SUBMISSION OF THE ADVOCACY CENTRE FOR THE ELDERLY TO THE SENIORS' ADVISORY COMMITTEE AT THE MENTAL HEALTH COMMISSION OF CANADA

June 28, 2010

The Advocacy Centre for the Elderly (ACE) applauds the work and mandate of the Seniors' Advisory Committee (the Committee) at the Mental Health Commission of Canada (the Commission). ACE would like to take this opportunity to contribute our views based upon our extensive experience advocating for seniors in Ontario and our expertise in the area of mental health law and addictions. While we understand that the Committee and the Commission have a national mandate, our submission will focus on the situation in Ontario, although many of the underlying issues and principles are applicable across the country.

After providing a brief introduction to ACE, we will examine the discrimination facing older adults with mental health and addiction issues by reviewing the problem of ageism and some general information about the prevalence of mental illness amongst seniors in Canada. We will then discuss some of the issues which ACE has identified as the most pressing for older adults with mental health and addiction concerns, as well as some recommendations for change.

ACE would be happy to participate in any further consultations or discussions with the Committee.

INTRODUCTION TO ACE

ACE is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been operating since 1984 and is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE receives, on average, over 2,500 client intake inquiries a year. These calls are primarily from the Greater Toronto Area but approximately twenty per cent are from outside this region. The individual client services are in areas of law that have a particular impact on older adults. These include, but are not limited to: capacity, substitute decision-making and health care consent; end-of-life care; supportive housing and retirement home tenancies; long-term care homes; patients' rights in hospitals; and elder abuse. Clients regularly seek our advice on issues relating to mental health issues.

In 2005, ACE represented Concerned Friends of Citizens in Ontario Care Facilities at the Ezz-El-Dine El-Roubi and Pedro Lopez inquest (commonly known as the "Casa Verde Inquest"). Forty-three witnesses gave evidence during the 34 day long inquest. The coroner's jury made 85 recommendations with regards to housing options for complex and behaviourally difficult older adults.

In addition to producing written educational materials in the forms of brochures and newsletters, ACE has written a text in excess of 600 pages that is now in its third edition entitled *Long Term Care Facilities in Ontario: The Advocate's Manual*. ACE is planning to publish a fourth edition in 2011.

As part of its law reform mandate, ACE staff frequently participates in government consultations as stakeholder representatives for the seniors' community. For instance, representatives from ACE sat as members on the Advisory Committee on Substitute Decision-Making for Mentally Incapable Adults (the Fram Committee), while ACE's Executive Director was appointed by the Attorney General of Ontario to chair the Interim Advisory Committee on Substitute Decisions. ACE also prepares written briefs for policy-makers and makes submissions to legislative committees when new legislation or legislative amendments on seniors' legal issues are proposed. For example, ACE was actively involved in the consultations respecting the development of the *Health Care Consent Act* and the *Long-Term Care Homes Act, 2007.*

OLDER ADULTS AND AGEISM

Ageism is prevalent in Canada. The Law Commission of Ontario has defined ageism as follows:

> Ageism may be defined as any attitude, action or an institutional structure which subordinates a person or a group because of age, or any assignment of roles in society purely on the basis of age. Most often in our society, ageism reflects a prejudice against older persons, a negative bias toward the aging. As such, ageism is broader than stereotyping, although stereotyping may lead to and support ageism.[1]

One recent study noted that 84% of Americans and 91% of Canadians over the age of 50 reported at least one incident of ageism; more than 50% reported multiple incidents.[2] Unlike other stigmatized groups, "social sanctions against expressions of negative attitudes towards the elderly are almost completely nonexistent."[3]

Ageism is further complicated by the fact that older adults are not a homogeneous group. Canada is a multicultural and diverse society where older persons experience life differently depending on a number of factors, including one's gender, colour, income, level of

[1] Law Commission of Ontario, *The Law As It Affects Older Adults – Consultation Paper: Shaping the Project* (May 2008), online: http://www.lco-cdo.org/en/documents/OlderAdultsMay08/documents/ConsultationPaper-OlderAdultsFINAL.pdf> at 16.
[2] Marcia Ory *e. al,* "Challenging Aging Stereotypes: Strategies for Creating a More Active Society" (2003) 25(3Sii) American Journal of Preventative Medicine 164 at 166.
[3] Sean Horton, J. Baker and J.M. Deakin, "Stereotypes of Aging: Their Effects on the Health of Seniors in North American Society" (2007) 33:12 Educational Gerontology at 1021 at 1023.

education, ethnicity or place of origin, place of residence, marital status, sexual orientation, family status and health. Discrimination against older adults is often compounded due to the intersection of age with other aspects of their identity, including mental health and addiction issues.

OLDER ADULTS AND MENTAL HEALTH

It is estimated that 17 to 30% or more of persons over 65 years of age has a mental health disorder.[4] This means that there are between 289,000 and 680,000 older adults directly affected by mental health issues in Ontario.[5] The following are specific statistics about the mental health of older adults:

- 10% of seniors living in the general community experience clinically significant depression while 25% of this group experience severe depression. This rate is probably higher given that depression in older adults is often not recognized and tends to be under diagnosed.[6] Within long-term care homes, the rate of depression for older adults increases substantially. The Canadian Coalition on Seniors' Mental Health estimates that up to 40% of long-term care home residents experience depression.[7]

- When compared with other age groups, individuals aged 65 years of age or older have high rates of suicide.[8]

- The Alzheimer Society of Canada recently stated that Canada is facing a dementia epidemic. Currently, there are approximately 500,000 Canadians with dementia, representing the most significant cause of disability among Canadians over the age of 65 years. It is expected that the prevalence of dementia will likely increase several-fold within 20 years.[9]

The British Columbia Psychogeriatric Association discusses how events or transitions in late life can affect a person's mental health:

[4] This statistic is dependent on the diagnoses included in the analysis: Canadian Mental Health Association, Ontario, *Mental Health and Addictions Issues for Older Adults: Opening the Doors to a Strategic Framework – Executive Summary* (February 2010) at 2.
[5] *Ibid.*
[6] Ontario Association of Non-Profit Homes and Services for Seniors, *Submission to the Minister's Advisory Committee on Mental Health and Addictions* (November 4, 2009) at 8.
[7] Canadian Coalition for Seniors' Mental Health, *Mental Health Issues in Long-Term Care Homes – A Guide for Seniors and their Families* (2009) at 12, online: http://www.ccsmh.ca/pdf/ccsmh_long_termBooklet.pdf.
[8] A.J. Bharucha & A. Satlin, "Late-life suicide: A review" (1997) 5(2) Harvard Review of Psychiatry 55.
[9] Alzheimer Society of Canada, *Rising Tide: The Impact of Dementia on Canadian Society* (2010) at 8.

> Age, disability and chronic health conditions are interrelated. Physical changes and chronic health conditions can have substantial impact on the psychological and social wellbeing of older adults by, for example, reducing opportunities for social engagement and relationships and their associated benefits.
>
> Life events or transitions that can occur as part of the normal aging process, may disrupt or threaten to change an individual's normal routine and activities, and consequently can affect an individual's mental health. Pressures from the environment that affect the majority of seniors include: retirement; changes in income level; and changes in social support networks (including caring for another individual, and coping with the death of a spouse and peers). For some, this may result in the development of a mental illness for the first time in late life.[10]

Therefore, ACE supports the following statement made by the Canadian Mental Health Association, Ontario about reducing stigma and ageism: "…seniors-specific education is needed to decrease societal stigma, self-stigma and benign ignorance about the difference between normal aging and signs of mental illness."[11] We further endorse the recommendations made by the Canadian Mental Health Association, Ontario to produce educational materials for seniors, seniors' groups and service providers to increasing awareness about ageism and discrimination.

INADEQUATE HEALTH CARE

Research indicates that not only are Canadians living longer, they are living longer in good health. Although seniors are more likely than younger people to have chronic conditions and to experience poorer health, seniors today are generally healthier than those of previous generations.[12]

However, older adults are often viewed as sickly and erroneously blamed for increases in health care costs. It has been suggested that such stereotypes support policies to reduce social programs for care. Also, these negative assumptions may send the message that older adults are not entitled to services and discourages them from seeking assistance.[13]

[10] British Columbia Psychogeriatric Association, *Promoting Seniors' Well-Being: The Seniors' Mental Health Policy Lens Toolkit* (2008) at 39-40.
[11] *Supra* note 4 at 4-5.
[12] Canada, Special Senate Committee on Aging, *Embracing the Challenge of Aging, Second Interim Report: Issues and Options for an Aging Population* by The Honourable Sharon Carstairs and The Honourable Wilbert Joseph Keon (Ottawa: March 2008) at 47.
[13] See, for example, Jane Aronson and Sheila H. Neysmith, "Manufacturing social exclusion in the home care market" (2001) 27 Can. Pub. Pol'y 2 151.

The situation is even worse for older adults with mental health and addiction issues and it manifests itself in stigma and a discriminatory allocation of resources. As noted by the British Columbia Psychogeriatric Association:

> There is a significant stigma attached to mental health problem and illness that can further contribute to poor mental health. This stigma is apparent in the inequitable allocation of medical and non-medical resources for older adults with mental illness and addictions in comparison to other illnesses such as diabetes and cancer.[14]

Physicians

Some physicians are reluctant to accept seniors as new patients on the basis of actual or perceived time demands, and the corresponding fear that they will not be compensated adequately for their time from the Ontario Health Insurance Program. Misperceptions about advanced age, coupled with the physician shortage in Ontario, make it extremely difficult for older adults who do not have a doctor to find one.

