Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

LONG-TERM-CARE HOMES – MEDICATION MANAGEMENT

(Section 3.10, 2007 Annual Report of the Auditor General of Ontario)

1st Session, 39th Parliament
58 Elizabeth II

Library and Archives Canada Cataloguing in Publication Data

Ontario. Legislative Assembly. Standing Committee on Public Accounts
Long-term-care homes – medication management (Section 3.10, 2007 Annual report of the Auditor General of Ontario) [electronic resource]

Issued also in French under title: Foyers de soins de longue durée – gestion des médicaments (Rapport annuel 2007 du vérificateur général de l'Ontario, section 3.10)
Electronic monograph in PDF format.
Mode of access: World Wide Web.
Issued also in printed form.
ISBN 978-1-4249-9993-4

1. Long-term care facilities—Ontario—Auditing. 2. Long-term care facilities—Pharmaceutical services—Ontario—Evaluation. I. Title. II. Title: Foyers de soins de longue durée – gestion des médicaments (Rapport annuel 2007 du vérificateur général de l'Ontario, section 3.10)

RA999.P45 O56 2009 362.1609713 C2009-964031-7

Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Steve Peters, MPP
Speaker of the Legislative Assembly

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Norman W. Sterling, MPP
Chair

Queen's Park
November 2009

STANDING COMMITTEE ON PUBLIC ACCOUNTS

MEMBERSHIP LIST

1st Session, 39th Parliament

NORMAN W. STERLING
Chair

TED ARNOTT
Vice-Chair

FRANCE GÉLINAS

PHIL MCNEELY

JERRY J. OUELLETTE

DAVID RAMSAY

LIZ SANDALS

MARIA VAN BOMMEL

DAVID ZIMMER

Katch Koch
Clerk of the Committee

Lorraine Luski
Research Officer

STANDING COMMITTEE ON PUBLIC ACCOUNTS

LIST OF CHANGES TO COMMITTEE MEMBERSHIP

LAURA ALBANESE was replaced by DAVID RAMSAY on September 15, 2009.

ERNIE HARDEMAN was replaced by TED ARNOTT on September 15, 2009.

CONTENTS

INTRODUCTION

Over 19 million drug prescriptions were filled for the 75,000 residents of Ontario's long-term-care homes in 2006/07. On average, then, there were about five prescriptions dispensed per week for every resident. As well, 23 to 28% of residents at the three homes visited by the Auditor were taking 12 or more prescription drugs. The Committee was surprised to learn about this massive use of prescription drugs in the homes, and thought the number of prescriptions issued to residents was one of several key findings in the Auditor General's value-for-money audit of medication management in Ontario's long-term-care homes (section 3.10).*

In May 2008 the Standing Committee on Public Accounts held a day of public hearings on this section of the Auditor's Report. Senior officials of the Ministry of Health and Long-Term Care (the Ministry) as well as representatives of two of the audited homes appeared before the Committee. (For a transcript of our proceedings, see Committee *Hansard*, May 1, 2008.) Our report highlights the Auditor's observations and recommendations contained in Sec. 3.10, and presents our own findings, views, and recommendations.

We endorse the Auditor's findings and recommendations. We would also like to thank the Auditor and his team for drawing attention to these important medication management issues in Ontario's long-term-care homes.

OVERVIEW

Number and Types of Homes

Long-term-care homes provide care, services, and accommodation to persons generally aged 65 or older who are unable to live independently and who require 24-hour nursing care and supervision. More than 600 long-term-care homes in Ontario provide care for about 75,000 residents, as mentioned above. More than half of the homes are for-profit nursing homes. Fewer than 20 % are not-for profit nursing homes, about 10 % are charitable not-for-profit, while less than 20 % fall into the municipal not-for-profit category.

