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Mercredi 12 mai 2010

Standing Committee on Public Accounts

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Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2009,
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Chair: Norman W. Sterling
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Hansard Reporting and Interpretation Services
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday 12 May 2010

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Mercredi 12 mai 2010

The committee met at 1229 in committee room 1, following a closed session.

2009 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.06, infection prevention and control at long-term-care homes.

The Chair (Mr. Norman W. Sterling): Good afternoon. My name is Norm Sterling. I'm the Chair of the public accounts committee of the Legislature. Today, we are going to consider section 3.06 of the 2009 Auditor General's report dealing with infection prevention and control at long-term-care homes.

In addition to witnesses and people from the Ministry of Health and Long-Term Care, we also extend a welcome to people from Extendicare Canada Inc., Nisbet Lodge and Provincial Long Term Care Inc. Thank you for coming. We hope you find the hearing informative, but we do appreciate your help as well.

We open today with a statement by the deputy minister, Saäd Rafi. So I would ask you, Mr. Deputy Minister, to proceed with your opening remarks.

Mr. Saäd Rafi: Thank you, Chair, and good afternoon. First, on behalf of the ministry, I'd just like to thank the Standing Committee on Public Accounts for the opportunity to talk to you about the Auditor General's report on infection prevention and control in long-term-care homes. As you mentioned, we have representatives from the homes with us as well. I'll leave them to introduce themselves and their team members. I believe they'll also be offering some brief remarks, as will I.

Let me just start by thanking the auditor and his team for what was, I think, some very thoughtful work and some helpful work to the ministry. Clearly, the ministry takes the health and safety of residents of Ontario's long-term-care homes quite seriously, and we feel it's of paramount importance to the ministry as well.

Long-term-care facilities, as we all know, are home to some of Ontario's most vulnerable citizens, and the ministry takes seriously our role in protecting and promoting their health and well-being.

Our concern and commitment to long-term-care residents has led to the government achieving the most substantive legislative change aimed at the long-term-care sector in decades. The Long-Term Care Homes Act, 2007, will come into full force and effect on July 1 of this year, when the accompanying regulations take effect.

Countless people have dedicated years to ensuring long-term-care reform is put in place that will safeguard the quality of life and health of residents across the province.

In the area of infection prevention and control, the new act categorically raises the bar on the steps and procedures that long-term-care homes must have in place to protect their residents. It also establishes a much more comprehensive inspection process regarding infection prevention and control. I'd like to underscore the following imperatives that the new act puts into place:

—Provincial inspection will include a detailed annual review of the infection prevention and control program, its procedures and the responses at each of the more than 600 long-term-care homes in Ontario.

—All long-term-care homes will have an infection prevention and control program that includes daily monitoring to detect the presence of infection in residents, as well as measures that prevent the transmission of infections.

—They will have to provide and track various prevention measures, including hand hygiene programs and the immunization of their residents.

—The act will require homes to ensure the presence of infections in residents is monitored and recorded and that this information is analyzed daily, reviewed at least once a month to detect trends, with the aim of reducing the incidence of infections and outbreaks.

These enhancements of infection prevention and control measures are in keeping with some of the best practices set out by the Provincial Infectious Diseases Advisory Committee. The changes will also address a number of the issues and concerns raised in the Auditor General's report.

Further to this, the province is also in the process of a massive redevelopment to modernize long-term-care beds across the province. The ministry knows that newer long-term-care homes have fewer infections. The three homes audited in the report were designed to specifications dating back to 1972.

The province has worked continually to modernize long-term-care beds, introducing 20,000 new beds between the years 2000 and 2006. The current redesign plans call for larger rooms that have a maximum of two

beds and that all have wheelchair-accessible washrooms. This will help homes to keep residents with infectious diseases adequately separated. The ministry plans to redevelop 35,000 beds in older long-term-care homes over the next decade to improve the quality of those accommodations.

Thirty-seven long-term-care homes, representing approximately 4,200 beds, have already committed to the redesign during phase 1 of the strategy, and the goal is to renew approximately 7,000 beds every two years. Phase 2 of this bed redevelopment is slated for early 2011.

I'd also like to make it very clear that I well appreciate that infection prevention and control in long-term-care homes is a complex and multi-faceted issue. They are first and foremost homes to elderly residents, who are more susceptible to acquiring infection because of their age and health conditions. Of course, every home is unique, with a different population mix.

Infections can be acquired in a range of settings, including hospitals and the general community, and brought into the home as well. The complex continuum of infection prevention and control requires us to embrace a systemic and collaborative approach in protecting residents from the spread and transmission of infections.

There are five distinct partners in the health system that are responsible for infection prevention and control. They all have complementary roles with respect to inspection, regulatory oversight, accountability, best-practice promotion and capacity-building. They are:

—the ministry's performance improvement and compliance branch, and I have with me Tim Burns, who's the director of that branch;

—the public health division in the ministry, which has a strong partnership with the local public health units across the province;

—I mentioned the Provincial Infectious Diseases Advisory Committee;

—14 regional infection control networks; and, of course,

—the local health integration networks themselves.

All these partners work closely together but play very distinctive roles. For example, the regional infection control networks, the RICNs, are designated to coordinate infection prevention and control activities and also to try to promote a standardized set of practices in health care facilities across Ontario.

PIDAC, or the Provincial Infectious Diseases Advisory Committee, provides the chief medical officer of health and her colleagues across the province with advice on issues such as standards and guidelines for infection control and emergency preparedness for any infectious disease outbreaks.

The compliance branch is responsible for monitoring, inspecting and evaluating whether all long-term-care homes in Ontario comply with a range of provincial requirements. But what is most crucial is that all the essential players are working in concert to promote and protect the health of long-term-care residents.

Collaborating with health system partners plays an important role in enhancing infection prevention and control at long-term-care homes. It's through partnership that the Just Clean Your Hands hygiene program was specifically adapted to the sector in October 2009 and implemented in homes at the beginning of this year.

Through partnerships, the ministry assembled a joint task force on medication management that examined issues related to medication management in homes and their impact on the quality of care and the quality of life of residents. Through collaboration, the ministry will in the fall of 2010 engage the regional networks, homes and other stakeholders to discuss how best to meet the recommendations of the 2009 PIDAC best-practice document, which helps in routine practices and precautions in all health care settings, not just long-term-care homes.