One possible explanation is the shortage of health care professionals who are knowledgeable about the aging process. In 2005, there were only 191 geriatricians in Canada, as compared to the 538 that were estimated to be needed by 2006.[15] Minimal amounts of teaching time are allocated to the issues of aging and dementia in Ontario medical schools, suggesting there will be future barriers for older adults in terms of not only accessing appropriate care but in receiving quality care.[16] Another explanation for the difficulties in finding a doctor is that some physicians "normalize" concerns of older persons, often assuming them to be related to the aging process and, consequently, provide inadequate assessment and follow-up.[17]

For these reasons, the Committee should work with medical schools and health care organizations to examine all aspects of the medical profession, including, but not limited to: reviewing medical school curriculum to investigate whether there are any barriers to and discriminatory misconceptions about working with older persons; studying compensation criteria to determine the feasibility of changing the payment schedule to encourage more physicians to work with older persons; and considering whether the *Regulated Health Professions Act*[18] can be amended to encourage on-going education and training in the field of geriatric medicine.

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[14] *Supra* note 10 at 6.
[15] Canada, Special Senate Committee on Aging, *Embracing the Challenge of Aging, First Interim Report: Embracing the Challenge of Aging* by The Honourable Sharon Carstairs and The Honourable Wilbert Joseph Keon (Ottawa: March 2007) at 72.
[16] Ontario Human Rights Commission, *Time for Action: Advancing Human Rights for Older Ontarians* (Toronto: June 2001) at 57.
[17] *Ibid.* at 61.
[18] S.O. 1991, c. 18.

Informed Consent

Ontario has legislation, namely the *Health Care Consent Act, 1996*[19] and *Substitute Decisions Act, 1992*,[20] governing decision-making for all people in the province. The law requires that health practitioners obtain informed consent to treatment from all individuals who are capable. Where the person is incapable, the law requires that informed consent be obtained from the person's substitute decision-maker. However, these requirements continue to be ignored and are often the focus of complaints at ACE by both older adults and their substitute decision-makers. We are frequently contacted by substitute decision-makers who have discovered that a mentally incapable person has been given a medication about which the substitute decision-maker knows nothing, and it is often not until they call us do they learn of the health practitioner's legal obligation to obtain informed consent prior to commencing treatment**.** This scenario is pervasive in long-term care homes, where the substitute decision-maker may not be aware of or present during the resident's appointment with the physician who provides care to the home, whereas in the community, the incapable adult is often accompanied by the substitute decision-maker.

Frequently, the complaints regarding lack of consent are about the prescribing of antipsychotic medication, which have the potential for serious side-effects or may, in fact, be contraindicated for use in the elderly. Antipsychotic drugs were initially developed in the 1950s to treat conditions such as schizophrenia but have become widely used to manage behavioural disturbances and agitation associated with dementia. By 2000, in addition to the known side-effects (e.g., sedation, falls and hip fractures, cardiac complications, weight gain, metabolic complications, neuroleptic malignant syndrome and cognitive decline), studies showed that the use of antipsychotic medications for older adults with dementia was associated with an increase in the risk of death.[21] The United States Food and Drug Association and Health Canada subsequently issued regulatory warnings, with the Food and Drug Association also requiring certain medications be packaged with a "black box" warning describing the risks associated with the use of these medications in the elderly.[22] Further, many of these medications are being used "off-lab1el", meaning that they have not been approved for the treatment of dementia.

According to the Canadian Institute for Health Information, 37.7% of residents residing in long-term care homes on public drug programs were prescribed antipsychotics in 2006-

[19] S.O. 1992, c. 30.
[20] S.O. 1996, c. 2, Sched. A.
[21] Brad Hagen *et al*., "Antipsychotic Drug Use in Canadian Long-Term Care Facilities: Prevalence, and Patterns Following Resident Relocation" (2005) 17:2 International Psychogeriatrics 179 at 180.
[22] Canadian Institute for Health Information, *Antipsychotic Use in Seniors: An Analysis Focusing on Drug Claims, 2001 to 2007* (2009) at 15, online: <http://secure.cihi.ca/cihiweb/products/antipsychotics_aib_en.pdf> at 1.

2007 versus only 2.6% of older adults living in the community.[23] A report from the Ontario Health Quality Council in 2010 affirms that shortly after admission to long-term care, one in six residents is prescribed a new antipsychotic medication that he or she was not previously taking and one in four receives a new drug for anxiety or sleep.[24]

The data from the studies of Hagen *et al.* and Conn *et al*., suggest that "Canadian rates of antipsychotic use in long-term care facilities may be among the highest in the developed world."[25] It was also noted by Hagen *et al.* that there is a tendency to keep residents on antipsychotics once they are taking antipsychotics. This is despite the fact that the risk of side-effects rises dramatically over time and other studies have demonstrated that the majority of long-term care residents receiving antipsychotics for behavioural problems can have these medications safely and effectively withdrawn without an increase in difficult behaviours.[26] Rochon *et al*. found that residents with a diagnosis of psychoses or dementia were the most likely to be given antipsychotic therapy if they lived in a facility with a high antipsychotic prescribing rate. In the words of the researchers:

> These results suggest that antipsychotic therapy is not being prescribed based on their clinical indication. Rather, the decision to prescribe an antipsychotic therapy appears to be related to the nursing home environment, with some environments being more permissive about antipsychotic use.[27]

Due to the various concerns about drug management in long-term care, the Ontario Health Quality Council recommends that the most dangerous drugs be removed from the formulary of long-term care homes.[28]

Within long-term care homes, failure to obtain any consent at all to treatment is often the norm. Other homes attempt to obtain "blanket" consents at the time of admission which purportedly apply to all treatments that might be prescribed during the course of their stay. This is not legal as it in no way meets the requirements of "informed" consent as defined by the *Health Care Consent Act*.[29] In some homes, treatment will be started, and some time thereafter a staff member will contact the substitute decision-maker to "advise" them that the resident is now taking the medication, failing to provide them with the requisite information and leaving no option open for "consent." In fact, our experience has been that where the substitute decision-maker subsequently does their own research on the medication and withdraws consent based upon the serious side-effects and questionable efficacy of the medication, they are often met with severe resistance by the physician and other health practitioners.

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[23] *Ibid.* at 16.
[24] Ontario Health Quality Council, *Quality Monitor: 2010 Report on Ontario's Health System* (2010) at 17.
[25] These comments are based on statistics from two different studies indicating that 29.8% and 30.8% of long-term care home residents are prescribed antipsychotic medications: *supra* note 21 at 188.
[26] *Ibid.* at 188-189.
[27] Paula Rochon *et al.,* "Variation in Nursing Home Antipsychotic Prescribing Rates" (2007) 167 Archives of Internal Medicine 676 at 682.
[28] *Ibid.* at 53.
[29] *Health Care Consent Act,* s. 11.

Rights Information

Pursuant to the regulations to the *Mental Health Act,* patients in psychiatric facilities must be provided with rights advice if they are found to be incapable to make decisions about treatment.[30] Rights advice is a process whereby an individual is informed of their legal rights by a rights adviser shortly after their legal status has changed. The rights adviser cannot be a person involved in the direct clinical care of the person to whom the rights advice is given. The rights adviser is required by law to explain the significance of the legal situation to the individual. If requested to do so, the rights adviser will also assist the person to: apply for a hearing to challenge the finding before the Consent and Capacity Board; retain a lawyer; and apply for financial assistance from Legal Aid Ontario. Prescribed government forms must be completed to verify that rights advice was given. The lack of, or untimely, rights advice can invalidate a finding of capacity. Rights advice is viewed as a legal protection to ensure fairness and access to justice.

Unfortunately, the requirements for rights advisers and forms pertain only to psychiatric in-patients who are found incapable with respect to treatment. Outside a psychiatric facility, section 17 of the *Health Care Consent Act* obligates health practitioners to "in the circumstances and manner specified in guidelines established by the governing body of the health practitioner's profession, provide to persons found by the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines." However, in long-term care, health care practitioners often fail to satisfy even these minimal requirements of providing rights information to individuals who they believe are incapable under the *Health Care Consent Act.* Residents are not informed when they are found incapable nor are they made aware of their statutory rights and the procedures available to exercise these rights. There are also problems with the policies of the various health Colleges respecting rights information. The policies of the Colleges do not necessarily ensure that the patient have the information necessary for the purpose of due process. As well, Colleges may not consistently enforce this requirement or discipline practitioners who fail to comply.

