MINISTRY OF LONG-TERM CARE

Report Back on the Gillese Inquiry

July 30, 2020

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A letter from Dr. Merrilee Fullerton, Minister of Long-Term Care on the release of the Government's Progress Report in Response to the Gillese Inquiry

One year ago, the Government of Ontario received the final report from the Honourable Eileen E. Gillese, on the *Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System* (Gillese Inquiry). The report outlined 91 recommendations for improving long-term care, many of which were focused on awareness, medication and staffing. The pages that follow respond to the Gillese Inquiry's first recommendation: a progress report on the steps taken by the province and our partners to address Justice Gillese's recommendations.

This has been a year of change, upheaval and reflection in the long-term care system, both in Ontario and around the world. Our government has been committed to reviewing Justice Gillese's thorough and informed recommendations from day one. Despite Ontario's focus on responding to COVID-19, over 80 per cent of Justice Gillese's recommendations are completed or under way. We know we have more work to do, and we will continue to make progress on these important recommendations.

Our government is committed to an ambitious modernization of long-term care and developing a resident-centred system. Ensuring our long-term care system provides Ontario's aging population with the support and care they need is a top priority for our government. An important way in which this is being done is by implementing the recommendations in the Gillese Inquiry.

To the surviving victim as well as the loved ones and families of all the victims who are engaged in the healing process, seeing the impacts of COVID-19 in long-term care and the release of this progress update may cause feelings of grief and anger. Please accept my deepest sympathies.

A significant amount of work has taken place to implement Justice Gillese's recommendations. I want to acknowledge those efforts and reaffirm our government's commitment to improve this system for residents and staff. I would also like to extend my gratitude to Justice Gillese and her team for their rigorous, insightful and thought-provoking recommendations.

Working collaboratively with residents, families and our healthcare sector partners across the province, we will deliver a long-term care system for Ontario that treats residents with respect, dignity and compassion and ensures their safety and well-being.

Sincerely,

Dr. Merrilee Fullerton
Minister of Long-Term Care

Introduction

In 2017, a registered nurse in Ontario pled guilty to eight counts of first-degree murder, four counts of attempted murder and two counts of aggravated assault, which occurred mainly in long-term care homes. She is currently serving eight concurrent life sentences for her crimes, with no chance of parole for 25 years.

Following her convictions, the Ontario government launched *The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System* led by Justice Eileen E. Gillese. The Gillese Inquiry identified key areas for improvement in the long-term care system to avoid similar tragedies from occurring in the future, including: staffing, medication management, oversight of the Institutional Patient Death Record and the coroner's investigation processes.

On July 31, 2019, Justice Gillese provided an ambitious roadmap within the recommendations of her report. The report is over 1,200 pages and divided into four volumes: a listing of her 91 recommendations, a detailed outline of the investigation into the offences, a strategy for safety, and an explanation of the inquiry process. Justice Gillese's first recommendation was for the government to report back publicly a year after the release of her final report. In keeping with that recommendation, this report provides an update on her recommendations which have been successfully implemented, those that are underway, and the ongoing work to strengthen and improve the long-term care sector across the province. Furthermore, the recommendations within Justice Gillese's report revolve around systemic issues in Ontario's long-term care sector and other settings and are grouped within four key themes: awareness, prevention, deterrence and detection.

Justice Gillese's report sparked significant reflection across the sector and has been taken to heart across government. In memory of those lost, the province is pleased to issue this report to the families affected and to the people of Ontario. The province continues to refer to Justice Gillese's recommendations as it builds a safer long-term care system.

In keeping with the format of the Gillese Report, this progress update will be presented by theme and will provide an update on the vital work that has been underway in Ontario's long-term care system over the past 12 months.

Current Context

In the process of implementing the Gillese Inquiry's recommendations, Ontario's long-term care system was confronted with the COVID-19 pandemic. Around the world, long-term care homes have been on the front line of the virus, and in Ontario it has been no different. As of July 2020, 52 per cent of long-term care homes have been impacted with over 1,800 residents and eight staff members passing away. However, many homes across the province have managed well through the pandemic by avoiding outbreak or significant spread of the disease. The challenges experienced by some homes with outbreaks underscored the staffing issues Justice Gillese addressed in her report.

The staffing concerns that have been amplified during this pandemic speak to the serious shortage of long-term care staff available province wide. As Justice Gillese recognized, this is a shortage that has been building for decades as our population has aged. The province created a standalone Ministry of Long-Term Care in the summer of 2019 specifically to address this and other challenges in the long-term care sector. The province is grateful for Justice Gillese's strong recommendations that concern staffing to help guide a path forward.

To shore up staffing supply on an emergency basis during COVID-19, the province requested the assistance of the Canadian Armed Forces in eight long-term care homes that had been the most severely impacted by the pandemic. The broader relevance of Justice Gillese's report was again demonstrated when the Canadian Armed Forces reported on deeply concerning circumstances discovered in five of the long-term care homes they were supporting. In response, the Ministry of Long-Term Care deployed long-term care inspection teams to conduct comprehensive, detailed inspections at high-risk long-term care homes. Local hospitals also began to temporarily manage the five long-term care homes mentioned in the Canadian Armed Forces report.

Justice Gillese's report offers a helpful guide for reforming long-term care. COVID-19 has demonstrated that the province cannot stop there. In order to fully address the systemic issues facing our long-term care system, the province needs to act on the additional concerns that have been highlighted during this pandemic and understand how they have contributed to the devastating impact of COVID-19. Ontario needs to build a system that works in the best interest of residents and the people that work so hard to keep them safe.

That is why the province has launched an independent commission to review the impact of COVID-19 on long-term care homes in Ontario. The commission will prioritize transparency and will be able to hold public hearings. Additionally, the province is committed to making the report from the commission public. The independent commission into long-term care will

provide an objective perspective on how the province can assist long-term care homes to better protect residents and staff by effectively managing any future outbreaks and contributing to the overall effort of improving the system across Ontario.