This is a community that will continue working diligently in partnership to ensure that some of Ontario's most fragile citizens are offered the protections they deserve.

I would like to turn it to the heads of the long-term-care homes who are with us today. They can introduce their team members and perhaps say a few words. I think we'd all be pleased to take your questions after that.

NISBET LODGE

The Chair (Mr. Norman W. Sterling): Just state your name and then make your presentation. Perhaps we can go down the line, so to speak.

Mr. Glen Moorhouse: Good afternoon. My name is Glen Moorhouse. I'm the executive director at Nisbet Lodge. Just behind me in the back row are Ama Amoa-Williams, who is our director of care, and Roxanne Adams, who looks after human resources and staff education.

We're pleased to be able to share with you some background on our organization and provide a few general comments on the Auditor General's report on infection control.

First of all, I'd like to say just a little bit about who we are and what we do. Ama is a registered nurse who has worked in long-term care and acute care for about 15 years. She has been Nisbet's director of care for the past three years. She also works part-time at Toronto East General Hospital. This is a valuable connection for us since it is our local hospital.

Roxanne Adams is director of human resources and staff education and also oversees continuous quality improvement. She has nine years' experience in the long-term-care field, some of which was at Extendicare. Prior to coming to Nisbet she had a private human resources practice. She also has her masters in adult education and has taken the administrators' course through OANHSS.

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One of the innovative projects she has been involved with is benchmarking quality indicator data with 20 other homes. This informal network is called the Alliance Group of Homes.

I have worked in the seniors' field for the past 30 years; I don't have my senior's card quite yet. About one

third of the time has been spent in long-term care and the other two thirds in the community sector. Over the last eight years I have been the executive director at Nisbet Lodge, and prior to that was ED at the St. Clair O'Connor Community.

Nisbet is a faith-based charitable organization that has served the seniors of east Toronto since 1973. Nisbet provides both long-term care and seniors' housing. Nisbet is a 103-bed long-term-care home; and McClintock Manor, a 62-unit seniors' apartment building.

Nisbet opened in 1973 and originally was a retirement home. By the early 1980s, those first residents had aged in place. The home was funded for two floors of what was then called extended care, and eventually the whole building became a charitable home for the aged. Nisbet has been accredited with Accreditation Canada since 1997.

Nisbet is a C home and, as such, has to redevelop within the next 10 years. The board has had an active redevelopment committee in place for some time. It is currently exploring redevelopment options that will allow the organization to continue to provide long-term care in the Toronto Central LHIN.

McClintock Manor opened in 1993 and provides a mix of rent-geared-to-income and market accommodation. It was designed as a continuum-of-care model whereby people can move in while independent, access home support services and then, if their care needs increase, move to the lodge.

Through the years there have been many examples of people transitioning from the manor to the lodge. People have also moved into McClintock to be closer to their spouse in the nursing home. The readers of the Beaches-East York Mirror have voted Nisbet as best in the retirement category for the last four years.

Nisbet is blessed to have over 90 volunteers who provide valuable assistance. Without them we would not be able to do all that we do. They help out in many ways, such as providing friendly visiting, serving on committees and feeding in the dining room.

The organization also operates a charitable foundation that raises funds for projects that benefit the residents. Over the years, these have included new hospital beds and resident room furniture and renovating the dining room and lounges. The current campaign, Planning for the Seniors of Tomorrow, is aimed at providing the professional expertise needed to redevelop the home from a C to an A facility.

In terms of the Auditor General's report, we are generally supportive of the recommendations. In fact, about 75% of the recommendations have been or will be in place by June 30. Some of these are:

—updated our infection prevention and control manual;

—implemented the ministry's Just Clean Your Hands program;

—connected with our local regional infection control network and hosted the train-the-trainer program for our area;

—created a housekeeping room-cleaning checklist;

—updated policy and developed a screening tool for FRI;

—updated policy and instituted twice-daily cleaning of rooms where C. difficile is present; and

—arranged for our infection control practitioner to receive formal training this fall.

There are two areas that our home flagged during the audit. The first has to do with resources. Nisbet generally does a good job in the area of infection control. Last year, in fact, we did not have an outbreak. We certainly think that infection control is very important. However, to fully implement and sustain these recommendations and those in the new long-term-care act, additional resources are required.

Nisbet is a stand-alone non-profit that does not have the benefit of a corporate head office—sometimes we wish we had one—or the economies of scale of a larger organization. PIDAC recommends that homes have one full-time infection control practitioner per 150 to 200 beds. Certainly at our home, infection control is just one hat worn by one of our registered staff. The auditor's report indicated that the actual number across Canada is 0.6%. We are members of OANHSS and support their recommendation to the ministry on this issue. Their recommendation was that, given the difficulty of finding these highly qualified personnel across the province, the focus should be on providing homes with the resources in the areas of staffing, education and actual infection control expenses.

The second area has to do with cohorting of residents with infections. As the deputy minister said, long-term-care homes are, first of all, homes. The recommendations may be appropriate in acute care but certainly not in our current facility, especially given that residents pay to live in the home. Nisbet does have the benefit of an infirmary, which is used in some situations. The ministry has indicated that this matter will be addressed through the new design standards associated with A homes.

Nisbet was the first home to be audited. I want to say that we found the auditor's team to be very professional and approachable.

In closing, I want to thank the members of the committee for your time and interest in this area. We'd be pleased to take questions at the right time.

The Chair (Mr. Norman W. Sterling): Thank you very much, Mr. Moorhouse.

In that the legislative building is a C-class building, I would invite anyone to remove their jackets, because it tends to get warm in here.

Please proceed.

Mr. David Ramsay: Are we getting rebuilt?

Mrs. Liz Sandals: Only the foundation.

The Chair (Mr. Norman W. Sterling): They can only do so much with this building.

Go ahead.

PROVINCIAL LONG TERM CARE INC.

Ms. Christine Ozimek: Good afternoon. My name is Christine Ozimek and I am chief operating officer of

Provincial Long Term Care, which operates five long-term-care homes across Ontario, including Regency Manor in Port Hope. With me today and seated behind me is Catherine Allison, our director of operations for nursing services for all of our homes.