One illustration of this problem is the rights information policy of the College of Physicians and Surgeons. Physicians are directed to inform an incapable person that a substitute decision-maker is responsible for making treatment decisions.[31] Where the patient disputes the need for a substitute decision-maker or disagrees with the involvement of the present substitute, the physician "must advise the patient of his or her options" which "include finding another substitute of the same or more senior rank, and/or applying to the Consent and Capacity Board for a review of the finding of incapacity."[32] A physician has a duty to "reasonably" assist the patient if he or she expresses a wish to exercise these options. This

[30] R.R.O. 1990, Reg. 741, s. 15.
[31] College of Physicians and Surgeons of Ontario, *Consent to Medical Treatment,* Policy Statement #4-05 (January/February 2006), online: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1544>.
[32] *Ibid.*

policy does not go far enough to ensure that the alleged incapable person is able to

exercise their rights or that the patient is informed of the process to challenge the finding of incapacity. The policy is too narrow, as it suggests that the physician does not have a duty to provide patients with information about their rights before the Board if they disagree with the finding of incapacity (as opposed to having a substitute decision-maker) or if they do not explicitly voice their disagreement.

The *Health Care Consent Act* contains similar requirements for consent to admission to a long-term care home. However, it does not specifically require evaluators, a specified category (usually social workers), to provide rights information to the individuals they find incapable of consenting to admission a care home.[33] The practice of most evaluators is to hand a pre-printed rights information sheet to incapable individuals, without providing a verbal explanation and although the information may be unclear and misleading. Further, there is no guarantee that the person will be assisted by the evaluator in obtaining legal assistance or contacting the Consent and Capacity Board to initiate the process to challenge the finding of incapacity.

In order to protect the security of individuals by educating them about their legal options after a finding of incapacity, ACE is of the view that section 17 of the *Health Care Consent Act* should be amended. Instead of leaving it to the regulated Colleges to set individual policies regarding the provision of rights advice, the legislation should create a specific duty on health practitioners to provide specified rights information which would be set out in regulation in all areas where findings are made under the *Health Care Consent Act*. Further, there should be a requirement that health practitioners complete a regulated form and give notice of a finding of incapacity to the person, similar to the Form 33 currently used if a patient in a psychiatric facility is found of consenting to a treatment with respect to a mental disorder.[34] The form would include a checklist indicating that the health practitioner had met the following requirements: satisfied the statutory requirements for consent; provided information about the appeals process; and, if instructed to do so, assisted the person to submit an application to the Consent and Capacity Board.

Therefore, ACE suggests that the Committee review the legislation and the policies of the various Colleges and demand adherence to the existing legislation in order to promote the rights of older adults, especially those with mental health and addiction issues.

[33] The definition of evaluators can be found in Reg. 104/96 pursuant to the *Health Care Consent Act.*
[34] *Mental Health Act,* Reg. 741, s. 15(1)(a). A copy of the Form 33, Notice to Patient under Subsection 59(1) of the Act and under Clauses 15(1)(a) and 15.1(a) of Regulation 741, can be found at http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-1088-41~3/$File/1088-41_.pdf.

LACK OF HOUSING FOR OLDER ADULTS WITH MENTAL HEALTH AND ADDICTION ISSUES

One of the major problems for older adults with mental health and addiction issues is the lack of sufficient, adequate, and affordable accommodation options. It is true that these shortages impact people of all ages with mental illness and/or addictions, but the problem can be more acute for seniors because they may also have concurrent physical or chronic health care needs. The lack of accessible accommodation for seniors with mobility impairments, and the discrimination that can arise in the rental housing market can include multiple *Human Rights Code*[35] grounds including age, physical or mental disability. Often, housing alternatives can only deal with *either* the mental health issue *or* the physical care issue, but not both, leaving the senior with very few options.

There are presently 622 long-term care homes with 76,109 long-term care beds across the province, which does not include specially licensed temporary long-term care beds.[36] Older adults entering long-term care tend to be of a more advanced age with complex health care needs ranging from dementia to major psychiatric conditions combined with physical illnesses. Generally, this population has a declining level of cognition and capacity, with approximately 55% of residents having a reported diagnosis of dementia.[37] The average age of a resident in long-term care today is 83 years.[38] That being said, there are many younger residents living in long-term care due to their medical conditions (e.g., acquired brain injury, Huntington's disease) and a lack of alternate accommodation.[39] Thus, long-term care homes are now serving a more diverse group of residents than ever before.

An issue which desperately needs a solution is the "difficult" or "high level of care" older adult seeking accommodation. These individuals often require high levels of complex care, due to behavioural issues stemming from dementia, psychiatric illness or other neurological diseases. Psychiatric facilities will not accept these individuals, as they repeatedly state that they only provide short-term assessment and not long-term housing. In any event,

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[35] R.S.O. 1990, c. H.19.
[36] Email from Kim Hewitt, Information Request Coordinator, Health System Information Management and Investment Division, Ministry of Health and Long-Term Care, to Lisa Romano, Research Lawyer, ACE (16 July 2009).
[37] Canadian Institute for Health Information, *Antipsychotic Use in Seniors: An Analysis Focusing on Drug Claims, 2001 to 2007* (2009) at 15, online: <http://secure.cihi.ca/cihiweb/products/antipsychotics_aib_en.pdf>.
[38] Ontario, Ministry of Health and Long-Term Care, prepared by Monique Smith, Parliamentary Assistant, *Commitment to Care: A Plan for Long-Term Care in Ontario* (Spring 2004) at 8, online: <http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_report04.pdf>.
[39] According to the Ministry of Health and Long-Term Care, based on the fall 2008 Levels of Care Classification review of 43,334 residents, 6.26% are younger than 65 years of age. There are more than 76,000 long-term care beds in the province, and it is not known how these residents were chosen to be classified, therefore the numbers may not be statistically accurate: Email from Kim Hewitt, Information Request Coordinator, Health System Information Management and Investment Division, Ministry of Health and Long-Term Care, to Lisa Romano, Research Lawyer, ACE (16 July 2009).

these facilities are inappropriate as they are unable to meet the older adult's concurrent physical health concerns. Also, decreases in long-term psychiatric beds due to health care

restructuring have resulted in older adults increasingly moving into long-term care rather than to psychiatric facilities. A lack of alternative housing, such as group homes, compounds the problems, resulting in long-term care often being the only possible housing.

ACE has heard anecdotal evidence that the applications to long-term care homes by persons with a psychiatric or addictions history are often "black-balled". Although the person will be deemed eligible for long-term care by the Community Care Access Centre and applications submitted to long-term care homes, one of the following three scenarios may occur:

1. Homes will not accept the person.
2. If accepted, applicants are either made ineligible when they reach the top of the waiting list based upon new assessments, or skipped over when spots become available because the bed is never "suitable". As a result, these seniors are forced to live in sub-standard housing in the community or remain in a hospital bed that can be unwelcoming and/or unable to accommodate their needs. This is costly to the health care system.
3. If the person is accepted and admitted into the home, the requisite level of care is unavailable. In our experience, the homes that accept high level of care individuals may be the least able to care for them, but are the only ones willing to admit them in order to maintain the required occupancy rates to receive full funding.

Even when an applicant with a mental illness or addiction is offered admission to long-term care, these homes are usually not an appropriate housing solution for these residents. The provision of mental health and addiction services in long-term care has been inconsistent across the province due to a lack of a coordinated and systems-based approach. While various resources do exist (e.g., Psychogeriatric Resource Consultants, High Intensity Needs Fund, Behaviour Intervention Response Teams), they are fragmented and represent a band-aid solution to a systemic problem.

One of the most significant obstacles to providing adequate care to residents with diverse mental health and addiction needs is inadequate staffing levels. The Geriatric and Long-Term Care Review Committee of the Office of the Chief Coroner for Ontario has reviewed several cases where residents of long-term care homes with dementia have assaulted other residents resulting in death. In their opinion, "no amount of education and skill-building with long-term care home staff can substitute for having an adequate number of staff available to provide the care and supervision to meet the care and safety needs of all of the residents, all

the time."[40] As a result, the Geriatric and Long-Term Care Review Committee recommended in its most recent annual report that the "Ministry of Health and Long-Term Care should urgently examine the issue of staff-mix and staff-to-resident ratios for the purpose of ensuring that sufficient, adequate, appropriate and safe care be provided to elderly residents in licensed long-term care homes."[41]

Further, staff is not sufficiently trained to manage behaviours and needs related to mental illness and addictions. Programs such as PIECES[42] and U-First[43] are admirable but ongoing funding is required to not only ensure that new staff is trained but that they are able to integrate and implement these best practices. The Ministry of Health and Long-Term Care has noted that "the day-to-day reality is that most PIECES trained registered nurses are usually fully occupied with the day-to-day demands of general resident care and cannot use their skills in behaviour support planning."[44]

The difficulties associated with staffing levels and training is compounded by the fact that personal support workers (PSWs) are unregulated. PSWs (also known as health care aides) provide the bulk of the hands-on care in not only long-term care and retirement homes but to older adults receiving home care in the community. They are often underpaid and receive minimal training, especially in the areas of mental health and addiction. However, when problems arise, it is difficult to hold these unregulated staff members accountable for their actions, as there is no independent College to complain to, and the institutions themselves are often reluctant or unable to properly discipline these employees.[45]

Once admitted to long-term care, the individual may act out, and even harm, another resident. Statistics show that the number of violent incidents is increasing in Ontario's long-term care homes. Between 2003 and 2006, the number of reported violent incidents among residents has more than tripled from 446 to 1,416 cases. Over the past ten years, there have been almost twenty resident-to-resident homicides in long-term care homes.[46] ACE is aware of at least two additional deaths in 2007 and 2009.