Management and Funding

Under the *Long-Term Care Act*, 1994, the Ministry funds homes for eligible residents. As steward of the health system, the Ministry is responsible for setting standards of care and conducting inspections of the homes to safeguard residents. While the Ministry sets care standards and conducts inspections of long-term-care

* As explained in the *2007 Annual Report*, value-for-money audits assess the administration of programs in the public sector and broader public sector that receive government grants. Their purpose is to identify instances where public funds were spent without due regard for economy or efficiency, or where procedures to measure or report on program effectiveness, were lacking.

homes to monitor compliance, physicians, contracted pharmacies, and nurses all have professional responsibilities for medication management.

Starting in April 2007, fourteen Local Health Integration Networks (LHINs) began playing a role in the planning and funding of long-term-care homes. In 2006/07, funding to the homes totalled $2.8 billion, which covers only a portion of total costs. Residents with sufficient means, pay between $1,500 and $2,100 a month for their accommodation. Long-term-care homes contract with pharmacies to provide to residents prescriptions and other medications ordered by a physician, as well as advice on medication-related issues. Although residents are eligible for benefits under the Ontario Drug Benefit (ODB) program, they contribute a co-payment (normally $2 per prescription) to the home's contracted pharmacy for their drug costs. Residents also are responsible for the full cost of most drugs not covered by Ministry programs.

Drug Costs

The Ontario Drug Benefit Program paid pharmacies about $333 million for more than 19 million drug prescriptions and associated dispensing fees for long-term-care home residents in 2006/07. Of this amount, drugs comprised $203 million with dispensing fees making up $130 million—almost 40% of the total. On average, then, the costs were around $2,700 per resident for drugs, and approximately $1,700 per resident for dispensing fees.

Selected medications, such as acetaminophen and cough medicine, are supplied by the Ontario Government Pharmaceutical and Medical Supply Service to the homes at no charge for resident use. The cost of these drugs was about $3.4 million in 2006/07.

Compensation Framework: Physicians and Pharmacists

The Committee sought information on the subject of physician and pharmacist compensation during our hearings and subsequently from the Ministry.

Physicians

The Committee asked the two audited homes that participated during our hearings about their contracts with physicians. Providence Manor, a 243-bed home based in Kingston, has 14 contracted physicians and one medical director. Leisureworld St. George, a 238-bed home, maintains a roster of three physicians who provide medical coverage 24 hours a day, seven days a week.

Generally, fee-for-service physicians attend to residents in long-term-care homes. They may be compensated through the Ontario Health Insurance Plan (OHIP) by claiming fees on a per "visit" basis with specified limits per month for routine assessments as well as admission and annual examinations. Physicians can also claim fees on a per "visit" basis, without limits, for seeing patients who fall ill during a month. A second option involves a "basket" approach—compensating physicians through OHIP with a monthly management fee that covers a core of

services such as routine visits (at least two per month), admission and annual assessments, medication reviews, discussions with staff, and completion of forms.

Physicians "visits" require an encounter with a resident. However, several classes of services do not require personal attendance by a physician in order to be billed under OHIP. For example, the physician can render services over the telephone to manage patients on blood thinners.

We also learned that the OHIP *Schedule of Benefits* includes a fee code for a periodic in-depth physical assessment of a resident. There are two such fee codes—one for the resident's annual physical exam and one for a comprehensive geriatric-oriented assessment conducted in a long-term-care facility. The OHIP *Schedule of Benefits* has no separate fee code for issuing or renewing a prescription, as this is considered part of the treatment as opposed to an assessment which is billable.

In addition, the homes' medical directors receive remuneration from the homes out of the Ministry funding they receive. These fees generally range between $10,000 and $30,000 per year, depending upon the number of residents, but the homes may choose to pay more.

Pharmacists

Pharmacists contracted to long-term-care homes dispense medications to residents when a prescription is issued. The pharmacy receives payment to cover the cost of the medication and markup, plus the dispensing fee (which includes the $2 dollar co-payment collected directly from the resident). The cost of ODB-eligible drugs is listed in the Formulary. The markup on such drugs is 8% of the drug cost. Dispensing fees, which are set by regulation, are currently $7 per ODB-eligible prescription. The Ministry does not regulate the cost of non-ODB eligible drugs, their markup, or the dispensing fees.