Informed by the results of this commission, the Gillese Inquiry and previous reports, the province will continue to transform Ontario's long-term care system to make it a safe, comfortable, and dignified place to call home. Nothing is more important than protecting the health and well-being of long-term care residents and the heroic staff who care for them.

Progress Update

Justice Gillese's recommendations provided an ambitious starting place, and to date, 80 per cent of Justice Gillese's recommendations are completed or underway as meaningful steps have been taken across the sector to bring about real, lasting change.

Throughout the state of emergency, many sector resources have shifted to addressing crises on the front-lines, and for this reason, there have been some delays in implementation of Justice Gillese's recommendations. However, the province and its partners are forging ahead and have been preparing to resume paused initiatives when Ontario gets through the COVID-19 pandemic.

"For the strategy to be effective, multiple stakeholders in the long-term care system must engage in its implementation – no one stakeholder can do it alone."

- Justice Eileen E. Gillese

The province has made long-term care a significant priority and is committed to making it better for both residents and staff. That is why from day one, Ontario has been determined to bring about lasting change. Some examples include:

- The Ministry of Long-Term Care established a project management team to coordinate the cross-government response to the Gillese Inquiry. The Office of the Chief Coroner for Ontario is now also staffed with two dedicated leads to develop and implement a strategic plan addressing the implementation of the recommendations; and,
- The Ministry of the Attorney General has provided funding to ensure counselling services can continue to be made available to the victims, families and loved ones for a period of two years at no cost to them, as recommended by Justice Gillese.

A number of Justice Gillese's recommendations are directed to external parties outside of the government. This report highlights some of the work of these partners as well. The Ministry of Long-Term Care and the Ministry of Health continue to work collaboratively with partners

across the health care system to enhance the safety and security of Ontario's long-term care residents and home care clients.

In response to the COVID-19 pandemic, the Ontario Long-Term Care Association (OLTCA) has been a key partner offering government guidance and support. The OLTCA represents nearly 70 per cent of Ontario's long-term care homes, located in communities across the province. Their members provide care and accommodation services to more than 70,000 residents annually. As the province modernizes the long-term care system, the OLTCA remains an important partner in the implementation of this work.

"The findings and recommendations from Justice Gillese's inquiry are helping to further strengthen homes' ability to provide safe, caring, and high-quality care. Working in partnership with stakeholders and the Government of Ontario, the Ontario Long Term Care Association and its members are committed to continuing to ensure the health, safety and well-being of residents and staff, and working to restore public confidence in Ontario's long-term care system."

--Ontario Long-Term Care Association

Ontario Health (OH) and the Local Health Integration Networks' (LHINs) senior leaders established a dedicated working group to assess and implement recommendations from Justice Gillese's Public Inquiry related to the provision of LHIN-funded home care services. This working group developed a comprehensive plan with more than 40 individual actions across 20 recommendations. OH/LHINs are focused on establishing a consistent implementation of the recommendations across all LHINs.

"At the inquiry, we provided information to help improve the system and protect residents and patients from harm. At this time, we also learned more about what you expect from CNO — and we didn't wait for Commissioner Gillese's final report before taking action to improve. In 2018 and 2019, we strengthened and enhanced our processes, and will continue doing so."

-- College of Nurses of Ontario

The College of Nurses of Ontario, the governing body for the province's Registered Nurses, took swift action to implement many of the recommendations directed to them in the Gillese Inquiry. The College has revamped its intake process following a mandatory report, such as the termination of a nurse, and has updated its orientation for intake investigators. The College has also been proactive in increasing awareness of intentional harm and best practices with the distribution of their web-based magazine, *The Standard*. Over 180,000 nurses receive and review this magazine, which covers a range of topics, including mandatory reporting guidelines, Code of Conduct for nurses and preventing patient harm.

AdvantAge Ontario, an association advocating on behalf of not-for-profit and municipal long-term care homes, proactively surveyed its members to determine their level of support and ability to implement Justice Gillese's recommendations. Respondents agreed with the recommendations pertaining to education/training, human resources, medication management, and an updated Institution Patient Death Record (IPDR). Some homes also reported that several of the recommendations were already currently practiced in their homes.

The Ministry for Seniors and Accessibility was consulted during the initial review of the Gillese Inquiry and remains a supportive partner of the work being done across government.

"Residents in Ontario's long-term care homes need to feel safe and comfortable, and their families need to be able to trust that their loved ones are receiving the best possible care. The Gillese Inquiry has been a critically important opportunity to bring all system partners together to find a way forward that supports the best possible aging experience for seniors. Full implementation of the recommendations in the report and the provision of much-needed resources to support the sector will ensure meaningful and lasting change for the better. AdvantAge Ontario is committed to working with and supporting the government where needed to meet the recommendations that will provide residents with a positive LTC home experience."

--AdvantAge Ontario

Awareness

The Gillese Inquiry emphasized the need for awareness across the health care sector of the risk of intentional harm and how to report it. Justice Gillese stressed the critical value that awareness brings to closing gaps in the long-term care system, stating that *"it is not possible to detect or deter something unless you are aware that it exists."*

In order to combat and prevent future tragedies in long-term care, the possibility of intentional harm by health care workers must be widely understood and recognizable.

With this in mind, the Office of the Chief Coroner is developing educational programs and materials that will help health care workers and the Ontario public become more aware of the possibility of intentional harm and understand the many vulnerabilities the senior population faces.

This includes clear expectations and the education and training necessary to prepare health care professionals to effectively recognize and respond to intentional harm within the long-

term care sector. Prior to the release of the Gillese Report, the province had developed and held educational sessions to the long-term care associations on intentional harm.

All of us have a role to play in keeping residents of long-term care homes safe. The Ministry of Long-Term Care is working with the Office of the Chief Coroner and the College of Nurses of Ontario to increase awareness among staff, families and visitors of long-term care homes of their duty to report any suspicions they may have of abuse or neglect.

Intentional Harm to Residents

To help build awareness across the sector, a strategic plan will be developed to highlight vulnerabilities faced by Ontario's senior population, including the possibility of intentional harm by health care workers.