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[40] Ontario, Office of the Chief Coroner, *Nineteenth Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner for the Province of Ontario* (September 2009) at 33.
[41] *Ibid.* at 11.
[42] PIECES is an acronym for Physical, Intellectual, Emotional, Capabilities, Environment and Social. It is a practical framework for assessment and supportive care strategies for older adults with complex cognitive mental health needs and behavioural changes.
[43] U-First is a method for shared problem-solving and care planning for persons with Alzheimer's and related dementias that utilizes PIECES concepts.
[44] Ontario, Ministry of Health and Long-Term Care, Draft Report, *Building a Better System: Caring for Older Individuals with Aggressive Behaviours in Long-Term Care Homes* (April 2007) at 12.
[45] An announcement was made on March 26, 2010 that the Ministry of Health and Long-Term Care decided not to regulate personal support workers: Health Professions Regulatory Advisory Council, online: http://www.hprac.org/en/projects/Personal_Support_Workers.asp.
[46] "Nursing Homes: Fear and Violence", *CBC News* (22 October 2007), online: <http://www.cbc.ca/news/background/nursing-homes/> and "Grey, Black and Blue", *CBC Marketplace* (17 October 2007), online: http://www.cbc.ca/marketplace/grey_black_and_blue/.

The Casa Verde inquest took place in 2005 after a cognitively impaired 74-year-old man, who had been at the long-term care home for less than a day, killed two other residents and seriously injured a third. The Coroner's Jury made 85 recommendations, many of which dealt specifically with the problems surrounding appropriate housing options for seniors with cognitive impairment and/or mental health issues and the resulting need for specialized homes and units for this population (a copy of the Coroner's Jury recommendations is attached to this submission).[47]

Recommendation 22 called on the Ministry of Health and Long-Term Care to:

> …fund specialized facilities to care for demented or cognitively impaired residents exhibiting aggressive behaviour as an alternative to long-term care facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of these residents in order that the facility be staffed by regulated Health Care Professionals (RN's and RPN's) who are trained in PIECES, and in sufficient numbers to care for these complex and behaviourally difficult residents.

The Coroner's Jury recommended that the government design these specialized units based on the model of the Dorothy Macham House at Sunnybrook Health Sciences Centre. The Dorothy Macham House is a care and research facility for ten residents who are veterans with moderate to severe dementia. These individuals have ongoing challenging behaviours that put others at risk of injury or that significantly disrupt the lives of other residents. The multidisciplinary team works collaboratively with the resident and the resident's family to design an individualized program. Residents are discharged only when the care team establishes that the resident is able to function safely in his/her previous unit or facility. There is no predetermined duration of stay. The Dorothy Macham House is viewed as the gold standard due to the positive results it yields.

Regrettably, while the Ontario government participated in the Coroner's Inquest, and in fact was the subject of many Jury recommendations, there has not been any significant movement to implement the recommendations dealing with these issues. Thus, these individuals continue to require care that does not exist at the present time in Ontario.

This systemic gap often leads to an inappropriate "cycling" of seniors from the community to long-term care homes to hospital, then to psychiatric treatment, then back to long-term care. This not only increases the burden on our health care system, but it is an unhealthy solution for the seniors involved. Under the current *Nursing Homes Act*, for example, homes can authorize psychiatric absences for up to 45 days (this timeframe will be extended up to 60 days once the *Long-Term Care Homes Act* is proclaimed on July 1, 2010) after which the resident loses his/her long-term care bed. That being said, it can be extremely difficult to have residents of long-term care homes accepted into psychiatric hospitals because these

[47] Recommendations 22 through 25 deals with specialized facilities and units, Office of the Chief Coroner, Recommendations from the Inquest into the Deaths of Ezzeldine El Roubi and Pedro Lopez (Inquest Dates: January 31 – April 18, 2005).

facilities are often not equipped or are unwilling to house seniors with mental health issues for extended periods of time. In addition, the hospital demand guarantees from the home that the individual will be accepted back by the home on a particular date even if the mental health issue has not been sufficiently addressed. Even where such guarantees are given, residents may still be refused re-entry to a home despite being cleared for return by the medical team at the hospital within the required timeframe (and despite this being contrary to the long-term care legislation). Seniors must then apply for long-term care and are put on lengthy waiting lists before eventually being transferred to a different long-term care home, often after long periods of time languishing in hospital (if any home can be found which will accept them). Finally, even where hospitalization for the mental health issue is appropriate, the psychiatric hospital may be ill equipped to deal with the senior's physical issues, leading to physical deterioration or continued transfers between psychiatric and general hospitals.

ACE is also aware of many cases where long-term care homes inappropriately sent residents to general hospitals on a Form 1 (Application for Psychiatric Assessment) pursuant to the *Mental Health Act* even when they knew that the resident did not require admission, in an attempt to rid themselves of what they perceive to be a "problem" resident.

We have also seen older adults and their families pressured and/or resigned (due to the lack of a better option) to accept placements in retirement homes although this is clearly unsuitable accommodation. Retirement homes are currently not part of our health care system; instead, they are tenancies and described as "care homes" under the *Residential Tenancies Act, 2006*.[48] Generally, retirement homes are designed for seniors who require minimal to moderate support with their daily living activities. While retirement homes may make available some care services pursuant to a contract with the tenant, the care services provided are neither funded nor regulated by the Ministry of Health and Long-Term Care, or any other government Ministry. Nevertheless, ACE has had several cases where persons found ineligible for long-term care due to their high care needs were sent to retirement homes. This is simply illogical, given that retirement homes are meant to provide lower levels of care to adults if they do not yet need long-term care placement.[49]

In the future, retirement homes may be dramatically different from what exists today. ACE believes the recent passage of the *Retirement Homes Act, 2010* will result in the privatization of health care for seniors and create a parallel private pay long-term care home system.[50] The new legislation, which will not be proclaimed until regulations have been

[48] "Care home" means a residential complex that is occupied or intended to be occupied by persons for the purpose of receiving care services, whether or not receiving the services is a primary purpose of the occupancy: S.O. 2006, c. 17, s. 2(1).

[49] In fact, the Geriatric and Long-Term Care Review Committee to the Chief Coroner commented on the risk of hospitals discharging residents who require long-term care into retirement home settings where their needs may not be able to be met. Although this case dealt with a senior with complex medical issues, similar risks are inherent when seniors go to retirement homes when suffering with complex mental health issues: Ontario, Office of the Chief Coroner, *Nineteenth Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner for the Province of Ontario* (September 2009) at 40.

[50] S.O. 2010, c. 11.

drafted, permits retirement homes to offer any level of care but without the same level of oversight as long-term care homes. Tenants will therefore be paying for health care services that would otherwise be covered by the government. It is expected that some long-term care home operators will change their homes to retirement homes as they will not only be able to operate the same business with a lower level of regulation but also charge more for the same services. One important example of an area where retirement home tenants will not have the same level of protection as residents of long-term care homes concerns restraint and detention. The *Retirement Homes Act,* as presently written, permits the restraint and confinement of tenants in secure units. While confinement in a secure unit in a long-term care home is considered a restraint, the legislation specifically states that *confinement* in a retirement home is not a restraint. We disagree with this section and do not believe it to be legally correct. If a person is prevented from leaving, he or she is restrained no matter what the legislation states. This interpretation of the law has the potential to be particularly detrimental to individuals with mental health and addiction issues.

In sum, the lack of appropriate housing options for seniors with mental illness and addiction issues is a critical problem. Long-term care homes have become the "dumping grounds" for difficult to place individuals of varying ages and with different conditions, given their mandate to admit anyone who qualifies for this type of care, whether or not it can truly meet their needs. It is paramount that the Committee support the implementation of the recommendations from the Case Verde inquest and to urge government to develop a comprehensive strategy to assist this vulnerable group.

AGING IN PLACE

The majority of older persons want to remain in their own home and the concept of aging in place is paramount to fulfilling this wish. In order for "aging in place" to be realized, affordable and accessible housing options and in-home supports must be available.

Home Care

Insufficient funding of community-based care has been identified as an obstacle for older persons seeking access to the health care system. According to the Ontario PsychoGeriatric Association, enhanced home care services are necessary to allow older persons living with mental illnesses to be supported at home.

The *Long-Term Care Act*, *1994*[51] sets out much of the legal framework for the delivery of in-home services in Ontario. Section 11 states that multi-service agencies are given the responsibility to provide and ensure the provision of community support services, homemaking services, personal support services and professional services.[52] Overall, the

[51] S.O. 1994, c. 26. This statute will be renamed as the *Home Care and Community Services Act, 1994* on July 1, 2010.

[52] Community Care Access Centres are responsible for determining who is eligible for publicly funded in-home services and for arranging the delivery of these services. However, the definition of Community Care Access

goal of the statute is good in theory as it confers benefits on those who need assistance at home. Unfortunately, it is extremely difficult for individuals to access the services. The statute says that the criteria for community based long-term care services will be set out in the regulations[53] but the only regulations that have been made only limit eligibility by stating that services are not available under certain circumstances or beyond certain maximums. Moreover, specific eligibility requirements are not known to the public. This is the opposite of a demand driven system and is the root of the problem.

A further restriction in the statute pertains to the funding envelopes provided to Community Care Access Centres (CCACs). Each CCAC is provided with a fixed amount of money each year. Due to shortfalls in the annual funding envelopes or budgeting decisions, CCACs may not be able to provide necessary services. Therefore, contrary to the law, mandatory services are often not provided. While there is a right of appeal regarding eligibility decisions, the CCACs control the initial stages of information about the review process and ACE is aware that individuals are frequently not advised of their rights and how to exercise them.