I speak on behalf of our company and on behalf of over 350 employees whose job is to provide best-in-practice care for residents across Ontario. Regency Manor is home to 60 long-term-care residents. Within that complement, we have 56 long-stay residents and four beds designated for short-stay or respite care residents.

I want to start by saying that like my colleagues who are with me today, the safety and care of the residents of our home are at the core of what we do. Families entrust us to care for their loved ones and in turn, we know that it is our responsibility and our duty to provide their vulnerable loved ones with the highest level of care possible. It is for that reason that we were very pleased to work with the Auditor General on this report. We appreciated the constructive approach the auditor and his staff took to understanding the impact infection can have in long-term-care facilities. We appreciated the focus on using both science and best-in-practice care standards for reducing the risk of infectious disease from spreading to or among our residents.

We are working together with the Ministry of Health to ensure that the most effective steps possible are being taken for the prevention and control of infections in our facilities. As a result of the work with the auditor and his staff, Regency Manor is pursuing initiatives pertaining to all four areas of recommendations arising from the report, with progress being made in all areas.

Here's a real-life example of some steps that we have taken to reduce the spread of infection in our facilities. I'm sure that if any of you have walked into a hospital or a long-term-care facility in Ontario, you would have seen hand sanitizers installed at virtually every entrance or exit. That's a very visible sign to people entering facilities, both staff and visitors, to use preventative measures to stop infection. The importance of hand hygiene is highlighted in this report and others before it.

As a result of working with the auditor, we have a renewed focus on handwashing. Before the auditor's report, our homes had hand sanitizer available at the entrances, exits and various stations within the home. We know that washing hands before and after contact with residents or their environment is a key aspect of preventing the spread of infection.

Some changes are being made in our homes with regard to this. To facilitate appropriate handwashing at the correct times, we are increasing access to hand sanitizer throughout our homes with the installation of permanent stations in each resident room. Additional surveillance of handwashing is taking place with monthly monitoring. Staff education is emphasized and aided through the use of Glo Germ, a product that, when coupled with UV light, demonstrates any contaminants left on hands after washing. These are simple acts, yet part of improving the process and outcomes as a whole.

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In addition to implementing the recommendations of the auditor's report, we have taken further steps to help fight infection in our facilities. As recommended in the report, the use of antibiotics is periodically reviewed in our homes. Currently, the information available to us is primarily the number of prescriptions in the home by antibiotic type for individual residents or on a population basis. This information has limited use.

To improve antibiotic stewardship, antibiotic prescribing needs to be tracked against the type of infection for which it is indicated. To do this, we contacted our pharmacy, MediSystem. I am pleased to report that MediSystem has agreed to implement a change to its database that will allow for tracking and reporting on this type of information. Tracking and reporting gives us the tools to make changes to antibiotic use and creates safer homes for our residents. It is anticipated that the change will take place in the second quarter of this year and will be made available to all providers that MediSystem serve. I should note that MediSystem provides pharmacy services for many providers in the province of Ontario, representing over 20,000 seniors.

To conclude, I wish to express my thanks to the auditor, the Ministry of Health and your committee for working together on finding and implementing the most effective solutions to solving this issue. As demographic changes occur and our society ages, we know this will continue to be an issue that we have to stay on top of and, in fact, for which we need to be ahead of the curve. We must continue to be vigilant in working together to do everything we can to use the most up-to-date science and best-in-practice measures to reduce and prevent the spread of infectious disease among the residents of our long-term-care facilities.

We were pleased to receive the auditor's recommendation and found the audit process to be an opportunity to learn and improve. We continue to make progress in implementing changes in response to this report.

The Chair (Mr. Norman W. Sterling): Thank you very much.

Mr. Tuttle.

EXTENDICARE CANADA
EXTENDICARE YORK

Mr. Paul Tuttle: Good morning, and thank you for inviting Extendicare to be with you here today. My name is Paul Tuttle, and I am the president of Extendicare Canada. With me is Sandra Moroso, administrator of Extendicare York.

Extendicare is a Canadian company that was founded in 1968 and is now one of North America's largest long-term-care providers, with 258 senior care centres and capacity for approximately 28,800 residents. We operate 82 homes across Canada, with 58 of them in Ontario. In addition, we operate ParaMed Home Health Care centres in 22 locations across this province.

Extendicare is committed to continuous quality improvement. Our department of quality and performance improvement is headed by a vice-president and is responsible for supporting and implementing quality initiatives across the organization.

Our goal is to maximize the quality of care, quality of life and, fundamentally, the safety of residents in our homes. In these three baskets I would place infection control in the safety basket similar to, for example, fire safety. So just as we have installed sprinkler systems in all our homes and have hired a fire safety inspector, we continually want to do our best with infection control. We have two certified inspectors in the company and our aim is to have more.

Extendicare York in Sudbury was the home that was selected to be a part of the infection prevention and control audit. York is a home that has faced its fair share of challenges. The building is over 35 years old and is home to 288 residents, so it's a very large older building. The staff is led by Sandra Moroso, the administrator, who is here with me today and who you will hear from shortly. Her commitment to her residents and her ability to empower her team are commendable. Being an administrator in long-term care, especially in the current changing environment, is one of the toughest jobs in health care, in my view.

Extendicare York is a home that has had challenges and today you will hear how York has implemented a number of measures to continue the improvement of their infection prevention and control programs. They have seen a significant reduction in the length of outbreaks and a reduction in the number of affected residents. I know that Sandra, who has expertise and experience in infection control, would be pleased to share more detail with you on these measures.

In conclusion, I thank the Auditor General for this report and others concerning long-term care as they have provided us an opportunity to evaluate our practices and to continuously improve upon them.

The Chair (Mr. Norman W. Sterling): Thank you very much, Mr. Tuttle.

The function of the committee is to take the auditor's report and try to make—or we will make—recommendations primarily directed at the Ministry of Health. But it really is our goal to try to improve the administration, to help senior managers impress upon employees, directors or people who are working under them to co-operate and try to improve the system. We know that your challenges are significant in the setting you are in. As well, I'm sure you're aware that we did a report on this very same subject in terms of acute care hospitals two years ago—I think in late 2008—and we recognize that there's a great difference between a home and a hospital.