This effort will be led by the Office of the Chief Coroner, focusing on establishing best practices across the long-term care sector, educating coroners and establishing an awareness campaign about the vulnerabilities the senior population faces. The Office of the Chief Coroner is partnering with Queen's University on this initiative which includes the establishment of a Centre of Excellence focused on elder vulnerability.

In response to the Gillese Inquiry, the College of Nurses of Ontario has been actively educating its members about the possibility that a health care worker may deliberately cause harm to a patient. This includes the use of a variety of social media platforms such as Facebook, Twitter and LinkedIn, as well as an article published in April 2019 in the *Journal of Nursing Regulation* entitled *"A Regulatory Response to Health Care Serial Killing."*

Also, to help enhance the investigation process, the College of Nurses of Ontario has created a standard list of questions for investigators to use when interviewing employers who have raised concerns about a nurse's practice.

Duty to Report

The *Long-Term Care Homes Act, 2007*, requires any person with reasonable grounds to suspect improper or incompetent treatment or care, or the abuse or neglect of residents, to report it immediately to the Ministry of Long-Term Care. This includes staff, but also members of the public.

The College of Nurses of Ontario has also revised their reporting guide to include information about a nurse's professional responsibility to act in their patients' best interest and protect

them from harm. The guide sets out clear expectations for members, particularly when it comes to reporting to the College any improper or incompetent treatment or care, suspected abuse or neglect by another registered staff.

Adhering to the reporting guide echoes the College of Nurses of Ontario's Code of Conduct, which describes the behavior and conduct the public can expect from all nurses.

Most recently, Ontario has developed posters to increase awareness among families, visitors and staff in long-term care of their obligation and methods to immediately report any suspicion of abuse or neglect of a long-term care resident. Working with partners in the long-term care sector, the province will continue to explore additional ways to educate and increase awareness of the reporting obligations around intentional harm and neglect.

Prevention

As noted by Justice Gillese, the best way to protect long-term care residents is through preventative measures. In this case, that includes enhanced hiring practices, improving staff capacity and encouraging excellence.

As a result, the Ministry of Long-Term Care continues to enact measures that will enhance regulatory compliance, encourage innovation and help adopt best practices across the sector.

Investing in staff training means better care for residents of long-term care homes. As Justice Gillese recommended, OH/LHINs are also focused on ongoing efforts to improve hiring practices in home care services and to provide supports that will help manage the proper and accurate use of medication for those who receive home care.

Investing in Staff Training

Twenty-one of Justice Gillese's recommendations relate to training and the importance of increasing staff capacity and competencies. That is why the Ministry of Long-Term Care is pleased that beginning in 2020-2021, there will be a new annual $10 million education and training investment for long-term care.

This investment will help to improve the quality of frontline care, outcomes for long-term care residents and ensure long-term care staff are developing new skills and adopting evidence-based practices. Investments in this fiscal year will focus on the response to issues identified during the recent COVID-19 outbreak in long-term care.

Greater Accountability by Home Care Providers

In January 2020, OH/LHINs included requirements for evidence of policies and procedures related to human resources practices and the reporting of unusual incidents in the annual pre-qualification application process for prospective contracted home care providers. The pre-qualification applications are the first step of an on-going process for external service providers to be screened and placed on a dedicated list of trusted service providers. The pre-qualification application process was completed for 2020-2021.

As a result of COVID-19, service provider contracts have continued without amendment. A revised version of the OH/LHIN's standard agreement for home care services is under development. The revised agreement will include updated obligations that will strengthen the safe delivery of OH/LHIN funded home care services and increase the accountability of service provider organizations.

In alignment with the amendments to the revised home care services agreements, OH/LHINs are updating and enhancing the framework for home care service provider auditing and performance management. This revised framework will include practices and provisions for ensuring compliance to contractual requirements related to human resources, risk management and the reporting of high-risk patient safety incidents.

Medication Safety in Home Care

In response to the Gillese Inquiry, OH/LHINs are working to increase awareness of the MedsCheck at Home program among eligible patients receiving home care services. This program, which is funded by the Ministry of Health, is for home care patients that are not able to physically attend a community pharmacy due to their physical and/or mental health condition.

The OH/LHIN's working group has conducted a survey on the use of the MedsCheck at Home program, highlighting its utilization and uptake across all LHINs. Through this program, patients have an opportunity to meet with a pharmacist at their home, ask questions about their medications, and have the pharmacist review their current medication supply, dispose of any unused or expired medications, and provide them with information on the benefits of their medications and how to safely store them.

The working group has also engaged with the LHIN's Professional Practice Advisory Committee in the development of patient-facing education materials on medication safety. The materials will focus on supporting patients in accessing the MedsCheck program articulated above, and

on the safe use of medications in the home. The group is also developing materials for patients and staff on the recognition of the signs and symptoms of medication toxicity, as well as the safe storage and disposal of medications.

To continue optimizing the effectiveness and safety of drug therapy in the province and improving outcomes for all patients, the Ministry of Health also continues to engage with the pharmacy sector on the modernization of the program.

Deterrence

Deterrence is another means to prevent harm to long-term care residents by creating additional safeguards within the system. The province has begun to implement a series of measures that will help deter malicious acts within long-term care homes.

In looking at deterrence, the Ministry of Long-Term Care focused on the challenges of medication management and staffing. Strengthening medication management systems improves safety and addressing staffing challenges improves the quality of life for both residents and staff in long-term care homes.

> *"I recommend that…the already solid medication management system in long-term care homes must be strengthened through infrastructure changes, the use of technology, and increasing the role of pharmacists. Second, I make recommendations that will improve medication incident analysis in long-term care homes by, among other things, the use of a standardized, rigorous incident analysis framework. Third, I make recommendations directed at increasing the number of registered staff in long-term care homes."*
>
> ***- Justice Eileen E. Gillese Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (volume 1, page 18)***

Medication Management and Safety

The province has been working to strengthen medication management in the long-term care system. Medication management refers to the process of prescribing, dispensing, storing, administering and destroying medication that long-term care licensees, physicians, nurse practitioners, nurses and pharmacy service providers use to avoid medication errors. This process is particularly critical for Ontarians residing in long-term care, who are prescribed an average of 9.9 drug classes per resident to treat multiple medical conditions.