We encourage the Committee to review the requirements for services to be provided by the CCACs as mandated by the *Long-Term Care Act*, the lack of regulations in respect to the criteria for access and eligibility to the various services, the funding agreements between the Local Health Integration Networks and CCACs, whether these support the obligations of the CCAC to provide the mandatory services as listed in the *Long-Term Care Act* and to find out whether individuals are obtaining the full benefit of the law.

Caregivers

Elder care is largely provided in the community by family members. Not only does this facilitate "aging in place", but it saves public resources. Regrettably, the services in place to support family caregivers are extremely limited resulting in an "all or nothing" system where families often feel they have no choice but to put their loved one into a long-term care home.

As noted by the Ontario Human Rights Commission, "workplace structures and expectations have not adjusted to the changed situation of families" whereby "caregiving responsibilities tend to be viewed as individual 'personal problems' rather than as a systemic issue."[54] Persons with caregiving responsibilities, consequently, are incorrectly perceived to be less capable and less committed to their employment than their colleagues.

Seniors with dementia or other mental health problems often require constant supervision and cannot be left alone. This can result in families who decide to care for such seniors having to be with them at all times, which often requires family members to leave paid

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Centres in section 1 of O. Reg. 33/02 only requires them to provide services in homemaking, personal support and professional services – not community support services.

[53] *Long-Term Care Act*, ss. 17 and 18.

[54] Ontario Human Rights Commission, *The Cost of Caring: Report on the Consultation on Discrimination on the Basis of Family Status* (Toronto: 2007) at 29.

employment. As well, the lack of sufficient support by the system means that they have little or no respite from their role as caregiver, often leading to the caregiver suffering from mental or physical illness themselves. Homecare is insufficient, especially where the senior has few physical ailments, but suffers from dementia. What is required here is respite support, of which very little is available through the Community Care Access Centre. Further, respite care in long-term care homes, while available, can be costly where the caregiver has already had to give up paid employment to stay at home, and therefore is out of the reach of many.

The Committee is encouraged to examine the inadequacy of supports in place to assist caregivers and possible solutions to this problem, such as respite, increased financial assistance, and providing social assistance to family members who give up employment opportunities to stay at home with older persons.

CONCLUSION

We understand that the Behavioural Support Systems project was launched in early 2010 to "create a framework for transforming the health care system for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions living in long-term-care homes or in independent living settings."[55] This project will be lead by the North Simcoe Muskoka Local Health Integration Network in partnership with Alzheimer Society of Ontario, the Alzheimer Knowledge Exchange, the Ministry of Health and Long-Term Care and supported by the Ontario Health Quality Council. While ACE is not familiar with the details of this project beyond the publicly available information, we applaud this initiative and hope that it receives adequate funding and the Committee examines its work.

While we understand that the Committee cannot direct government to take particular actions, we suggest that it encourage the provincial government to develop a provincial mental health and addiction strategy that addresses the needs of older adults. One concrete strategy is to consider the benefits of establishing a single entry access system and clear admission criteria for persons seeking continuing accommodation within the mental health and addictions system. For instance, the possibility of Community Care Access Centres being responsible for admissions to not only long-term care homes (as they do now) but also specialized mental health and addiction hospitals and complex continuing care units within general hospitals should be considered.[56] This would allow equitable

[55] Information about this project can be found at http://akeresourcecentre.org/BSS.

[56] Complex continuing care refers to the provision of continuing, medically complex and specialized services in either freestanding hospitals or in designated beds within acute care hospitals. Patients typically have long-term illnesses which are unstable, or disabilities typically requiring skilled, technology-based care not available at home or in long-term care homes: *Public Hospitals Act,* R.R.O. 1990, Reg. 552, s. 10. However, the legislation sets no specifics as to what type of care these facilities are to offer, and most set their own admission criteria. Therefore, it is difficult to ascertain exactly what services and to whom these hospitals provide care.

access for all Ontarians to provincially funded health care rather than the haphazard and secretive system that exists now.

It is abundantly clear that the current mental health and addictions system in Ontario is broken and is failing older adults. The province needs to develop and implement a mental health and addictions strategy for *all* older adults living in Ontario. The starting point must be providing sufficient accommodation and supports to allow older adults with mental health and addiction issues to continue to live at home in the community as long as possible. Specialized housing and programming for "hard to place" seniors must also be created to fill the void that currently exists.

Appendix "A"

INQUEST TOUCHING THE DEATH OF EZZ-EL-DINE EL-ROUBI and PEDRO LOPEZ – JURY RECOMMENDATIONS[57]

The following recommendations are not presented in any particular order of priority:

Need for MOHLTC to Make Long Term Care A Higher Priority

Recommendation 1:

That the Ministry of Health and Long-Term Care (MOHLTC) should give increased priority to the health care needs of the elderly and, in particular, the serious challenges faced in treating elderly cognitively impaired residents, by immediately developing and implementing a plan (or "Framework") to ensure appropriate standards, funding, tracking and accountability in Long Term Care (LTC) and other facilities treating such individuals.

Recommendation 2:

The Ontario Seniors' Secretariat, in consultation with stakeholders in the long-term care system should initiate a public education campaign to decrease the stigma attached to elderly people with dementia and other cognitive difficulties.

Recommendation 3:

The MOHLTC, in consultation with the College of Family Physicians, should design and implement an expanded and on-going education and support programme for family physicians to assist them in the early detection, diagnosis and treatment of dementia and related behavioural problems and in accessing available community resources for the client and family caregivers.

Recommendation 4:

It is recommended that the MOHLTC take immediate steps to implement the "Ten-Point Plan for Improving the Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario".

Rationale: It is recommended that the MOHLTC recognize that due to health care restructuring LTC facilities have become "new Mental Health institutions" in Ontario, without the funding and resource necessary nor a recognition of the

[57] The Jury Recommendations have been reformatted for the purpose of this document but the contents have not been altered.

anticipated needs given the demographics in Ontario related to the increased aging population with cognitive impairments. (Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario).

Office Of The Chief Coroner

Recommendation 5:

The Office of the Chief Coroner publish these and all other inquest recommendations on its website.

Recommendation 6:

The Office of the Chief Coroner publish all Annual Reports of the Geriatric and Long-Term Care Review Committee on its website. Notification of publication should be sent annually upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community Care Access Centres, and resident and family advocacy groups, as well as all police forces in Ontario.

Recommendation 7:

The Office of the Chief Coroner thoroughly investigates all suspected homicides in long-term care.

Recommendation 8:

The Office of the Chief Coroner review all other potential homicides in long-term care homes which have occurred since 1999 and publish a special report with respect to all of these deaths. This report should be published on the website of the Office of the Chief Coroner, and notification of publication should be sent upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community Care Access Centres, and resident and family advocacy groups, as well as all police forces in Ontario.

The College of Physicians and Surgeons of Ontario

Recommendation 9:

The College of Physicians and Surgeons of Ontario communicate to its members the importance of preparing discharge summaries and providing them to the family physician within 7 days from discharge.

Recommendation 10:

The College of Physicians and Surgeons of Ontario clarify the issue of confidentiality when issues of abuse arise. Specifically, the specifics of this case should be reviewed, discussed and the content published by the College in its "Members Dialogue" and on its website.

Recommendation 11:

The MOHLTC, in consultation with CCAC's should revise the Health Assessment Form to ensure the health professional completing the form has a clear understanding of the purpose of the form and the importance of including a detailed diagnosis, prognosis, specialist reports, psychiatric or psychological assessments, behavioural concerns, and all information that would have an impact on the client's ability to be cared for in a long-term care facility in a manner that ensures the safety of both the client and other residents. The structure of the form itself should also be changed in order to accommodate the above noted recommendation.

Recommendation 12:

The Health Assessment Form should be amended to include a "drug profile" which analyzes the side effects of prescribed drugs on LTC applicant.

Recommendation 13:

The Health Assessment Form should be amended to include a separate section that seeks information about incidents of aggressive or violent behaviour of the applicant that have occurred in the applicants past.

Rationale: Report from the Geriatric and Long Term Care Review Committee on the Deaths of Mr. El-Roubi and Mr. Lopez.

The Ministry of Health and Long-Term Care

Recommendation 14:

The Ministry of Health and Long-Term Care website be amended to include detailed information for physicians and families about the long-term care application process and the importance of providing detailed and up-to-date information to the Community Care Access Centre and upon admission to the long-term care home.

Recommendation 15:

The Ministry of Health and Long-Term Care produce a monthly bulletin to be sent to all long-term care homes, Community Care Access Centres, associations, resident councils,

family councils, and other interested parties, providing information regarding policies, programmes and other information of assistance. This bulletin should also be available to the public on the Ministry of Health and Long-Term Care website.

Recommendation 16:

The Ministry of Health and Long-Term Care produce and distribute information pamphlets in all major language groups. Specifically, the pamphlets should include information about long-term care and in-home care, the application process, and living in a long-term care home.

Recommendation 17:

The MOHLTC in consultation with health care professionals should take immediate steps to issue standardized monitoring forms for all LTC facilities (i.e. wanderers record, daily flow sheet, medication administration record, screening tools for placement of residents, placement criteria score sheet, residential functional profile, behavioural/ aggressive behaviour checklist, etc.)