The pharmacy and the long-term-care home arrange the frequency of medication dispensing (weekly or monthly) through a contractual agreement. Typically, medications are dispensed to residents of the homes on a weekly basis in packaging agreed upon by the home and the pharmacy. The homes view weekly dispensing as preferable in terms of efficient storage and the easier managing and administration of medication by nursing staff. Such an approach yields less prescription drug waste in the home should there be a change in the medication therapy. Pharmacists submit claims for payment to the Ontario Drug Benefit Program which include drug cost, markup, and dispensing fees each time a product is dispensed, which is typically on a weekly basis.

Legislative and Regulatory Framework

Long-term-care homes are regulated, licensed, or approved by the Ministry under three statutes—the *Nursing Homes Act*, the *Charitable Institutions Act*, and the *Homes for the Aged and Rest Homes Act*—which have varying requirements. Policies set out in the *Long-Term Care Homes Program Manual* apply to all the homes. While the above-noted statutes were in force at the time of the audit, all

will be replaced by Bill 140, the *Long-Term Care Homes Act*, 2007, which received Royal Assent in June 2007, but has yet to be proclaimed.

OBJECTIVES AND SCOPE OF THE AUDIT

The Committee welcomed the opportunity to review the first value-for-money audit in the long-term care sector since the Auditor General's mandate was expanded in 2005 to include the broader public sector. The audit objective was to assess whether medications for residents in these homes were managed efficiently, safely, and in an appropriately controlled way in accordance with legislation, policies and procedures. The audit work was primarily conducted at three homes: Hamilton Continuing Care, a 64-bed for-profit nursing home; Leisureworld St. George, a 238-bed for-profit nursing home in Toronto; and Providence Manor, a 243-bed charitable home in Kingston.

The Auditor concluded that the three audited homes had procedures in place to ensure that they obtained physician-prescribed medications and administered them to residents in a safe and timely manner. Yet, audit staff observed ways in which homes could improve medication-management practices as well as the secure storage and handling of drugs.

ISSUES RAISED IN THE AUDIT AND BEFORE THE COMMITTEE

Significant issues were raised by the audit and before the Committee. We attach particular importance to seven of these issues below.

Modifying the Compensation Framework

The Committee is concerned about the lack of incentives in the long-term-care sector to encourage physicians to prescribe—and pharmacists to dispense—the *least* number of prescriptions.

Under the current system of compensating pharmacists, the more often drugs are dispensed, the more often the dispensing fees are charged by the home's pharmacist. As we pointed out earlier, on average there are about five prescriptions dispensed per week for every resident. One reason for this is that often the pharmacies initially fill prescriptions with just enough medication for one week and thereafter refill the prescriptions weekly. Each refill generates a new dispensing fee for the pharmacist. The Committee notes that almost 40% of the total cost of drugs for residents in long-term-care homes relates to dispensing fees rather than the actual cost of the drugs.

Committee Members are also aware that new regulatory provisions, O.Reg 264/08 under the *Ontario Drug Benefit Act,* came into force on July 28, 2008. For the majority of listed drug products dispensed to ODB recipients, pharmacists will be reimbursed a maximum of two dispensing fees per medication per recipient in any calendar month. Some limited exceptions are allowed, such as where reduced quantity dispensing is warranted for patient care and safety. The Ministry's

rationale for the change was to reduce the rate of growth in the number of dispensing fee claims. The new dispensing fee payment conditions do not apply, however, to residents of long-term-care homes. Members were curious as to why the Ministry has not applied these payment conditions to prescriptions dispensed to residents of long-term-care homes.

The Committee was also concerned that the current system does not do enough to encourage doctors to prescribe the minimum number of drugs to residents.