In that light, we would invite any one of you, particularly those people who are from the operating sector, to make suggestions to us as we go through as to how we can encourage not only your homes but all homes in Ontario to improve their control over infectious diseases.

We'll now move to questions. Mr. Shurman?

Mr. Peter Shurman: Thank you very much, all of you, for being here and for the interesting presentations.

We get a number of different things—we meet every week in this committee—and sometimes our jaws drop when we hear horrific stories. This is not one of them. This is, as the Chair has suggested, a bit of give and take, because having had some personal experience with long-term-care facilities, I think, by and large, you do a pretty good job. So my questions will be more to elicit information than to try to cast aspersions or blame.

I'd like to quote from some of the material that was provided to us in briefing and then ask you about it. This is relative to information lacking on health care-associated infection cases in long-term-care homes. What it said was: "Although the ministry ... has introduced a number of initiatives to help prevent and control infectious diseases in long-term-care homes, it" lacks "information on the total number of cases of most HAIs in" these "homes. The information collected at the homes" visited by the audit team "was generally not comparable because the homes defined and counted HAIs" differently.

I suppose I'd like to start with the deputy minister and ask: Why is there a lack of reporting and so much inconsistency in the reporting?

Mr. Tim Burns: It's Tim Burns. I'll try to answer on behalf of the ministry.

I would emphasize that I think with the public reporting on compliance records, the public reporting that's available now through the Ontario Health Quality Council and the public reporting on patient safety, there is an overriding commitment to get to a point where we can report publicly with comparable information.

The state of play now is that we're not far enough along in having specifically comparable symptomology that could be comparable from home to home, and we need to consider as well the administrative burden that that might place on homes. So it's a case, I would suggest, where we are continuing to follow through on the general commitment to publicly report but haven't yet got the methodology for it.

Mr. Peter Shurman: If I can reduce that to about 10 words—and I'm not being a smartass here—this is about pulling things together. It's not a lack of will; it's about getting things on side.

Specifically, would there be, at this point, a web-accessible reporting form, for example, that would put standardized information into a central database—but interpret what you're saying as: Not everybody in every home would be using it in the same manner?

Mr. Tim Burns: Yes. I don't think the methodologies have caught up to our technical capabilities. We have the technical capability; we don't yet have the methodologies that would be consistently in use in our communities.

Mr. Peter Shurman: In order for the public or for us to know that from home to home to home—making informed decisions, for example, on the placement of our loved ones—how would we get any benchmarks if

indeed what you're telling us is, and I believe the auditor also underscored this, there are no benchmarks?

Mr. Tim Burns: I think I have to say that I accept that. We have to work toward them, toward comparable measures which could be fairly and efficiently publicly reported, but we don't have them as of today.

Mr. Saäd Rafi: If I could just add: I think that if you're making a relative choice, we're trying to report on the effectiveness, the service, and resident satisfaction, and then move to other indicators as well. Obviously we need to do more work on the methodology with infectious diseases, but we're also trying to assess the effectiveness, service and quality of homes themselves. That's what our inspection methodology is about. That's what the public reporting through the Ontario Health Quality Council is striving to do for all homes starting in 2011.

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Mr. Peter Shurman: I think there's a fair amount of concern, not so much with the idea of a regulatory environment that says, "Here's what you're going to do because at the end of the day we'll get the following result"—that seems to be in place. What doesn't seem to be in place is that consistency and that ability for all of us out here who are not experts in the field or members of the Ministry of Health to rely on the information we're getting.

I'll cite an example that came up again in the auditor's report. Infection control professionals, or ICPs: In most but not all cases, an ICP has been appointed. If my memory serves, the auditor found that there were two appointed in two of the three homes you studied and one didn't have the ICP.

Mr. Jim McCarter: Yes, a number of them were appointed but—and this is the same, really, across Ontario—many of them don't have the designation. I think one of the introductory comments referred to that as being a challenge.

Mr. Peter Shurman: My concern is that the regulation that requires an ICP to be appointed in each home isn't met, apparently, at this point. So, notwithstanding the regulation that there be one, it almost seems like in businesses over a certain size in the province of Ontario, you have to have an appointed person for security and safety, and he or she has to hold meetings every once in awhile. We all know that in larger companies maybe it's done and in ones that are closer to the limit maybe it's not or maybe there's just a name attached to that position.

What is the situation now with regard to ICPs and the consistency of enforcement of that aspect? And take it beyond that and talk to us about the training that is or isn't there for this person.

Mr. Tim Burns: I'd like to start the answer to that question, and I'm going to call on my colleague Lyn Fabricius, because you went on to the inspection and enforcement side—

Mr. Peter Shurman: I went on a little longer than I'd like to, but I think it's an important aspect. Please take all the time you need.

Mr. Tim Burns: It may have been obvious from some of the deputy's remarks that this particular system is undergoing a great deal of change at the moment. We have requirements that are now in a manual which, come July 1, will be updated and incorporated into the regulations.

I'll speak about the manual, which has been in place for some years. That now requires all homes to have a designated infection control program lead, and that person is responsible for planning and evaluating the ongoing training of all staff in appropriate prevention control measures. So that's a general requirement that has been in place.

We actually have a colleague here who's quite a bit more expert in this area than I am, who can talk about what we would expect of that person, their general duties, and then what we would do to make sure that those duties are being performed—

Mr. Peter Shurman: I'd like to hear that colleague talk about those duties and then, after she does, I'd like to hear whether or not we have the ability to rely on the ministry to tell us that 10%, 20%, 30% or 100% of homes in the province have a person of that quality or calibre.

Ms. Lyn Fabricius: I'm Lyn Fabricius. I'm an environmental health adviser with the ministry and I'm one of the ones who specifically inspects against infection prevention and control in the homes.

I would say that 100% of our homes have a designated person who we call an infection control practitioner. We check for that on inspections on an annual basis. As the experts, the environmental health advisers check for that, as well. They have the requirement to hold meetings; we don't say how many, but it's usually quarterly in the homes. The ICP is required to do monitoring, surveillance, statistics and some trend analysis, as well.