Rationale: Uniformity will ensure a “continuity of care” across all long-term care facilities throughout Ontario (Report -Commitment to Care: A Plan for Long-Term Care In Ontario - Prepared by Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care - Spring 2004).

Placement of Individuals

Recommendation 18:

It is recommended that the MOHLTC, after appropriate consultation, review eligibility and admissions regulations and policies to ensure that individuals exhibiting or prone to aggression be assessed prior to the eligibility decision and only be placed in specialized facilities or LTC facilities with appropriate specialty units.

It is further recommended that if the decision is made to continue to place such individuals in LTC facilities, that the MOHLTC must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self and others. If unregulated staff are assisting the regulated health professional on these specialty units/facilities they must be U-FIRST trained.

Rationale: Report from the Geriatric/Long Term Care Review Committee on the deaths of Mr. El Roubi and Mr. Lopez.

Recommendation 19:

It is recommended that the MOHLTC and all CCAC's change their policies to ensure that in cases of potential residents with cognative impairment, with actual or potential aggressive behaviours, that the Community Care Access Centre health professionals should ensure that a comprehensive medical assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry.

Recommendation 20:

Where behaviours have been identified as presenting a risk to self or others, admission to any facility should be delayed until the behaviours have been appropriately assessed and a care plan has been developed. In such cases, the MOHLTC should ensure that there are interim alternatives to placement in the long-term care facility until the individual has been assessed and an appropriate plan of care has been developed such as:

i) appropriate support in their homes up to 24 hours a day to assist the family;
ii) beds available at an appropriate alternative facility (hospital, mental health facility or specialized facility)

Recommendation 21:

That the MOHLTC review the delays in obtaining Psycho geriatric assessments to ensure that such assessments are available in a timely way and to take steps to address the delays, such as increasing the numbers of Psycho geriatric assessors and resources available in every region.

Specialized Facilities and Units

Recommendation 22:

The MOHLTC should fund specialized facilities to care for demented or cognatively impaired residents exhibiting aggressive behaviour as an alternative to LTC facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of these residents in order that the facility be staffed by regulated Health Care Professionals (RN's and RPN's) who are trained in PIECES, and in sufficient numbers to care for these complex and behaviourally difficult residents.

Recommendation 23:

The facilities, in consultation with experts in the field, should be designed using the model of the Dorothy Macham Home at Sunnybrook and Women's College Health Science Centre to meet the physical and staffing requirements of these high needs residents.

Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors (Exhibit 67, p.4) Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report March, 2001 - (Exhibit 40, p.1)

Recommendation 24:

The MOHLTC should ensure that these facilities are accessible for the individuals who are not appropriate for placement in long term care facilities. This means that there should be sufficient beds for the region's needs, in all regions that there is no barriers to admission for the individuals who require this specialized care (eg. no requirements that the resident be "stable" to be transferred there from long term care facility, no requirement to be a war veteran or only referred by institutions).

Recommendation 25:

The MOHLTC should immediately mandate and fund specialized units in sufficient numbers in each region to care for residents with behavioural problems. The MOHLTC should consult with healthcare professionals and experts working in the field in setting standards for these units. These units should be regulated by the MOHLTC rather than based on the LTC facility's definition of a "specialty unit". The units should include:

i) beds in appropriate physical spaces (ie. Private rooms located close to nursing stations, etc.) in which residents stay for a short period of time while they are assessed and an appropriate care plan is developed.
ii) If appropriate, the resident, once they are assessed and a care plan developed may be transferred to other units where the care plan will then be implemented. Attention must be paid to ensuring that the care plan is transferred completely, and that follow-up resources are available to the unit caring for the resident.
iii) Some of these units may also be set up based on a long term residential model where residents would live in these units for the entire duration of their behavioural complications.

Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report - March, 2001 Review of Homicides in Long Term Care Facilities by the GLTCRC

Revision to Long Care Funding Model

Recommendation 26:

That the MOHLTC, in consultation with stakeholders, should revise the funding system presently in place for LTC facilities within the next fiscal year. Any new system (such as the MDS (Minimum Data Set) model presently being contemplated by the MOHLTC) should be designed to ensure that the funding model is sufficient to take into account the higher skill level of staff required for residents with dimentia and other mental health problems and, in particular, give sufficient weight to actual and potential aggressive behaviours to ensure adequate staffing, sufficient time and resources for LTC facilities if they are responsible to manage residents with such behaviours.

Rationale: Commitment to Care - A Plan for Long-Term Care In Ontario Prepared by Monique Smith - Spring, 2004

Recommendation 27:

That MOHLTC report back to the Coroner's office, prior to the one year review, with a time line to ensure funding model review is given priority in fiscal year and implemented in a timely way.

Recommendation 28:

That the MOHLTC retain PricewaterhouseCoopers, or a similar consultant, to update the January 2001 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators,* and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario Long Term Care facilities given the significant number of Ontario residents with cognative impairment and complex care needs in LTC facilities. This would include determining the appropriate amount of direct RN care that is required, the indirect RN care and the total hours per resident per day of overall Nursing and Personal Care (RN, RPN, and HCA) on average.

Recommendation 29:

That the MOHLTC in the interim, pending the evidence-based study should fund and set standards requiring LTC facilities to increase staffing levels to, on average, no less than .59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal car for the average Ontario case mix measure. The funding formula for the Nursing and Personal Care envelope must be immediately adjusted to reflect this minimum staffing.

Recommendation 30:

That the MOHLTC, once the updated evidence based study is received, should set out standards based on this information, for all Ontario LTC facilities to ensure that Ontario LTC facility residents are given appropriate nursing and other staff hours. At a minimum the staff hours must be comparable to other similar jurisdictions and are sufficient to meet the needs of present and future Ontario LTC facility residents.

Rationale: Report of a Study to Review Levels of Service and Responses to need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators - - January 11, 2001; PricewaterhouseCoopers Report - Report of a Study to Review Levels of Service and Responses to Need in a Sample of Long-Term Care Facilities and Selected Comparators - January 11, 2001

Recommendation 31:

Pending the remodling of the funding system, the MOHLTC immediately review and revise the present CMI system to ensure cognitive impairment and behavioural problems are sufficiently weighted in the CMI system to ensure sufficient funding for appropriate skilled staff for assessment, monitoring and management of residents prone to these behaviours.

Rationale: “Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility” - Interim Report - March 2001

Recommendation 32:

Pending the remodeling of the funding system, the MOHLTC immediately review the present CMI system to ensure that cognative impairment and behavioural problems are properly identified and captured under the system. As the present system depends on charting of behaviours, the system should ensure that those RN’s who are assessing and charting the behaviours have sufficient time to actually assess and record the behaviours. In addition, all staff that the RN’s are supervising must also have the training and time to report the behaviours in order that the behaviours be appropriately picked up by the system.

Recommendation 33:

Pending the remodeling of the future system and implementation of training for all staff, additional funding must be provided and tracked to ensure that a PIECES trained Registered Nurse at each facility is designated for those residents on each shift, due to the unpredictability of behaviours and level of risk associated with these residents.

Rationale: Service Provisions Manual - Ministry of Health and Ministry of Community and Social Services - Service Provision - Objectives and Functions (1994-1997)

Working Conditions

Recommendation 34:

In order to attract and retain sustainable Registered Nurses' to provide the skilled continuity of care required, the MOHLTC should take immediate steps to enhance the working conditions in LTC facilities including:

i) immediately change the funding system to ensure parity in wages and benefits with Ontario hospital Registered Nurses; and
ii) increased number of full-time RN positions and increased the total percentage of fulltime RN positions significantly;
iii) Monitor and track LTC facilities use of funds in the Nursing and Personal Care Envelope to ensure that funds are used to meet the agreed upon staffing mix and RN/resident ratios;
iv) Monitor and decrease significantly the use of agency nurses and other LTC staff by LTC facilities.

Professional Standards of Regulatory Colleges to Protect the Public

Recommendation 35:

Given the College of Nurses' Ontario mandate is to protect the public and that it has set standards of practice for RN's and RPN's (including different scopes of practice between RN's and RPN's and express responsibilities for RN's in supervision and delegation to unregulated health care workers) the RN staffing levels must be sufficient to allow the RN in the LTC facility to have time to adhere to the standards set out by the Ontario College of Nurses.

Rationale: Chart - "Profile of Practice Expectations *for* RN's and RPN's - College of Nurses of Ontario Practice Guideline, "Utilization of Unregulated Care Providers (UCP's)

Recommendation 36:

The MOHLTC staffing standards and the implementation of the staffing standards by the LTC facilities must ensure that the RN has sufficient time to ensure that she/he has time fo*r* collaboration with physicians, RPN's and Psycho geriatric Resource Consultants and sufficient time to adequately supervise, teach and delegate to the unregulated workers.