Prior to the release of the Gillese Report, the province was working to improve medication management. This included the creation of a working group with key sector partners that was tasked with identifying barriers to effective medication management in long-term care homes and solutions that would address these barriers. The goal for this work is to improve medication safety so that long-term care residents do not experience adverse outcomes, such as falls and unnecessary hospitalizations, as well as intentional harm.

That is why the Ministry of Long-Term Care plans to launch a Medication Safety Technology (MST) program in 2021. This program will support long-term care homes in adopting technologies that will strengthen long-term care medication safety. The ministry will be consulting with stakeholders in the development and implementation of this new program.

The ministry is also partnering with the Institute for Safe Medication Practices Canada (ISMP) for three years to support long-term care homes in strengthening medication safety. This work will include addressing Justice Gillese's specific recommendations with respect to how to detect potential medication incidents that would otherwise go unnoticed.

In response to the Gillese Inquiry recommendations, the Ministry of Long-Term Care has also taken direct action with respect to medication safety. The Minister of Long-Term Care issued a directive that set clear requirements for long-term care homes regarding documenting, reviewing, analyzing and reporting the use of glucagon – a manufactured product that can be administered to raise glucose levels in the blood and is used to treat severe and unresponsive hypoglycemia. The directive also sets out requirements for homes regarding documenting, reviewing, analyzing and reporting residents experiencing incidents of severe hypoglycemia and unresponsive hypoglycemia.

During inspections, long-term care inspectors will ensure that homes are complying with the Minister's directive. This includes ensuring that homes are documenting and tracking trends around the use of glucagon and resident incidents of severe hypoglycemia and unresponsive hypoglycemia to help identify patterns.

In addition, in direct response to the Gillese Inquiry, the Ministry of Long-Term Care has provided guidance to long-term care homes regarding:

- The reporting of critical incidents involving either missing narcotics or allegations of staff-to-resident abuse so that the ministry can better identify possible patterns of activity during the inspections process; and,
- Best practices regarding the destruction and disposal of insulin cartridges.

Long-Term Care Staffing Study

In February 2020, the Ministry of Long-Term Care launched a study, with support from an external Advisory Group, to help inform a comprehensive staffing strategy for the long-term care sector. Appropriate staffing levels in long-term care homes are essential to meeting the needs of residents. As the sector continues to experience a severe shortage of personal support workers and other key roles, the study includes the Advisory Group's advice and recommendations on the staffing model and skill mix to support current and future sector needs, and critical factors associated with improving long-term care workforce recruitment and retention.

The Advisory Group met on an ongoing basis and engaged with a variety of long-term care sector partners, including associations, operators and labour unions, to better understand the range of perspectives on staffing issues facing the sector. Through these conversations, it was evident that staff are committed to their residents and want to provide high quality, resident-centered care; however, the current circumstances, including staff shortages, can make this difficult. It was also clear that resident quality of life is the paramount goal of long-term care. The Advisory Group recommends that the government take action on a number of priorities, including an increase to the number of staff working in long-term care, a change in the culture at both the system and individual home level, and a focused effort to attract and retain staff in the long-term care workforce.

Detection

To ensure the safety and security of residents, the province is focused on providing long-term care homes with the necessary tools and protocols to assist in the early detection of intentional harm. This includes tailoring the death investigation process as it applies to deaths in long-term care homes.

The government's key deliverables related to detection were improved death investigations, redesigning the Institutional Patient Death Record, developing statistical modelling of unexpected deaths, and enhancing long-term care home inspections.

Death Investigations

As referenced earlier in the report, during the pre-consultation phase of a long-term care death investigation, all coroners will be required to engage with the families of a deceased resident as a best practice and advise if a death investigation needs to be undertaken. If a coroner decides not to pursue a death investigation, they must provide the reasoning for their decision in writing to the Office of the Chief Coroner.

To ensure residents, families of residents and long-term care homes understand the death investigation process, the Office of the Chief Coroner and the Ontario's Forensic Pathology Service have also developed a revised brochure on death reporting and the investigation process and shared this with all 626 long-term care homes across the province.

To help identify deaths that may have resulted from intentional harm, the Office of the Chief Coroner and the Ontario Forensic Pathology Service are developing an autopsy examination protocol for long-term care resident deaths and will provide educational resources to coroners and forensic pathologists once this new protocol is developed.

Redesigning the Institutional Patient Death Record (IPDR)

In collaboration with Queen's University, the Office of the Chief Coroner will be developing a revised IPDR or alternate model, in consultation with subject matter experts and users. Justice Gillese particularly focused on the process by which the coroner is notified when a death has taken place at a long-term care home.

The *Coroners Act* requires licensed long-term care homes to report all resident deaths to the Office of the Chief Coroner. Coroners investigate all non-natural deaths as well as those in which significant care concerns have been raised.

The IPDR is a tool that was developed to both collect death notifications and to assist long-term care staff in identifying deaths that should be immediately reported to a coroner. The IPDR is hosted on ServiceOntario's website and consists of a series of questions that must be answered in order to be submitted to the Office of the Chief Coroner.

The Office of the Chief Coroner will be revising the reporting process based on current evidence, in order to better identify non-natural and unexpected deaths. This new data collection tool will be integrated with a predictive tool developed by Ministry of Long-Term Care to identify individual unexpected deaths and long-term care home-level death trends to support decision making around death investigation. A tailored IPDR or alternate model will

also be made available for use in deaths occurring in the private homes of those having recently received publicly funded home care.

Implementing the revised IPDR will include appropriate training and clear instruction on how this tool should be utilized across the long-term care sector and within the home care sector. This tool will also provide more transparent, evidence-based information to help determine whether, in respect of resident deaths, a death investigation is needed.

In the meantime, the Ministry of Long-Term Care and the Office of the Chief Coroner will continue to work with all long-term care homes to ensure that existing IPDR forms are submitted electronically.

Statistical Modeling for Unexpected Deaths in Long-Term Care Homes

The Ministry of Long-Term Care created four preliminary data analytics models that can be used to identify long-term care homes with a higher than expected number of deaths.

