call bell testing, etc.

A formal maintenance tracker allows for better oversight and reduces the risk of missed maintenance potentially resulting in harm to residents and staff.

Recommendations

4.10.1 Management should consider implementing a formal maintenance tracker to allow for better oversight, with a corresponding review process to ensure all required maintenance is completed and exceptions are monitored and resolved in a timely manner.

Management Response

Management agrees and have made development of a formal maintenance tracker a priority for the Homes.

Action Plan: 4.10.1
In Q1 2024 our partners in the Community and Health Services Housing Branch procured a consultant to review maintenance processes, including a tracking system. A five-year project plan will be developed with LTC Management to procure, train and implement a new digital tracking system.

Owner:
Director, Seniors Services

Target Completion Date: (Q/Y)
Q4 2025

4.11 Accounts Receivable

Opportunity exists to strengthen the collection process of overdue accounts receivable balances.

Based on discussions with staff and a review of account balances, there are opportunities to better clarify the process and responsibilities for collections on overdue accounts.

As at December 31, 2023 the following balances are 60 days plus overdue:

- Maple Health Centre, approximately $124K
- Newmarket Health Centre, approximately $63K

Overdue accounts receivable can have negative implications for the financial health, operational efficiency, and reputation of the long-term care homes.

Recommendations

4.11.1 Management, in consultation with Legal, should develop a formal accounts receivable collection policy and process. The policy should include collection responsibilities, timing and communication with residents and families.

Management Response

Management agrees there is a need to strengthen the collection process for Long Term Care accounts in arrears.

Action Plan: 4.11.1

- Management will work in partnership with finance and legal partners to develop a formal accounts receivable collections policy and process in alignment with corporate collection policies.
- Management will ensure the process includes roles and responsibilities, communication to residents and substitute decision makers and timelines.

Owner:
Director, Seniors Services

Target Completion Date: (Q/Y)
Q4 2025

End of observations

Original signed

Michelle Morris
Director, Audit Services