I think what the challenge is and where some confusion is, is that as recently as perhaps five or six years—and what PIDAC speaks about is that they want the ICPs to have their certification in infection control, CIC, and that has been a little bit of a challenge. It's usually done by nurses while they are still working—and health inspectors can be CICs, as well. They're usually working in the homes doing this. So I'm hearing it takes about two years, on average, to take the course because they are working full-time. Our regional infection control networks throughout the province are really helping out with this particular program, but it's relatively new, so we don't have that many in place.

Mr. Peter Shurman: You don't have that many in place, which means that the answer to my question—are we consistent and in place in 100% of cases?—has got to be, at this point in time, no.

Ms. Lyn Fabricius: No. We have 100% infection control practitioners in our homes, but they don't have that certification in infection control. That's the difference

Mr. Peter Shurman: Okay, six of one, half a dozen of the other.

Ms. Lyn Fabricius: Yes, okay.

Mr. Peter Shurman: What's the degree of reliability—and I'll direct this to the deputy minister.

Apparently, we have 100% in place, but we don't have 100% training. What's your deadline, or what's your target, for having people in those homes who are fully trained and capable?

Mr. Saäd Rafi: We haven't established a deadline. We have regulations that will come into effect, and we'll be monitoring, evaluating and inspecting against those regulations. We'd be happy to talk to you about what the inspection requirements are as well as penalties associated with inspection for violating regulatory requirements.

This is a movement that was done over some time, through consultation with the homes. It is one of several recommendations that came out of consultation as well as our own legislative and regulatory requirements.

We haven't put a fixed date on that requirement because we want to give homes the ability to get their individuals trained and in place. Once the regulations are in place, that will give us a little bit more by way of enforceability.

Mr. Peter Shurman: Let me move on to another—again, I'll quote one sentence from our briefing material. The RICNs—that's the regional networks—noted in 2008 that "only 15% of non-acute-care facilities (primarily long-term-care homes) used external benchmarks, and 21% did not use any benchmarks at all." Why would that be? That's startling to me. In fact, I would even use the word "frightening," because benchmarks suggest that we can measure things across the board on a consistent basis, and apparently the auditor has found we can't.

Mr. Tim Burns: Bear in mind I'm a layperson, so I offer this with modesty. As I reviewed the materials in preparation for this discussion, what struck me was the emphasis in the PIDAC materials themselves on surveillance and the specifics of an individual and the symptoms they're presenting, and how different the dynamics of infection can be from home to home—even within a home—and from community to community, so the straight use of benchmarks sometimes could actually be unhelpful or misleading. It's really essential to look at the symptoms that are being presented by individual residents and to surveil them constantly.

Mr. Saäd Rafi: Could I also add that what everybody learned post-SARS caused the development of PIDAC, the committee. Infectious disease outbreak management and methodologies associated with that have really come into the public health realm in only the last several years. I think it's a learning exercise for people in health care overall, not just in long-term-care facilities but in public health, in acute care and elsewhere.

I think these individuals will respond in a minute about their own embracing of these requirements: the government and the ministry's approach to fundamentally restructuring the sector through legislative reform and now regulatory reform.

Those findings are not disputed, certainly, but are also an opportunity to continue to drive the type of change that is really fundamental to the sector.

The Chair (Mr. Norman W. Sterling): Mr. Ouellette's going to finish off the next six minutes of this round.

Mr. Jerry J. Ouellette: A couple of questions: We know that there is patient movement through a number of the facilities in these homes—location, preference and moving into a preferred location. What are the protocols for infection notification within the facilities? Are there first protocols internally; externally within the entire system; and then throughout the entire health care system? When we dealt with infection control in the past, one of the key concerns was the ability to notify other sectors within various areas. What are the protocols that you have established internally and externally?

Mr. Paul Tuttle: If I understand your question correctly, you're talking about—

Mr. Jerry J. Ouellette: You have an infection in one location. On a regular basis, we see patient transfer from one location to get to a preferred location, for family reasons, for spousal reasons, for all sorts of reasons. There must be some form of notification within all the facilities for understanding of what infections are taking place and the potential of transfer of infectious diseases throughout numerous facilities.

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Mr. Paul Tuttle: With the Chair's permission, I'm going to call on Sandra Moroso, who is with us at Extendicare York. She can tell you in a more concrete way what happens. I can tell you that many of our infections are acquired when people come back from hospital. You wouldn't always know, but you should know and, in most cases, would know. There are certain protocols we have on admission—screening processes—which, again, with your permission, I think Sandra could talk about. It would be very enlightening for the committee.

The Chair (Mr. Norman W. Sterling): Good. I think when we were doing the hospitals on the same subject, they were saying that they might get a patient from a long-term-care facility who would bring an infectious disease to them, but it wouldn't necessarily be divulged, or it was unknown. There just didn't seem to be a protocol from here to there. We're interested in the transferring of relevant and important information. As well, we're interested in trying to determine who should be overseeing this. Should it be the LHIN? Should it be the Ministry of Health?

So you're going to call forward—

Mr. Paul Tuttle: I'd like to call Sandra to talk about specifics.

Ms. Sandra Moroso: Just to answer your question, it's multi-faceted. If a home is in an outbreak, public health is notified immediately, and they're the ones that determine the outbreak.

Mr. Jerry J. Ouellette: Is it one case that causes—is that the standard for an outbreak?

Ms. Sandra Moroso: There are criteria that have been developed by the PIDAC document. For example, for a respiratory outbreak, if there are two cases over a 24-

hour period, we notify public health, and public health will determine whether or not we continue to do our surveillance or whether or not we actually go into an outbreak.

If we go into an outbreak, public health will determine the outbreak, and they will communicate that to our community providers. In terms of the community providers, they contact CCAC so that they're aware of whether or not we can receive admissions or discharges from our home, and they will tell us whether or not we can discharge to another long-term-care home.

If a resident requires emergency services to the hospital, we do transfer residents who may be in an outbreak to the hospital. There is a transfer form that we use, and we indicate on the transfer form that the home may be in outbreak. If the resident is one of the residents who are actually affected, we do put that on the form as well to communicate that to the hospital.

Over the last couple of months in Sudbury, we have had a very unique partnership with our hospital: the nursing outreach program. This program is on a trial basis. An emergency nurse will come into the long-term-care home to provide some urgent care. We're trying to reduce the number of transfers from long-term care to the hospital. We've just initiated this program.