Through diligent assessments, the province has selected three models that demonstrate strong performance to determine unexpected deaths in long-term care homes and support the Office of the Chief Coroner in investigating such occurrences. Additionally, these models can be used to flag long-term care homes with elevated actual mortality compared to expected mortality. Similarly, long-term care homes could be flagged based on the number of unexpected deaths that have occurred.

To thoroughly test and validate these methodologies and ensure accuracy, the province has collaborated with Ontario researchers recommended by the Institute of Health Policy, Management and Evaluation at the University of Toronto.

Once validated, the province will continue to work with the Office of the Chief Coroner to ensure accurate and timely data is being fed into the models to support implementation.

Long-Term Care Quality Inspection Program

The Ministry of Long-Term Care has refined its Long-Term Care Home Quality Inspection Program to better identify homes that are facing challenges in providing a safe and secure environment for residents.

Modernization efforts aim to make inspections timely and risk-based, with an improved early resolution processes for complaints. Another ongoing element of this strategy is a fulsome evaluation of the current proactive inspection methodology.

These changes also align with the government's modernization of all regulatory compliance programs across the province to one that is more compliance focused and risk-based.

In consultation with stakeholders and advocacy groups across the long-term care sector, the ministry has created a modernized Long-Term Care Performance Report (LPR) to set inspection priorities and monitor performance challenges in long-term care homes.

The LPR provides critical data to measure the performance of each Ontario long-term care home based on risk, while considering provincial averages and benchmarks. The LPR will assist in the scheduling of long-term care home inspections that are created on a risk-based framework. This ensures that homes with repeated complaints and critical incidents, poor compliance history and other risk factors are subject to a more extensive inspection.

The modernized LPR will also give individual long-term care homes the ability to better manage and monitor their own programs, while ensuring that higher risk areas are prioritized and addressed in a timely manner.

Changes to the Long-Term Care Quality Inspection Program will increase transparency and ensure greater safety and quality care in long-term care homes, so Ontario families can continue to have confidence in the long-term care system.

Also, in response to Justice Gillese's advice, Ministry of Long-Term Care inspectors can now search the Critical Incident Reporting System electronically prior to an inspection to determine whether a staff member has previously been involved in an incident of missing narcotics or resident abuse.

Finally, in response to the onset of COVID-19, the role of ministry inspectors was refocused to ensure resident safety remained the number one priority. As the situation progressed, the role of inspectors evolved to ensure the right resources were made available to keep residents safe and to support long-term care homes through the pandemic. The inspection methodology continues to be assessed during this time.

Conclusion

The province has worked to accomplish sector-wide change to help strengthen the safety and security of Ontarians in long-term care, while improving their quality of life.

The province would like to thank our dedicated stakeholder partners and advocacy groups for their ongoing efforts to implement Justice Gillese's recommendations.

Working collaboratively, the long-term care sector has been able to move forward in implementing significant change to help build awareness, enhance preventative measures, deter malicious acts and detect wrongdoing. Moving forward, Ontario will continue to take the necessary steps to prevent future tragedies from occurring across the long-term care sector.

An independent commission was launched in July 2020 which will provide additional perspective on how the province can assist long-term care homes better protect residents and help to repair and rebuild long-term care in Ontario.

Ontario will also remain committed to continuing vital reform across the long-term care system to ensure that all current and future residents are treated in a safe and secure environment with the dignity, respect and compassion they deserve.

The government would like to again express sincere and heartfelt sympathies to the surviving victim and to the families and loved ones of all victims. While this is not a consolation for your loss, your experiences have brought significant change and continue to rally the long-term care sector around transformation and revitalization. The province will work together with our sector partners toward a brighter future for long-term care.

The health and well-being of all Ontarians – including long-term care residents, their families, and staff – will always be the province's top priority.

Appendix A: Status Update on Justice Gillese's Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System Recommendations

Completed Recommendations

Theme	Rec #	Progress update
Prevention	**1**	The Ministry of Long-Term Care publicly released a report on the steps taken to implement Justice Gillese's recommendations one year after the release of her final report. The ministry's report provides an update on the recommendations that have successfully been implemented, those that are underway, and broadly, the work that is ongoing to strengthen and improve the long-term care system.
Awareness	**2**	The Ministry of the Attorney General is funding counselling services to victims and their loved ones until 2021. Justice Gillese met with victims, families and witnesses to offer counselling supports. Counselling services were provided to 12 individuals. The Ministry of the Attorney General has continued to fund these services to those who require them. These counselling services will continue to be funded until July 2021.
Awareness	**23**	The Ministry of Long-Term Care launched an education campaign in homes to raise awareness among staff, volunteers and visitors about their reporting obligations when they have reasonable grounds to suspect improper or incompetent treatment or care, or the abuse or neglect of residents.
Detection	**25**	The Ministry of Long-Term Care has refined its Long-Term Care Home Quality Inspection Program to better identify homes struggling to provide a safe and secure environment for residents. After consulting with the long-term care sector and advocacy groups, the ministry modernized the Long-Term Care Performance Report.
Detection	**26**	Long-term care inspectors ensure that all critical incident reports and complaints relating to high-risk incidents are given the highest priority and inspected as quickly as possible to ensure that any ongoing risk to residents is immediately remedied.