The impact that a large amount of drugs can have on elderly and often frail residents of the homes worries Committee members. For instance, the Auditor's report highlighted research by the American Medical Association on the use of antipsychotic drugs in Ontario long-term-care homes. It indicated that one-third of all residents were prescribed these drugs. More importantly, the research showed that individuals residing in homes with the highest total prescribing rates were three times as likely to be prescribed an antipsychotic drug as those living in homes with the lowest prescribing rates. As stated earlier, the Auditor's Report also noted that many residents (between 23% and 28% at the three audited homes) are prescribed 12 or more different regularly scheduled medications, which doubles the risk of an adverse drug reaction compared to residents taking five or fewer drugs.

We also question whether residents of these homes, many of whom take a number of drugs, are receiving periodic comprehensive clinical assessments to assess the resident's overall health and tolerance to the medications. We believe that residents taking multiple medications face increased health risks and may benefit from more frequent geriatric consultations or detailed physical assessments.

The Committee acknowledges the Ministry's position that physicians and pharmacists are accountable to their respective professional colleges. As well, we do not wish to imply that these professionals do not always act in the best interest of their patients. However, we believe that the current compensation mechanism for both physicians and pharmacists working in these homes should be reviewed. The objective of the review should be to consider changes to the compensation system that will encourage better resident care and medication management within the funding resources available.

Long-Term-Care Homes' Contracts with Pharmacies

Long-term-care homes enter into contracts with pharmacies to obtain prescription drugs and other medications ordered by physicians for their residents, as well as medication-related advice. The Ministry's *Long-Term Care Homes Program Manual* states that there must be a written service contract between the home and the pharmacy that includes quality management expectations. We heard that pharmacy services must be available to the homes 24 hours a day, seven days a week.

The Auditor recommended that these written contracts be more explicit in terms of Ministry requirements—particularly the type and frequency of procedures the

pharmacy is expected to perform, and the reporting to take place when assessing the home's compliance with medication-related policies.

During the public hearings, Members asked two of the audited homes, Providence Manor and Leisureworld St. George, a series of questions about their contracts with pharmacies. While Providence Manor indicated that it has had a long-term relationship with its local pharmacy, Leisureworld St. George noted that the home had issued a Request for Proposals (RFP) for a new pharmacy contract about four years ago.

Committee Members also asked about the existence of conflict-of-interest guidelines applicable to a home and the pharmacy seeking a contract. Ministry officials noted that general conflict-of-interest guidelines exist in both the service agreement with a long-term-care home, and the Ministry's *Long-Term Care Homes Program Manual*.

We were further interested in whether a pharmacy, in order to secure a contract, could pay money to the long-term-care home in question.

Leisureworld replied that it did not believe this to be the case. However, the pharmacy may provide a number of free services as an added benefit to obtaining the contract such as additional staff education and in-service training, services and staffing paid for out of the pharmacy's profit margin.

As the Committee is concerned about the potential for conflict of interest between the homes and the pharmacies, we were pleased to hear that Leisureworld issued an RFP when it sought a new pharmacy for the homes in its chain. We consider a robust, competitive process for selecting a new pharmacy provider to be the best route for long-term-care homes that are seeking this service.

Informed Consent to Treatment with Medication

Two of the audited homes lacked documentation to show that they had obtained the informed consent required to treat a resident with new medication. Documentation at the third home did show that consent had been sought, but it lacked the identity of the person contacted.

In response, the Auditor recommended that long-term-care homes ensure that consent to treatment of a resident with new medication is obtained and documented in a timely manner from either the resident (when he or she is capable of giving consent), or from the resident's substitute decision-maker. During our public hearings, we asked the long-term-care homes for any practical suggestions or approaches they could offer on the issue of obtaining consent, and were told that the Joint Task Force on Medication Management convened by the Ministry may be promising. It will address many of the issues identified in the Auditor's *2007 Annual Report*, including the consent issue, and has been widely endorsed by the long-term-care homes sector. The Committee is also interested in the obtaining of consent as it pertains to medical directives or "standing orders"

for over-the-counter medication. The Ministry advises that the Joint Task Force's work will include an examination of this aspect of the consent issue.