Accountability

Recommendation 37:

To ensure that the funding provided to long-term care facilities is sufficient to provide the level of care required by residents and that the assessed needs of the residents are being met, the MORLTC should, in keeping with the recommendations of the Office of the Provincial Auditor:

i) Develop standards for staffing in LTC facilities including the number of RN hours of direct and indirect care per resident, the mix of registered and non-registered staff and the staff to resident ratios depending on the complexity of care needs of the residents at the facility; and
ii) Track staff to resident ratios, the number of RN hours per resident and the mix of registered and non-registered nursing staff and determine whether the level of care provided are in accordance with the standard, the specific service agreements of the facility and are meeting the assessed needs of residents; and
iii) Monitor to ensure compliance and accountability of funds given to LTC facilities.
iv) Data regarding the facilities staffing levels, including RN to resident ratios and average numbers of RN hours (direct and indirect) per resident, in addition to compliance reports in LTC homes should be public and easily accessible fo*r* review by both request and on the public website. This will ensure that all relevant individuals and entities (including the families and CCAC employees) have this information to make decisions regarding appropriate facilities. This information must be kept current.

Rationale: Pricewaterhouse Coopers Report - Report of A Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators - January 11, 2001; Report - Commitment to Care: A Plan for Long-Term Care in Ontario - prepared by Monique Smith - Spring 2004

Immediate High Needs Funding for Cognitively Impaired/Aggressive Residents

Recommendation 38:

That MOHLTC immediately review and revise their “High Intensity Needs Program” to ensure that every LTC facility has access to additional funding for immediate staffing increases to care for *existing* cognatively impaired residents safely. The revised programme should ensure the funding is used by LTC facilities to provide RN care for all such residents who are prone to or assessed with potential aggressive behaviours.

The program should ensure that the funding is available for an appropriate period of time and, at a minimum until the resident has been appropriately assessed, an appropriate nursing care plan is developed, and in the opinion of a psychogeriatric resource person, the resident is stable enough that he/she does not provide a risk to self or others if not closely monitored.

Rationale: OANHSS, "Mental Health Issues and Long Term Care"

Recommendation 39:

The MOHLTC should review its High Intensity Needs Program to ensure that transitional beds in long-term care facilities are available for *newly assessed* high risk residents while waiting assessment and/or to ease their transition into a long-term care setting. The Ministry should expand the program to ensure:

i) It is available on admission where aggressive behaviours have been identified;
ii) It is available for residents being admitted directly from the community;
iii) It is available on an on-going basis until a psychogeriatric assessment can be completed and a safe care plan can be implemented;
iv) Funds are available to provide the resident with a private room at the basic ward rate, if necessary;
v) There are sufficient funds to provide one on one care by a PIECES trained RN.

Specialty Training

Recommendation 40:

The MOHLTC should set mandatory standards and provide designated funding to ensure that all staff interacting with cognatively impaired residents in LTC are PIECES/U-First trained. This includes those individuals who make decisions regarding admission and placement, as well as those managing the individual's care.

Rationale: PIECES Manual Report - Commitment to Care: A Plan for Long-Term Care in Ontario -- prepared by Monique Smith - Spring 2004

Recommendation 41:

More specifically, it is recommended, that the MOHLTC create and enforce standards requiring all RN's working in LTC to be PIECES trained as a priority. Such standards should set out time lines such as ensuring that all RN's presently on staff are PIECES trained within one year, and shall include PIECES training as part of the orientation for new staff.

The MOHLTC shall ensure that there are adequate classes in each region to address the waiting lists and have all RN's trained within one year.

Recommendation 42:

That the MOHLTC create and enforce standards requiring all administrative and management staff who are involved in admission decisions and staffing decisions to be trained in either the full PIECES course or the ENABLER course.

Recommendation 43:

The Ministry of Health and Long-Term Care, in order to support PIECES trained staff, require that physicians providing services in long-term care homes be knowledgeable about the programme.

Recommendation 44:

Health Care Aids should have a college or governing body which regulates them. As part of their education they should be trained in psycho-geriatric, aggressive behaviours.

Recommendation 45:

That the MOHLTC create and enforce similar standards requiring that all other staff (RPN's and HCA's) be PIECES/U-FIRST trained in a timely way and that there be adequate classes without waiting lists to facilitate this training.

Recommendation 46:

The MOHLTC set standards, monitor and enforce such standards, to ensure that all facilities have at least one Registered Nurses' with PIECES training on staff on all shifts and available to do PIECES assessments.

Recommendation 47:

That the MOHLTC reinstate funding for all expenses associated with PIECESIU-FIRST training, including travel expenses and wages to backfill for equivalent staff to ensure that all LTC facilities have their staff appropriately trained and continue to have new staff trained.

Recommendation 48:

That the MOHLTC immediately review and address any institutional barriers that may exist that prevent RN's and LTC facilities from accessing PIECES training (ie. preconditions for administrators, funding issues, waiting lists or being, under-resourced in certain regions).

Recommendation 49:

The MOHLTC, in consultation with psychogeriatric health care professionals, should ensure that Psycho-Geriatric Assessment Teams with established referral patterns are available to all Ontario communities. These teams must be accessible on an urgent basis for CCAC case managers, LTC admissions staff, and PIECES-trained Registered Nurses and other health care providers in order to ensure that all applicants with complex and/or aggressive behavioural concerns can be thoroughly assessed prior to admission to a long-term care facility.

Specific funding and legislation should be put into place by the MOHLTC to develop and maintain these Psycho-Geriatric Assessment Teams.

Rationale: Through the inquest testimony, we the jury believe that in order to properly care for the ever increasing complex care elderly patients, all heath care professionals must be properly trained in order to care for their needs. Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care In Ontario

Psychogeriatric Assessors and Consultants: Links to the Facilities

Recommendation 50:

That the MOHLTC increase the number of fully funded, full-time Psychogeriatric Resource Consultants and Psychogeriatric Assessors doing assessments through the Geriatric Outreach teams and monitor delays. MOHLTC should ensure that there are sufficient “PRC's” (Psychogeriatric Resource Consultants) and Psychogereatric Assessors available in a timely way to assist the Psychogeriatric Resource persons and other Registered Nurses in managing cognatively impaired residents in LTC facilities (and other facilities where these residents may be placed).

Placement and Admissions

Recommendation 51:

That the regulations and policies regarding long term care should be reviewed by the MOHLTC to ensure that there is an integrated continuum of care. The MOHLTC policies should ensure consistency in managing these cognitively impaired individuals so the risk is managed appropriately both before and after admission to a LTC or other facility.

Recommendation 52:

The regulations, policies and structure of all Ontario CCACs should be reviewed to ensure an integrated continuum of care. Each CCAC should be structured for continuity of care by the case managers to ensure completeness and consistency of information.

Community Care Access Centres

Recommendation 53:

The Community Care Access Centre ensure that when completing the long-term care application, case managers make every effort to interview all family members living with the applicant. Where the applicant is mentally competent, consent must be obtained from the applicant first.

Recommendation 54:

The Community Care Access Centre ensure that where the. applicant for long-term care is mentally incompetent, the spouse, if mentally competent and available, must be interviewed as part of the application process.

Recommendation 55:

The Community Care Access Centre ensure that where the applicant for long-term care is mentally incompetent, the substitute decision-maker is interviewed as part of the application process. No application may be allowed to go forward without such an interview-taking place.

Recommendation 56:

The Community Care Access Centre's policies be amended to require proper documentation in all client files. Included in this documentation must be: (a) the full names and relationship of all persons that they speak to about an applicant, including during telephone conversations and face-to-face meetings; (b) time, date and length of conversations and meetings; (c) content of discussions and all relevant information.

Recommendation 57:

The Community Care Access Centre require that all documentation must be completed at the time of the conversation or meeting, or as soon as possible thereafter. All documents must be signed and date stamped in order to ensure authenticity.

Recommendation 58:

CCAC's should include with the assessment package sent to long-term care facilities a social assessment that would include the client's interests, wishes, family dynamics, and ethnic, cultural and religious considerations.

Recommendation 59:

The MOHLTC, in consultation with the CCAC sector, should consider including a provision in legislation and Ministry policy that limits the choice of clients who have been assessed as posing a risk to others due to physically aggressive or violent behaviour. Clients who are assessed as posing this risk, should be required to choose a LTC home with a specialized behavioural unit designed to deal with the clients behavioural concerns.

Recommendation 60:

That the Regulations, including the PCS Manual be revised by the MOHLTC to ensure that there is a requirement that an assessment of risk to self and others is done by the CCAC *prior* to placing the individual in any LTC facility. This revised regulation and the accompanying policy, would require the CCAC to consider a full assessment of the applicant's mental health status and behavioral problems prior to the determination of eligibility. It would also require the CCAC to consider the particular LTC facility and assess its resident population (the frailty of other residents, the competing high needs of other residents, the level of staffing, the numbers of Registered Nurses available, the presence of an appropriate specialty unit etc.) as part of the CCAC process and the determination of whether the resident is eligible for admission to LTC and should be placed in that particular LTC facility.

Rationale: Placement Coordination Service Manual

Recommendation 61:

That the MOHLTC review their regulations and policies to clarify the crisis admission process. At a minimum, standards must be set to ensure that complete and accurate information is obtained prior to decision making about an applicant's eligibility and admission, despite the fact that the family is in crisis. The policy should ensure that no decisions regarding eligibility and placement are made without all relevant information. This information must include, but is not necessarily limited to, information from the entire health care team such as, information from all relevant family members, family physicians, and specialists. Information from other community resources such as psychogeriatric assessments and, where appropriate the police, should also be obtained. If the information is inadequate at the time of the application, the family should be notified and the CCAC should not make the placement arrangements until all relevant information is obtained and should ensure alternative resources are made available to the family in the interim.