Theme	Rec #	Progress update
Detection	**27**	When conducting inspections and establishing inspection priorities, the Ministry of Long-Term Care is guided by the Long-Term Care Performance Report.
Detection	**28**	The Ministry of Long-Term Care uses the Long-Term Care Home Quality Inspection Program Performance Assessment to identify long-term care homes struggling to provide a safe and secure environment for their residents.
Detection	**30**	Before beginning an inspection involving either missing narcotics or allegations of staff-to-resident abuse, the Ministry of Long-Term Care ensures that the assigned inspector reviews previous critical incident reports to determine whether the staff member involved in those incidents is named in earlier reports.
Awareness	**40**	The College of Nurses of Ontario used social media and its member newsletter to educate its members and staff about intentional harm by care providers.
Awareness	**41**	The College of Nurses of Ontario has reviewed and strengthened its intake investigation process by training intake investigators on various topics, such as the health care serial killer phenomenon, identifying all relevant contacts in an investigation, and assessing risk levels.
Prevention	**42**	The College of Nurses of Ontario has reviewed and improved its policies and procedures to reflect the possibility that a nurse or other health care provider might intentionally harm those for whom they provide care.
Prevention	**43**	The College of Nurses of Ontario had conducted research on intentional harm in health care settings. They have shared this research with other regulators and individual organizations. Presentations have been made to the regulators of registered nurses across Canada and the National State Board of Nursing, which includes some American states and Canadian and international partners.
Awareness	**44**	The College of Nurses of Ontario reports it has reviewed its education program requirements. In order to enter practice, the College of Nurses of Ontario confirms nurses must competently provide care to patients of all ages, including caring for an aging population.
Awareness	**45**	The College of Nurses of Ontario identifies that nursing education programs are required to offer student placements in a variety of health care environments. The College of Nurses of Ontario will continue to review how they can promote student placements in long-term care homes.
Awareness	**46**	The College of Nurses of Ontario is educating long-term care home employers on what, when and how to report their concerns about a nurse's conduct. This includes launching a new section on the College of Nurses of Ontario's website just for employers with streamlined sections with this information.

Theme	Rec #	Progress update
Awareness	**47**	The College of Nurses of Ontario launched a revised version of their mandatory reporting guide to include easy-to-understand information about what, when and how to report a concern to them. The reporting guide has been overhauled and is part of the College of Nurses of Ontario's orientation program.
Awareness	**48**	The College of Nurses of Ontario has revised its mandatory reporting form and process for submitting reports, including clearer instructions and the ability to submit the form electronically.
Awareness	**49**	The College of Nurses of Ontario's revised reporting guide includes information on a nurse's professional accountability to act in their patients' best interest and protect them from harm. Additionally, their code of conduct describes the behaviour and conduct that all nurses are professionally accountable for.
Detection	**55**	Effective July 10, 2020, all coroners must engage families or the substitute decision maker of a deceased long-term care home resident when determining whether or not to investigate the death.
Awareness	**56**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service has produced an electronic brochure on death reporting and the investigation process for long-term care homes and families of residents.
Detection	**57**	Effective July 10, 2020, all coroners must submit case selection data forms through the Regional Supervising Coroner for all cases in long-term care homes where a coroner determines that a death investigation is not required. This is no longer a voluntary practice.
Prevention	**63**	The Ministries of Long-Term Care, Health, and Seniors and Accessibility have been collaborating on how to serve older Ontarians living in a variety of settings and requiring different levels of services. This coordination and collaboration has been strengthened as the government responded to the COVID-19 pandemic in 2020.
Awareness	**68**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service have established a dedicated team to develop and lead the implementation of Justice Gillese's recommendations.
Awareness	**69**	Queen's University has been engaged by the Office of the Chief Coroner and the Ontario Forensic Pathology Service as an adult education specialist responsible for developing education and training on the vulnerabilities of the elderly population.
Awareness	**74**	The Minister of Long-Term Care issued a directive to long-term care home licensees requiring they document, review and analyze the use of glucagon.

Theme	Rec #	Progress update
Awareness	**75**	The Minister of Long-Term Care issued a directive to long-term care home licensees requiring they document, review and analyze the use of glucagon.
Deterrence	**80**	The Minister of Long-Term Care issued a directive to long-term care home licensees requiring they document, review and analyze the use of glucagon.
Deterrence	**81**	The Minister of Long-Term Care issued a directive to long-term care home licensees requiring they document, review and analyze every incident of severe hypoglycemia or unresponsive hypoglycemia.
Detection	**82**	The Minister of Long-Term Care issued a directive to long-term care home licensees requiring they document, review and analyze the use of glucagon.
Deterrence	**84**	The Minister of Long-Term Care issued a directive to long-term care home licensees requiring they document, review and analyze the use of glucagon.
Deterrence	**85**	The Ministry of Long-Term Care has conducted a staffing study, supported by an external advisory group. The group engaged with long-term care organizations and offered advice and recommendations on long-term care staffing.

Recommendations in Progress

Theme	Rec #	Progress update
Detection	**14**	The OH/LHINs Home Care Service Provider 2020/2021 pre-qualification application required service provider organization applicants to provide evidence of their human resources practices and their reporting and investigation practices for unusual incidents.
Detection	**15**	The revised version of the OH/LHINs standard contract for home care services will require home care service providers to maintain permanent personnel files when they renew their service agreement with Ontario Health in 2020/2021.
Detection	**16**	OH/LHINs' Service Provider pre-qualification application for 2020/2021 included a requirement for the provision of evidence of policies and procedures related to the reporting of unusual incidents, including unauthorized entry.

Theme	Rec #	Progress update
Detection	**17**	Early engagement between the Office of the Chief Coroner of Ontario and Ministry of the Health is underway to implement a process in home care similar to Institutional Patient Death Records. The first step is to review and update the Institutional Patient Death Record and develop education and training materials for health care providers by the Office of the Chief Coroner and the Ontario Forensic Pathology Service. The implementation of a similar process in home care will be the next phase of this work.
Prevention	**20**	The Ministry of Long-Term Care is reviewing quality of life measures among residents, including looking to other jurisdictions and engaging with key partners.
Prevention	**21**	In 2020/2021, the Ministry of Long-Term Care will launch a new annual $10 million education and training fund.
Prevention	**22**	The Ministry of Long-Term care is reviewing the impact of lifting the training exemption for medical directors, physicians and registered nurses in the extended class as laid out in this recommendation. Early policy development was initiated, but external engagement has not proceeded due to COVID-19.
Prevention	**24**	The Ministry of Long-Term Care is working to clarify what is considered reasonable grounds and improper or incompetent treatment. This will help clarify the circumstances in which a person has reasonable grounds to suspect improper treatment and to report it to the director.
Detection	**29**	This recommendation proposes the escalation of future inspections when a non-compliance has been issued to a long-term care home for not reporting when there are reasonable grounds to suspect improper treatment, improper care or unlawful conduct. The Ministry of Long-Term Care is reviewing resident quality inspections, and this recommendation is part of this larger review.
Detection	**31**	The Ministry of Long-Term Care and the College of Nurses of Ontario are in regular communication and are discussing formal communication and information sharing options.
Detection	**32**	With the health system transformation currently underway, OH/LHINs have determined that the implementation of a single events reporting system and the inclusion of a dedicated, searchable field for staff members involved in incidents, are not feasible at this point in time. However, to begin addressing work related to this recommendation, OH/LHINs will focus on the inclusion of additional mechanisms to enhance reporting compliance and ensure appropriate follow-up to patient safety events across the province.