Medication Errors

The best practices of the Institute of Safe Medication Practices Canada dictate that identifying and reviewing medication errors is important to the prevention of similar future errors; two of the audited homes, however, were poor at ensuring that all medication errors were reported. A standard definition of a medication error is lacking in this sector.

The Auditor recommended that long-term-care homes, in association with the Ministry, should develop a consistent definition of what constitutes a "medication error." The Auditor also recommended that homes should ensure that medication errors are consistently identified, documented, and reviewed on a timely basis to minimize similar future similar occurrences.

We heard that one of the first priorities of the Joint Task Force on Medication Management will be to create a "made-in-Ontario" definition of "medication error" that is specific to the long-term-care sector. The Ministry explained that various definitions of a medication error already exist among nurses and pharmacists. However, there is no consistently applied definition. Currently medication errors are recorded and reported to both the Ministry in a critical incident system (CIS) report and to the home's administrator. Once the new definition of a medication error is developed by the Joint Task Force, it will be incorporated into the CIS.

Use of High-Risk Drugs

International experts maintain that certain medications are generally more harmful than beneficial to older adults. In 2006, more than 5,700 residents aged 65 and over in long-term-care homes across Ontario were prescribed at least one of a sample of eight high-risk drugs on the Beers List of medications available in Canada. Drugs on the Beers List are identified as "potentially inappropriate" for seniors due to an elevated risk of adverse effects.* In addition, these drugs were dispensed to at least 20% of the residents in 30 of the Ontario homes. The three audited homes were not among this group.

The Auditor recommended that the Ministry, in collaboration with the College of Physicians and Surgeons of Ontario, periodically review the usage of higher risk drugs at long-term-care homes.

* The Beers List was first developed in 1991 by Dr. Mark H. Beers, an American gerontologist, who created the list according to the following criteria: appropriate use of medication, effectiveness, risk of adverse events, and the availability of safer alternatives. Updated in 2002, it includes about 50 medications or classes of medications considered to pose a high risk to adults 65 or older.

During the hearings, the Ministry informed us that the use of high-risk drugs in the homes has decreased over the last five years. Subsequently, we learned from the Ministry that information published by the Institute of Clinical Evaluative Sciences indicates that for every 100 long-term-care home residents in Ontario, 7.2 were being prescribed at least one inappropriate medication in 2006/07. That rate represents a slow and steady decline since 2002/03 when it stood at 9.9.

The Committee heard that the issue of residents being prescribed inappropriate drugs will be a subject for future discussions between the Ministry and the College of Physicians and Surgeons of Ontario (CPSO). As the Committee feels that the prescribing of inappropriate drugs to residents calls out for concerted action, we are encouraged by this.

High-Risk Psychotropic Drugs

Psychotropic drugs, prescribed to address mental health disorders or behavioural problems among the elderly, have one of the highest rates of potential adverse reactions. A common condition treated with psychotropic drugs is dementia, which refers to a range of symptoms caused by disorders that affect the brain. One in 13 Canadians over age 65 has the condition.

Research published in the *Journal of the American Medical Association* has indicated that psychotropic drugs are generally ineffective in managing symptoms of dementia, such as agitation and delusions. The research points to non-drug psychological and social interventions as a more appropriate first line of treatment for dementia patients. Psychogeriatric programs care for people with challenging behavioural issues stemming from dementia.

The Auditor recommended that the homes should adopt consistent criteria for referring residents to specialized psychogeriatric programs and ensure that sufficient numbers of staff are appropriately trained in those criteria.