Recommendation 62:

That the legislation, regulations and policies be reviewed to ensure that there is a mechanism for the conditional placement of residents in LTC facilities. If, after admission, a resident is found to have a complexity of care such as aggressive behaviors that cannot be safely managed, or to have requirements beyond the staffing ratios and staff expertise of the LTC facility, the CCAC shall be responsible for overseeing the immediate removal of the resident and their placement in a more appropriate setting. The LTC facility should not be left with the responsibility of finding alternative services, such as an acute care hospital, a specialized Centre or another LTC facility with a more appropriate unit.

Recommendation 63:

That the LTC facility, through its Director of Care or delegate, when reviewing the CCAC materials to determine if the facility has the physical and nursing expertise to safely admit the individual, should be given sufficient time, resources and mechanisms to make this determination. This may include the LTC facility meeting with the resident and family prior to the decision to admit being made, and the facility having the means to accept the resident on a conditional basis.

Recommendation 64:

The Ministry of Health and Long-Term Care long-term care home policies be amended to include requirements for the review of applications for long-term care. Specifically, all documentation received from the Community Care Access Centre must be reviewed by the long-term care home, and there must be written documentation stating that all care requirements have been considered and are able to be met within that facility.

Recommendation 65:

The Ministry of Health and Long-Term Care amend the RAI-HC tool to include elements which have been identified as predictors for violence, such as suspicion and paranoia. It is further suggested that a geriatric psychiatrist or other geriatric mental health specialist review the form to ensure that all appropriate mental health issues are captured therein. The form should also be changed to accommodate “progress notes”.

Rationale: The RAI-HC was introduced by the Community Care Access Centre to replace the initial client assessment forms. This tool needs to be amended to provide a more “holistic” view on the patient which would include behavioural issues.

Recommendation 66:

That the MOHLTC and the CCACs should review the requirements for all employees who are applying the RAI-HC tool or who are making eligibility decisions to ensure that they are the appropriate PIECES-trained health professional such as an RN. They should have the appropriate education and qualifications to holistically make assessments, including the abilities and skills to understand underlying medical causes of cognitive impairment, multiple medical diagnosis and treatments, the impact interaction of multiple medications and all assessment tools.

Recommendation 67:

That the CCAC should ensure that there are no inappropriate admissions because LTC facilities are funded based on occupancy levels. At no time should residents be admitted to fill empty beds if that facility is not appropriate for the resident.

Recommendation 68:

The Ministry of Health and Long-Term Care take immediate steps to end weekend and evening admissions to long-term care homes. Implicit in this recommendation is that the Ministry's "Sustainability Program" be cancelled.

Assessment Tools

Recommendation 69:

The Ministry of Health and Long-Term Care, in consultation with health care professionals working in the long term care industry, should develop a aggression risk assessment tool for cognitively impaired residents with abnormal behaviours to assist in predicting future aggressive behaviours. The risk assessment tool should address an individuals military history, alcohol and drug addiction.

All assessment tools should be kept current and new tools should be incorporated into mandatory training.

Recommendation 70:

The MOHLTC, in consultation with health care professions working in the industry, should ensure that regulated staff (all regulated health care professions, social workers or other professionals who may be given responsibilities for assessments and admission decisions) are kept current in their training and that appropriate time is designated for these professionals to be able to implement the tools into the assessments and admission decisions.

Communication

Recommendation 71:

Given that families, family physicians and others with relevant information necessary for placement and admission may not readily provide all relevant information, either unintentionally or intentionally, the MOHLTC, CCACs and Long Term Care facilities should review the applicable legislation, regulations, policies to ensure that:

i) the appropriate regulated health professionals, who are trained in both a holistic approach and have probing assessment skills and interview techniques, are responsible for obtaining the information from all relevant members of the families, physicians, hospitals, other health and community sources, and criminal information where appropriate;

ii) the CCACs structure is reviewed to ensure an integrated model to ensure the resident is being followed by a single case manager who has responsibility to ensure the information is consistent, comprehensive thorough; and

iii) any issues, real or perceived, regarding consent to releasing relevant information is addressed systemically to ensure that all relevant medical, social, cultural, criminal, and environmental information is available to the health care team both making decisions regarding eligibility, placement and providing management of care of cognitively impaired residents with aggressive behaviors.

Recommendation 72:

Given Ontario's ever increasing multicultural population, it should be recognized that language and cultural values may be a barrier to obtaining all relevant information. In light of this reality, the MOHLTC, CCACs and LTC facilities should:

i) where the applicant for long-term care is unable to communicate with the case manager due to a language barriers, the Community Care Access Centre utilize a translator independent of the family or substitute decision-maker: (a) to ensure that the person is aware of the process, (b) if they are capable they are, in fact, agreeing to placement and, (c) if incapable, they are able to voice their opinions and concerns with respect to any placement. Funding for interpreters must be made available to the Community Care Access Centres by the Ministry of Health and Long-Term Care. These translation services should also be made available to all LTC facilities.

ii) ensure that policies and training reflect the heightened need for clear communications in cases of potential aggression, including cultural sensitivity to the issue of domestic assault or placement of elderly in institutions;

iii) ensure that language issues do not increase alienation or trigger aggressive behaviors when individuals become residents of facilities where staff do not speak their language or that language issues not be a barrier to staff adequately assessing and managing such behaviors; and,

iv) that if placement must be to a facility that does not provide services in the language and with the cultural sensitivity required, that admission be delayed until there are assurances that there is all relevant information obtained, that the treatment plan is in place to address the short and long term needs of the individual in being moved to an institution that does not speak their language.

Long-Term Care Homes

Recommendation 73:

All LTC facilities must have a set "admissions team" which consist of:

(i) LTC facility's Administrator,
(ii) The LTC facility's Director of Care,
(iii) The LCT facility's Chief Medical Administrator, and
(iv) One PIECES-trained staff RN.

All members of this "admissions team" must be present on the day the patient is admitted into their respective LTC facility.

Recommendation 74:

Long-term care homes ensure that when a resident is admitted to a long-term care home, all staff who may have direct contact with a resident are provided with all necessary information about that resident.

Recommendation 75:

Long-term care homes have a method (taped or written) of ensuring that staff are provided with all updated patient information if they are unable to attend the shift report, whether due to being on a short shift, being late for work, or having to attend other duties during the report. The resident's chart must be read and reviewed at the start of each shift. All reports whether written or on tape, must place particular emphasis on new admissions and on instructions for monitoring residents who require additional observation. The MOHLTC should establish a half-hour paid "hand-over" to accommodate this recommendation.

Recommendation 76:

Long-term care homes require that their staff document in their progress notes all details of conversations and meetings, include the names of the persons they speak or meet with, the relationship of the person to the resident, and the contents of the conversation. All documents must be signed and date stamped in order to ensure authenticity.

Recommendation 77:

Long-term care homes be required to train their staff at least semi-annually on the different type of emergency codes and the responses expected from them. Included should be training for staff on how to deal with physically aggressive patients. All LTC homes should also be required to set out a contingency plan to deal with patients who exhibit aggressive behaviours.

Recommendation 78:

The MOHLTC must make mandatory all core in-service training sessions for HCA's and must ensure that their positions are backfilled if they are on duty, or are remunerated if required to attend courses on their time off or scheduled off day.

Recommendation 79:

All LTC facilities must ensure that pictures of all LTC patients be placed on the front of their respective medical records for easy identification. In addition, LTC facilities should implement identifiers (i.e. colour coded shoe laces) for differing patients who are suffering from cognitive, behavioural or physical issues.

Recommendation 80:

The MOHLTC should ensure that doctors who head LTC facilities should either have a degree in geriatrics or should have geriatric training.

Investigations

Recommendation 81:

Where the police investigate an incident in a long-term care home or an incident involving a Community Care Access Centre, the Ministry of Health and Long-Term Care shall complete their own, thorough investigation as soon thereafter as possible, to determine whether there have been any breaches of the legislation or policies.

Recommendation 82:

The Ministry of Health and Long-Term Care track violent incidents in long-term care homes using the FMIS system. A specific report of violent incidents should be produced on a monthly basis.

Recommendation 83:

The Ministry of Health and Long-Term Care adapt the FMIS system to include homicides as a specific category of unusual/accidental deaths in its "Accidental Deaths" database or, alternatively, create a specific database to track homicides.

Publication of Circumstances of the Deaths of P. Lopez and E. El-Roubi

Recommendation 84:

It is recommended that the Office of the Chief Coroner for the Province of Ontario should request that the Geriatric and Long Term Care Review Committee publish a comprehensive account of the circumstances surrounding and leading to the deaths of Pedro Lopez and Ezzeldine EI-Roubi, including the recommendations arising from this Inquest. This report and the recommendations of this jury should also be distributed to all LTC facilities, all CCACs, all educational institutions for both regulated and unregulated health care professionals and all Colleges regulating health care professions and Social Workers in the Province of Ontario and the professional association and Unions representing staff at long term care facilities and CCACs.

Recommendation 85:

That the office of the Coroner within one year of this inquest follow up on the implementation of the jury's recommendations and provide a report to be made public and directed to all relevant parties working in the long term care sector in Ontario.