Theme	Rec #	Progress update
Detection	**33**	OH/LHINs are developing materials as a reminder for service provider organizations on the contractual requirements for events reporting and will request acknowledgement of these requirements.
Detection	**34**	The development of training modules for appropriate OH/LHIN home care staff on events reporting and investigation is being explored.
Awareness	**35**	OH/LHINs are developing patient and staff-facing education materials on the recognition of the signs and symptoms of medication toxicity, and safe storage and disposal of medications.
Awareness	**36**	A survey was distributed to LHINs to ascertain current use of the MedsCheck at Home program by home care patients. The OH/LHINs will be assessing how to increase awareness and use of this program.
Deterrence	**37**	In alignment with the amendments to the revised home care services agreements, OH/LHINs are developing a new framework for home care service provider auditing and performance management that will ensure compliance to contractual requirements related to human resources, risk management and the reporting of incidents.
Detection	**39**	Early engagement between the Office of Coroner of Ontario and Ministry of the Health is underway to implement a process in home care similar to Institutional Patient Death Records. The first step is the review and updating of the Institutional Patient Death Record and development of education and training materials for health care providers by the Office of the Chief Coroner and the Ontario Forensic Pathology Service. The implementation of a similar process for home care will be in the next phase of this work.
Detection	**50**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service is collaborating with Queen's University on redesigning the existing Institutional Patient Death Record or developing an alternate model. Queen's University will be conducting a needs assessment and engaging both experts and users in order to develop a tool that addresses each requirement of this recommendation.
Detection	**51**	Once the revised Institutional Patient Death Record or alternate model is complete, an implementation plan to address the operational requirements of the recommendation with an emphasis on training for the long-term care sector will be developed.
Detection	**52**	The Ministry of Long-Term Care has released a memo in consultation with the Office of the Chief Coroner and the Ontario Forensic Pathology Service reminding all long-term care homes to submit the existing Institutional Patient Death Record electronically.

Theme	Rec #	Progress update
Detection	**53**	The Ministry of Long-Term Care, the Office of the Chief Coroner and the Ontario Forensic Pathology Service are developing an approach to require the submission of an Institutional Patient Death Record (or alternate reporting model) when a resident dies in hospital within 30 days of being transferred to the hospital from a long-term care home.
Detection	**54**	Once the revised Institutional Patient Death Record or alternate model is complete, the Office of the Chief Coroner and the Ontario Forensic Pathology Service will develop an implementation plan to address the operational requirements of the recommendation with an emphasis on training for the long-term sector.
Detection	**58**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service is working to integrate the involvement of forensic pathologists in the process of investigation of long-term care home resident deaths.
Detection	**59**	An evidence based, standardized protocol on autopsies performed on the elderly is in progress. A draft protocol for stakeholder consultation will be complete by December 2020.
Detection	**60**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service are reviewing options for a new service delivery model that contemplates health care professionals who will dedicate all or a portion of their professional career to death investigations. Competency based training and a defined contractual relationship with the service providers will be included.
Detection	**61**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service are working with Queen's University to develop training modules for all investigating coroners, including a module on death investigations within long-term care homes.
Prevention	**62**	Ministry of Long-Term Care is committed to playing an expanded leadership role in continuous quality improvement and providing additional supports to long-term care homes that require coaching.
Awareness	**64**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service are working with Queen's University in the development of a strategic plan that will oversee the promotion of awareness of elderly vulnerabilities. These efforts will include a curriculum and Center of Excellence. This work will be initiated through a needs assessment exercise with key partners and stakeholders referred to in recommendation 70.

Theme	Rec #	Progress update
Awareness	**65**	The Office of the Chief Coroner and Ontario Forensic Pathology Service are working with Queen's University in the development of a strategic plan that will oversee the promotion of awareness of elderly vulnerabilities. These efforts will include a curriculum and Center of Excellence. This work will be initiated through a needs assessment exercise with key partners and stakeholders referred to in recommendation 70.
Awareness	**66**	The Office of the Chief Coroner and the Forensic Pathology Service is working with Queen's University to develop specific educational modules for coroners and death investigators and the long-term care homes on vulnerabilities of the elderly population. A standardized curriculum will also be developed and disseminated amongst health care partners responsible for training and education identified in recommendation 70.
Awareness	**67**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service are working with Queen's University to establish a Centre of Excellence on vulnerabilities of the elderly by 2022.
Awareness	**70**	The Office of the Chief Coroner is working with Queen's University to develop specific educational modules for death investigators and the long-term care homes on vulnerabilities of the elderly population. A standardized curriculum will also be developed and disseminated among the partner organizations referenced in this recommendation.
Awareness	**72**	Through the needs assessment exercise, the Office of the Chief Coroner will consider matters such as risk management, patient/resident safety, patient/resident outcomes, and/or professionalism when developing standardized content on vulnerabilities of the elderly including intentional harm.
Awareness	**73**	The Ontario Chief Coroner and the Ontario Forensic Pathology Service will develop a strategic plan and curriculum to inform the education content for the organizations in recommendation 70. This material will inform development of each organization's policies, practices and procedures.
Deterrence	**76**	The Ministry of Long-Term Care is launching a Medication Safety Technology program in April 2021. This program will support long-term care homes in adopting technologies that will strengthen long-term care medication safety. The ministry will be consulting with stakeholders in the development and implementation of this new program.