While the Ministry indicated in the audit report that it has provided such training to over 5,000 long-term-care home staff, the audited homes noted that only a limited number of nursing staff has had such training. During the hearings, the Ministry pointed out that the Joint Task Force on Medication Management will consider the issue of prescribing potentially high-risk medications, including psychotropics, to residents.

Drug Interactions

Between 23% and 28% of residents (at least age 65) at the audited homes were taking a dozen or more different regularly scheduled medications in 2007. Studies indicate that the likelihood of an adverse reaction increases with the number of medications taken. None of the audited homes had undertaken specific policies or procedures for increased monitoring of these residents.

The Auditor recommended that long-term-care homes monitor more closely those residents taking a new higher-risk medication, and that they also document the

results of this monitoring. As well, the Auditor recommended that homes take actions to consistently identify and document adverse drug reactions in an effort to prevent future occurrences.

During the hearings, the Ministry said that the issue of multiple prescriptions to treat residents' multiple health conditions is "on the table." There is room for improvement, and this will require engaging physicians who work in long-term-care homes (and who write the prescriptions) in a discussion about best practices in matters of medication management in this setting. The Ministry added that the CPSO is willing to engage in that dialogue with its physicians. The Joint Task Force will examine this issue as well.

Overriding of Automatic Drug Alerts

The Ministry has built information alerts for pharmacists into the Ministry's Ontario Drug Benefit program computer system. The level-1 alert is the most serious drug combination notice.

In 2006 there were 18,000 level-1 alerts warning of an inappropriate drug combination that should not be dispensed or administered. Over 90% of these alerts were overridden by the homes' pharmacists, with the drugs in question being dispensed to residents of more than 400 long-term-care homes. The Auditor's Report noted that pharmacists may have contacted the prescribing physician to obtain approval to override the alert.* And many alerts may simply be repeats as the system generates the same notice each time the prescription is filled.

The Auditor recommended that the Ministry, in collaboration with the College of Physicians and Surgeons of Ontario, review the frequency with which residents receive drugs which set off unique drug-to-drug interaction alerts, and to take appropriate follow-up action where the use of higher-risk drugs and pharmacy overrides of alerts seems disproportionately high.

The Ministry explained that with over 19 million prescriptions filled for residents of the homes annually, the 18,000 level-1 alerts in 2006 represent 0.095% of total prescriptions.

When Committee members asked if they should stop worrying about the overridden alerts, the Ministry responded that the alerts serve a purpose. They are an appropriate flag and clinicians do need to be cautious around the use of certain drugs. The Ministry takes comfort that these flags are in the system and require the pharmacists to make a conscious decision as to whether they are going to dispense the drug or not.

---

* The Ministry's written comments in the Auditor's Report state that the Auditor General's observations on drug-alert overrides and medications that may be contra-indicated for seniors reflect upon physicians' prescribing practices.

The Ministry added that pharmacists have to use their professional judgment to determine the appropriateness of dispensing the drug. Furthermore, it is a standard of practice that if pharmacists identify any concerns regarding a prescription, they will contact the prescriber to verify the use and need for the prescription.

The Committee has drafted a series of recommendation to address the above-noted issues.

RECOMMENDATIONS

The Standing Committee on Public Accounts is strongly concerned about the over-medication of long-term-care home residents and concludes that the present compensation mechanism for physicians and pharmacists should be restructured.

Therefore, the Committee recommends that:

1. The Ministry of Health and Long-Term Care review possible changes to the compensation framework for physicians and pharmacists regarding residents of long-term-care homes with one objective being to ensure that residents are not over-medicated. More specifically:

   - the Ministry should assess whether the OHIP fee schedule adequately encourages physicians to conduct more in-depth, geriatric-focused assessments of long-term-care home residents which can assist in identifying health problems related to over medication; and
   - the Ministry should consider removal of the exemption for long-term-care homes in s. 18(8)(b) and (10) of O. Reg 201/96 under the *Ontario Drug Benefit Act* from the prescribed limits on the payment of dispensing fees set forth in s. 18(7) and (10). The Ministry should report back to the Committee indicating whether it agrees with this recommendation. If not, the Committee seeks an explanation from the Ministry as to why it has exempted long-term-care homes from the provisions.

