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Lessons for the Long Term – Ombudsman's opening remarks, September 7, 2023

Good morning, and welcome to everyone here today at Queen's Park, and all who are joining us online.

First, I want to acknowledge that this land is the traditional territory of many nations, including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. It is now home to many diverse First Nations, Inuit and Métis peoples, and my colleagues and I are grateful to live and work on this land.

I am here today to talk about "Lessons for the Long Term." That is not just the title of my report – it's the key reason for my investigation into long-term care and the resulting recommendations.

More than 4,000 long-term care residents and 13 staff members died from COVID during the first two years of the pandemic – almost 2,000 of them in the first few months. Long-term care residents account for one-third of Ontario's COVID death toll.

That's a disproportionate impact on a vulnerable segment of our society.

I am aware that there have already been other reviews and reports about the devastating effects of COVID-19 on long-term care in this province. However, our investigation did not duplicate the work of the other reviews. Rather, we focused on the Ministry of Long-Term Care's Inspections Branch, and we uncovered evidence that was not previously revealed about how this important oversight function collapsed when COVID hit.

I have made 76 recommendations, all aimed at ensuring this province is better prepared to protect long-term care residents and staff when the next health emergency arrives. I'm pleased to report that all of my recommendations have been accepted, and the Ministry has pledged to report back to me on a regular basis on its progress in implementing them.

This report goes into great detail about the Ministry's inspections regime, which, even before the pandemic, was strained. However, the evidence we gathered reveals that the challenges of COVID completely overwhelmed it.

Our investigation identified problems with nearly every aspect of the Inspections Branch's processes during the first COVID wave. The Ministry had no plan or guidelines for how to do inspections during a pandemic. So none were done for

seven weeks, even as reports of outbreaks and health risks to residents and staff inside the homes poured in.

Inspectors did not have access to personal protective equipment (PPE) or training in infection prevention and control. Many were directed to contact long-term care homes by phone and take on more of a supportive role, rather than an investigative one. They relied on self-reporting by the homes.

We discovered that extremely serious COVID-related issues – such as infection prevention and control or personal protective equipment usage – were not inspected in a timely manner, or at all. The Inspections Branch also did little – often nothing – when homes did file reports about COVID-19 outbreaks.

Even when inspections resumed and violations of the law were found, the Inspections Branch often took the least severe enforcement action available, even in very serious situations. Homes were given many months to fix significant issues that posed a serious risk of harm to residents. And the action taken was often documented in confusing and poorly written reports.

The direct result of the lack of inspections, reports and enforcement was a lack of protection for residents and staff, and a lack of accountability for the system.

We have included in this report some stories from families of residents who tried in vain to get the Ministry to respond to their concerns about the conditions within the homes their loved ones were living in. Several of these residents died before anything was done.

For example, “Peter” complained three times about the lack of COVID infection control and his mother’s worsening condition at the home – and again after she died. An inspection was not done for six months.

“Raheem” complained three times about a home’s lack of COVID infection control putting both his parents at risk. His father died and his mother was hospitalized. The Ministry ultimately inspected the home but took more than two months to issue an inspection report.

We also describe some disturbing cases where, based on our review of the inspection reports, homes were not penalized to the extent they could have been, despite repeated findings of non-compliance.

The good news is that, in addition to accepting my recommendations, the Ministry has already made several improvements. It has a new policy that provides for training, communication and PPE across the province in case of a pandemic, and a checklist to follow when it happens.

However, there is still work to do. Among other things, it remains to be seen whether inspectors and the Ministry will take enforcement action when appropriate.

The Ministry's goal should always be to confirm that long-term care homes are complying with legislated requirements – and to act quickly when they don't.

Ensuring the safety of residents and staff must be the primary mission of the Branch and reflected in its work culture.

It is also crucial that the government strengthen the long-term care sector's ability to respond to crisis, by ensuring there are enough inspectors, and by revising legislation to expand the circumstances in which homes must report critical incidents.

Homes should not be relieved of their responsibility to properly document resident care, even in emergencies.

COVID-19 has not gone away, and it will not be Ontario's last pandemic. I am hopeful that if my recommendations are implemented – and the province remains committed to remembering the lessons from this experience – it will be ready when the next threat arrives. Long-term care staff, residents and their loved ones – and all Ontarians – deserve nothing less.

I'm now happy to take your questions.

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