Part of what the nurse will do is provide urgent care in our home, and if the resident requires urgent care or has to be transferred to the hospital, she will follow the resident in the hospital and provide us feedback when the resident comes back. If, for example, the resident is exposed to something at the hospital, she'll let us know that so that we can prepare and ensure that we have our protocols in place when we receive the resident back.

Mr. Jerry J. Ouellette: Is there any communication between the various facilities? Using the Sudbury example: You have the outbreak and it goes to the hospital. Are there other facilities in Sudbury notified of that outbreak?

Ms. Sandra Moroso: We go through our community care access centre. There's not a public announcement through public health. There are times when public health will make a determination that they're going to let the public know about an outbreak. It depends on the severity of the outbreak. I have heard on the news, as an example, that there might be a Norwalk outbreak in our community, but that's public health's call.

Generally, we try to do it through the system, so if we're transferring a long-term-care resident to another long-term-care bed, CCAC will make that call to the other long-term-care home. It is their decision whether or not they accept the resident.

Mr. Jerry J. Ouellette: Okay.

The Chair (Mr. Norman W. Sterling): Could I just ask, is the procedure consistent or the same in the other nursing homes that we're talking about?

Ms. Christine Ozimek: Yes, it is.

Mr. Glen Moorhouse: We're also part of the emergency outreach program through our local hospital as well—

The Chair (Mr. Norman W. Sterling): And are all 600 nursing homes across Ontario in that?

Mr. Tim Burns: Yes—and I hope we'll see nods at the other side of the table.

On the question of a transfer of a resident from one home to another, the receiving home would treat that person as a new admission and would implement all the appropriate screening protocols they would for any new resident coming into their home. So, on the receiving side, there would be no distinction between a transfer and a new admission, I don't believe.

The Chair (Mr. Norman W. Sterling): And the hospital would get the same kind of information? I'm not seeing a lot of nods.

Mr. Glen Moorhouse: We also use the transfer document that my colleague mentioned.

The Chair (Mr. Norman W. Sterling): So the hospital receiving somebody from the long-term-care facility would know that the patient had C. difficile or—

Interjections: Yes.

The Chair (Mr. Norman W. Sterling): Ms. Sandals.

Mrs. Liz Sandals: Ms. Carroll has some questions too.

Actually, I find it quite comforting that public health has the lead role in managing infection notification. That's actually what I always understood, in terms of outbreaks.

On this whole business of baseline, it seems to me, particularly in the case of something like C. difficile or MRSA, that you're dealing with something that's likely to be hospital-acquired, and in those instances at least, the baseline is almost what's going on at the neighbourhood hospital and who's coming back from hospital with those infections, as opposed to some absolute background baseline.

Anyway, I wanted to ask about consistency and then public reporting. In one of my local long-term-care homes a few years back, they were talking to me about a pilot they were involved in, which seemed to be a common assessment tool. I'm wondering what has become of that over the last few years and how that would help with common measurement and common communication. Has that matured to be helpful?

Mr. Paul Tuttle: I can speak to that, and I'm sure others might add.

One of the things the ministry didn't mention but is a very good thing that has been done is to introduce what's called the minimum data set to the common assessment instrument you're talking about. One of our problems is lack of consistent information. Now, for the first time, I have in front of me—for example, there's a group called the Canadian Institute for Health Information, and we get data through that as well, as you may know. I have 19 indicators in front of me, just a sample, and I can benchmark Extendicare York versus the rest of Extendicare in Ontario versus the province of Ontario through getting data through CIHI. As we go forward, that instrument is going to collectively allow us to know a lot more about the system. But it's not just a system instru-

ment; it helps people at Sandra's level, too, to know exactly what's going on in the universe that's their home. This has really moved us forward in terms of benchmarking, and we appreciate the progress that has been made.

Mrs. Liz Sandals: From the ministry's point of view, then, if you've got all the different homes using a common assessment tool and common data systems, does that begin to allow you to start to get some of the benchmarking you need?

Mr. Saäd Rafi: Yes, most definitely. I would add, as well, though, that this is a benefit for—as an assessment tool on basically the strengths and the problems and the maladies associated with a particular patient at one end of the system, resident at the other end of the system, that will help emergency departments and CCACs, in their placement, to know when someone should go from acute care services in a hospital, and should they go to a long-term-care facility? Should they go home? Should they go to supportive housing? Should they get some assisted living assistance? Is it palliative care? This resident assessment instrument that Paul talks about, the minimum data set—it's referred to as RAI-MDS—is now getting rolled out not only in all homes that have agreed to take this on, and all of them have, but other facilities in the continuum of care, from the hospital right through to other assessors like CCAC case managers and so on.

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It's a really significant assessment tool that not only helps with benchmarks, but just helps them manage people's care better so that they don't deteriorate while waiting for care. They're actually assessed quickly and they can get occupational therapy, physiotherapy, whatever the individual requires, at the home and right from the hospital as well.

Mrs. Liz Sandals: Moving on, then, with the whole issue of public reporting, again it seems to me that a year or so ago I remember a report coming out that did some public reporting around long-term care, because I remember getting media calls: Did I want to comment on my local homes?

My recollection is that that was beginning more to report on complaints data, but I would be interested in a conversation and actually the provider's reaction: What are the indicators that perhaps the public is really interested in getting and what are the indicators that the ministry is interested in seeing? Because from different people's perspectives, I suspect that different indicators may have different import. Which ones would be valid and which ones aren't valid? Because if you don't have apples to apples, they're not very valid indicators.

Mr. Saäd Rafi: Really, virtually everywhere in the developed world there is an interest in using quality as the measure of service, whether it's in industry—and health care is no different. So Ontario is moving to establish quality requirements in the full spectrum of care. There is legislation being tabled that will address the hospital sector to begin with, but many times it's the community sector that has been ahead in many respects with the implementation of quality measures and quality outcomes based on evidence and indicators.

To that end, the province created the Ontario Health Quality Council, individuals in health professional fields who would assess and publicly report on quality measures established, whether it's at the hospital level or—one of their sole mandates is public reporting.

They started, I believe, in 2009 or 2010—

Mr. Tim Burns: Early this year.