   The Committee acknowledges that any potential changes will need to be discussed with the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists. The Ministry should report back to the Committee by December 31, 2009 on the results of its review and discussions with the two Colleges.

2. In view of the Auditor General's findings that between 23-28% of residents at the three audited long-term-care homes were prescribed 12 or more different medications—which increases the risk of an adverse event—the Committee wishes to see the development of a process to oversee the continuing health and safety of residents taking more than a specified number of medications. For example, the Ministry of Health and Long-Term Care could explore the development of a periodic mandatory review—conducted by a specialist or a multi-disciplinary team—of those residents taking more than a specified number of medications. The Ministry should report back to the Committee on whether it agrees with this recommendation and, if so, what actions it proposes to take. If the Ministry does not agree, the Ministry should report to the Committee on why it disagrees.

3. The Ministry of Health and Long-Term Care provide an analysis to the College of Physicians and Surgeons of Ontario (CPSO) of the Ontario Drug Benefit database which reports on physicians' prescribing patterns in long-term-care homes. The Committee would like to see a decrease in the prescribing rates of inappropriate or higher-risk drugs (such as those on the Beers List) to residents in long-term-care homes—particularly in those homes where a significant percentage of residents are being prescribed the same higher-risk drug. The Ministry should report back to the Committee with an update on the results of this, including how the CPSO has used this data.

4. The Ministry of Health and Long-Term Care examine the feasibility of requiring each long-term-care home to post annual statistics (and in the future, trend data) on the average number of prescriptions dispensed to each resident and the percent of residents being prescribed higher-risk drugs (such as those on the Beers List). The Ministry should report back to the Committee on whether it is willing to implement this initiative, and if so, when.

With respect to other issues discussed during the Committee's hearing, the Standing Committee on Public Accounts recommends that:

5. The Ministry of Health and Long-Term Care provide to the Committee a report regarding the deliberations of the Joint Task Force on Medication Management. The report should outline the specific issues the Task Force is expected to address, and when its recommendations are going to be made. It is the Committee's expectation that among the Task Force's other matters, it will consider the issues of informed consent to treatment with medication and medication errors.

6. The Ministry of Health and Long-Term Care provide to the Committee a report within 90 days of the Ministry receiving the recommendations of the Joint Task Force on Medication Management. The report should outline the actions the Ministry plans to take for each recommendation.

7. The Ministry of Health and Long-Term Care undertake efforts to require long-term-care homes to abide by Ontario's *Health Care Consent Act, 1996,* particularly with respect to informed consent to treatment with medication. The Ministry should report back to the Committee on the results of its efforts, indicating how it plans to monitor the homes' degree of compliance with the Act.

8. The Ministry of Health and Long-Term Care expand the training of long-term-care staff (beyond the 5,000 already trained) in techniques which seek to deal with resident dementia-related behavioural problems. In addition, the Ministry should consider other interventions or options to deal with residents' behavioural problems before resorting to drugs. The

Ministry should report back to the Committee indicating the progress of these initiatives.

9. The Ministry of Health and Long-Term Care should report to the Committee indicating whether it plans to utilize information in the Ontario Drug Benefit database to identify trends or abnormally high rates of pharmacists overriding unique drug interaction alerts. The report should also indicate whether the Ministry has shared this information with the College of Pharmacists.

Except for Recommendations no. 1 and 6 where we have put forward a different time frame, we ask the Ministry of Health and Long-Term Care to provide the Committee Clerk with a written response within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly.

The Chair of the Standing Committee on Public Accounts has written to officials of the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists asking them to report back to us after reviewing our Report with their position on these Committee recommendations that affect their members.