Theme	Rec #	Progress update
Deterrence	**77**	The Ministry of Long-Term Care is launching a Medication Safety Technology program in April 2021. This program will support long-term care homes in adopting technologies that will strengthen long-term care medication safety. The ministry will be consulting with stakeholders in the development and implementation of this new program. Funding formulas are being determined as part of the program design.
Deterrence	**83**	A three-year agreement with the Institute for Safe Medication Practices (ISMP) Canada has been initiated to provide support to the long-term care sector in strengthening medication safety. This will include the development of guidance on the use of rescue agents and tools that may help to identify potential medication incidents, in addition to other supports for the long-term care sector with respect to medication management and medication safety.
Detection	**86**	The redesigned Institutional Patient Death Record or alternate model is in the planning stages. This redesign will include measures to increase death investigations in long-term care homes.
Detection	**87**	The data analytics model methodology is completed. Development of the tool for the Coroner's Office will begin in Fall 2020.
Detection	**88**	The Office of the Chief Coroner and the Ontario Forensic Pathology Service has conducted early discussions with the Ministry of Health on an analytics approach with respect to the data collected under the new model.
Detection	**89**	The Ministry of Long-Term Care's data analytics model methodology is completed. The model will be integrated with the revised Institutional Patient Death Record or an alternate model to inform death investigations in long-term care homes.
Detection	**90**	The Office of the Chief Corner and the Ontario Forensic Pathology Service will be developing a tailored Institutional Patient Death record or alternate model for the home care setting in collaboration with its community care partners.
Detection	**91**	Once developed, training and education on the tailored Institutional Patient Death Record or alternate model will be delivered on behalf of the Office of the Chief Coroner and the Ontario Forensic Pathology Service by Queen's University.

Recommendations Not Currently Underway

Theme	Rec #	Justice Gillese's Recommendation
Detection	**18**	Home care service providers are strongly encouraged not to use subcontractors. If subcontractors must be used, service providers must establish formal practices to verify that subcontractors are properly reporting complaints and risk events to them, and conducting rigorous screening and background checks of all staff who will provide services to Local Health Integration Network clients.
Prevention	**19**	The Ministry Long-Term Care must expand the funding parameters of the nursing and personal care envelope to permit long-term care homes to use these funds to pay for a broader spectrum of staff, including porters, pharmacists, and pharmacy technicians.
Detection	**38**	OH/LHINs should amend their services agreements to require, as a condition of approving a service provider's proposed subcontractor, that: • the service provider ensure the subcontractor is conducting rigorous screening and background checks of all staff; andthe service provider establish a process to verify, on an ongoing basis, that the subcontractor is properly reporting all complaints, risk events, and other incidents to it.

Recommendations to Licensees

The below recommendations are currently at various stages of completion across the 626 long-term care homes in Ontario.

Theme	Rec #	Justice Gillese's Recommendation
Deterrence	**3**	Licensees should provide training to both management and registered staff. The training provided to administrators and directors of nursing should be about human resources, conducting workplace investigations and on their reporting obligations to the Ministry and the College. Registered staff are to receive training on the requirements of the *Long-Term Care Homes Act, 2007*, as it relates to prevention of resident abuse and neglect, the home's medication administration system and reporting of medication incidents and training on the redesigned Institutional Patient Death Record.
Deterrence	**4**	Licensees should amend their contracts with medical directors to require them to complete training for direct care staff such as abuse recognition and prevention as well as behaviour management. Additionally, medical directors should take the Medical Director course from the Ontario Long Term Care Clinicians within two years of assuming the role.

Theme	Rec #	Justice Gillese's Recommendation
Deterrence	**5**	Licensees should pay for the costs of the training, cover staff salaries during the training, and backfill shifts as necessary in order to ensure management and registered staff can regularly attend training. Note: The Ministry of Long-Term Care launched an annual $10 million education and training fund. This funding will assist licensees in strengthening training of staff.[1]
Deterrence	**6**	Licensees should adopt a hiring / screening process that includes robust reference checking, background checks when there are gaps in a resumé or if the candidate was terminated from previous employment, and close supervision of the candidate during the probationary period.
Prevention	**7**	Licensees should require directors of nursing to conduct unannounced spot checks on evening and night shifts, including weekends.
Detection	**8**	Licensees should maintain a complete discipline history for each employee so management can easily review it when making discipline decisions.
Detection	**9**	Licensees should ensure staff submit the Institutional Patient Death Record electronically to the Office of the Chief Coroner and the Ontario Forensic Pathology Service.
Prevention	**10**	Licensees should take reasonable steps to limit the supply of insulin in long-term care homes.
Prevention	**11**	Licensees should minimize the use of agency nurses by developing proactive strategies such as maintaining a roster of casual employees who are members of the regular nursing staff and can cover shifts in the case of an unexpected absence.
Deterrence	**12**	Licensees should thoroughly vet agencies before entering into contracts with them. If agency nurses must be used, licensees should ensure that the agency's management and staff have the knowledge, skills, and experience required to provide services effectively and safely for the home's residents, including on the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations.

[1] Note Recommendation 5 is directed to licensees but is included in tallies of recommendations in progress due to the Ministry of Long-Term Care's funding commitment.

Theme	Rec #	Justice Gillese's Recommendation
Deterrence	**13**	Licensees should ensure contracts with agencies: • require the agency to, at all times, have a roster of nurses who have been oriented to the licensee's home and meet the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations; • set out clear responsibilities and expectations for the agency in terms of its hiring, screening and training of registered staff; and,set out a clear process for reporting performance concerns from the licensee to the agency.
Awareness	**71**	Long-term care homes, residents' councils, family councils, Ontario Association of Residents' Councils and Family Councils Ontario should ensure that the information they deliver is consistent and suitable for their particular audience.
Deterrence	**78**	Management within long-term care homes should cultivate a "just culture" in the home – one in which human error is dealt with openly rather than punitively.
Detection	**79**	Long-term care homes should analyze medication incidents and adverse drug events through an incident analysis framework that includes screening for the potential of intentional harm.