Mr. Saäd Rafi: —in February 2010 to report on—public reporting on long-term-care facilities, on several indicators. Maybe I can ask Tim to address some of those indicators.

Now, it was through a cross-section of homes, but in 2011 the Ontario Health Quality Council, the OHQC, wishes to move to all homes and drill down on these indicators as well that look at the quality of care and the quality of service provided.

Can you talk about the indicators?

Mr. Tim Burns: Yes. The indicators that the OHQC is reporting on—I should mention as well that the intent is to go system-wide by 2011. There are 70-odd homes that are already putting forward their data, for which I think they should be recognized, because they are leaders and they are actually measuring themselves publicly on outcomes in a way that the rest of the system is not yet doing.

There are four or five broad domains, which are keeping people healthy, keeping residents safe, the extent to which services are resident-centred, access measures, and there are measures of appropriateness in resourcing.

On keeping people healthy, which speaks to the bulk of the indicators, I think those are almost exclusively derived from the RAI-MDS. They have the advantage of having been captured right at the bedside by the care teams and then aggregated up through the system. Those would include things like bladder function; pain control; mood; weight and nutrition, which are exceedingly important; mobility; pressure ulcers, which is an area where a lot of work is being done to improve things; daily use of restraints, a matter very important to families; potentially inappropriate prescribing through polypharmacy or contraindicated drugs; falls; inappropriate behaviour or inappropriately managed behaviour; and infection rates—urinary tract infection and bladder infection, I believe, are the ones up there now. And there is a series of other indicators. There are 33 in total.

Mrs. Liz Sandals: I would be interested in the operators of the homes in terms of your experience, if you have any, with public reporting. Have any of you been involved in the public reporting?

Ms. Christine Ozimek: Our home is in the process of working with the MDS system. We haven't graduated yet, so we're not involved yet with the indicators that Mr. Tuttle has spoken about. Of course, public reporting in terms of our compliance is currently available and all homes in the province are participating in that.

Mrs. Liz Sandals: Any other comments?

Mr. Glen Moorhouse: We're a phase 8 home, so we haven't graduated yet either. But we certainly are supportive of public reporting through the quality council.

Mr. Paul Tuttle: I could just add that Extendicare operates in other provinces. This is the only province that we operate in with public reporting or a real regulatory framework that includes an inspection process. We would tend to take what we do in Ontario and export it to the other provinces too because it seems to make sense. You start at the highest benchmark and then you try and do those things in Saskatchewan or elsewhere where we operate. So we take the public requirements here and tweak them a bit and we'll use them elsewhere as well.

Mrs. Liz Sandals: Okay. Thank you. Ms. Carroll has some questions as well.

The Chair (Mr. Norman W. Sterling): Go ahead, Ms. Carroll.

Ms. M. Aileen Carroll: The Auditor General's office prepared for us, as part of our work, a chart which gives a recommendation, and then the ministry response, and then the implementation status as of April. In the first section, which is screening for infectious diseases, it makes reference to the fact that the ministry is increasing base funding for accommodation services and that the increase will be effective April 1, just gone by, and that will mean an increase of $1.55 per resident per day, or $565 annually, which comes to over $43 million for MOH. I know too that $30 million in one-time funding was committed to support the sector.

I just wondered if you wanted to share with the committee just how this funding, the ministry's funding, increased for accommodation services, will support long-term-care homes if they were to improve the infection prevention and control practices we've been talking about.

Mr. Saäd Rafi: The amount of funding that any sector would want or need in terms of their desired level would probably exceed all our grasps. However, the increases have been consistent—not that particular amount, but there have been varying amounts of increase year over year. There has been a 50% increase in overall funding to the sector in the last seven years, which represents approximately a $1.2-billion increase on a base of about $2.1 billion, so from 2003, at $2.1 billion, to 2009-10, about $3.3 billion. That's one thing.

But I also think the increases belie some of the other changes that the ministry has put in place. Some of the increases over the years have meant that there are more RNs, RPNs and personal support workers in homes. Clearly, there has been an increase, as you mentioned, on the per diem, and that will take effect. But the institution of the regional infection control networks in each region I think has helped as well. Over that period of time, the ministry has surpassed the association's interest of $6,000 per resident, currently at a funding level of $7,435 per resident.

I think all those things are great and it's important to talk about the dollar aspects, but also the training that has been put in place. I think what you heard from the heads of the homes about the simple yet effective steps that have been put in place as well, which are important and bear mentioning—the Just Clean Your Hands initiative; the simple, cheap and cost-effective installation of hand sanitizers in every room; cleaning checklists. We take some of these things for granted, but those are important because they allow a key element in the operational aspects of the home to know what it is they have to remember to undertake on a regular basis—and improve processes and public reporting, and the redevelopment of the facilities, albeit over a long period of time, to bring older facilities up to current standards, which I think is a critical need as well.

You may want to elaborate on that.

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Mr. Tim Burns: Specifically, increases this year are—the $1.55 that formed part of our response here goes into what is called the "other accommodation" envelope. The deputy has been outlining how important it is to manage the whole system and the whole home. The "other accommodation" envelope is where laundry, housekeeping and environmental services come from. Otherwise, the nursing and personal care is direct care to residents. It's important to get both of those right, both the direct care and the building services, if you will.

To the extent that that accommodation envelope should fall behind inflation or there are cost pressures which aren't met there, the concern would be that housekeeping services might suffer, and therefore they're less well positioned on infection control. So a decision was made to augment the funding in that envelope.

The other funding is more specific to the implementation of the act. Final decisions haven't been made, but the commitment has been made for that for over $30 million, and that will support our continuing investments in training and the like, which will help. Again, it was mentioned how valuable that is in infection control.

Ms. M. Aileen Carroll: The reference here is to one-time funding. I'm not sure how one-time funding can support continuing. It's very interesting, and I appreciate the detail you've provided, both the deputy minister and yourself, and it may be an error on our part, but it says that $30 million in one-time funding has been committed to support the sector to meet the expectations we've—I just want to be sure that when you say I should get my envelope straight, that I am getting my envelope straight. No offence or anything—

Mr. Tim Burns: The reason it's listed as one-time now is because—it's provided for in the multi-year plan, but we are just going into a change period where we're trying to understand how best to support the system in implementing the act and how best to retool our own systems within the ministry. Therefore, it would be premature to make a permanent increase in any one area. It's a commitment to the change, but we haven't yet specified for all time where exactly it will land, if that is helpful at all, because the needs will change quite a bit over the next couple of years as the legislation implementation proceeds.

Mr. Glen Moorhouse: I know that OANHSS has actually been surveying its members about what potential additional operating costs will come out of the new regulations, and that's an ongoing process.

The Chair (Mr. Norman W. Sterling): Thank you.

Can I just clarify something with Mr. Burns? You talked about methodology and your problem in terms of recognizing these particular infections in long-term-care homes. My question to you is—on page 181 of the auditor's report, he says, and we have found out before, that "Ontario hospitals are required to report publicly on several patient safety" factors "including health-care-acquired infectious diseases, such as C. difficile, MRSA, and VRE, and on hand-hygiene compliance" with "health care workers. Long-term-care homes, however, are not subject to similar reporting...."

What's the problem with methodology if we have a methodology already in place with regard to hospitals? Why isn't the same methodology used with long-term-care homes?

Mr. Tim Burns: I don't think I'm competent to give you a full answer on that. There are, in fact, as we speak, teams at the ministry that are looking at the viability and meaningfulness of reporting on patient safety indicators in long-term care; for example, handwashing rates and so forth. So what is being done already in hospitals—there is a team actively looking at making that available for homes. That's the issue of hand-hygiene compliance and that kind of thing.

In terms of the benchmarking, this is the part where I just don't feel I could give you an appropriate answer. What I do know, from what I've been reading and in consultation internally, is that there are very unique local circumstances.

I would contrast this with what we've just talked about on the common assessment, which is where there's a lot of science around what constitutes a good benchmark. When your daily use of restraints might be exceptional and needs to be looked at: That's an area where there is a lot more definitive science and the benchmarks would be less arguable, so to speak; whereas, in a given community, in one part of a building versus another, what might be a benchmark—if you picked one, you would run the risk that it's a misleading benchmark. What you really need to do is look at every resident and all their symptoms. According to my understanding of best practice, each home individually has to understand its own baseline on infection and watch for deviations.

The Chair (Mr. Norman W. Sterling): But we already have that between hospitals—one hospital and the other hospital. I don't understand. I presume that you would want to have the same benchmarks right across the whole health care sector, be it a person in a hospital or in a long-term-care facility etc. Wouldn't the best idea be to go to the long-term-care association? It's in their interests that there be a consistent benchmark across so that one is not being measured differently than the other.

One of the reasons that we did the infectious disease control report late in October 2008 was because we were concerned about the urgency of the situation. And the urgency is no less here. We're concerned about infectious diseases in long-term-care homes. My concern is that I'm hearing excuses, and not legitimate excuses, as to why we're not going forward.

Mr. Saäd Rafi: Could I ask the auditor to maybe let us know what he found in the way of benchmarking in hospitals for infectious diseases?

The Chair (Mr. Norman W. Sterling): Essentially—

Mr. Saäd Rafi: Just to finish, I don't think we're trying to give you excuses. I think what we're trying to say is that it's under development and we perhaps just need to give you a better answer. I think both of us aren't able to do so. I'd just like to learn what the benchmarking is because perhaps we're doing things we—

Mr. Jim McCarter: We went into the hospitals, and I think the point was, at that time, they weren't publicly reporting. We had made a recommendation along the lines to consider public reporting. As of September 2008, the ministry had basically set out some guidelines, and there is public reporting in the hospitals.

I think my sense is, if I understand the Chairman's question: Can you not just take those benchmarks and apply them to long-term-care homes? But I think Mr. Burns was saying that they think there are some differences that may not be applicable and they don't want to go ahead with that unless they're really sure they're consistent, if I understand—

Mr. Saäd Rafi: Yes, and I don't mean to be semantic and I'm not trying to be argumentative. I'm trying to draw a distinction between reporting and benchmarking. I think you've just applied that term interchangeably and I don't believe that's accurate or appropriate. So while I agree with your point on reporting, I'm just trying to query what you found hospitals doing in benchmarking. That's what we'd like to figure out how to imprint into the long-term-care facilities.

Mr. Jim McCarter: I think what we found, when we talked to long-term-care homes, as far as benchmarking, is that they indicated that they do track infectious diseases and they wanted to see if they were getting worse or getting better than the historical perspective. We had some feedback from the homes saying, "Locally, if we start reporting between the different homes, we just want to make sure that we have apples to apples so we're not looking bad versus another home." We did get some anecdotal feedback with respect to that, if I could put it that way.

Mr. Saäd Rafi: Yes, okay. That helps, actually.

The beginning of the answer is that we are now, I guess, more systematically inspecting homes. We are starting to roll out a software methodology that will be available to inspectors that will allow them to capture mandatory inspections on infectious disease reporting, prevention and control. That will then lead to baseline information for which we might be able to then get to the point you're talking about, which is to say, "Okay, here's the trend analysis. The best in class, through these best practices, identified through the PIDAC reporting, should

have this kind of level of both prevention and control." We're not there yet for certain. We will endeavour to get a complete answer to your query.

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The Chair (Mr. Norman W. Sterling): Ms. Gélinas.

M^me^ France Gélinas: I want to start by saying that I'm really pleased to meet all of you on the panel. Mr. Tuttle, I especially wanted to tell you that I hold some of your team of leadership in Sudbury, both Extendicare York and Extendicare Falconbridge, in very high regard. The Nancy Foreman and Dennis Boschetto team was very—how can I say?—spectacular in what they do. Sandra is certainly a very good replacement. Huge shoes to fill, but she rose to the occasion, and we're really happy to have her as leadership in long-term care in Sudbury.

My first question will have to do with the different homes' relationship to the regional infection control networks. How, in practical terms, has it been useful to you? Because I have a smidge of an inkling as to what your answer's going to be, how could it become more useful to you? Whoever wants to go first, Sandra or—

Ms. Sandra Moroso: I would say: Absolutely, it has been imperative that we have a relationship with the infection control network at a variety of levels. First of all, our physicians do access the infectious diseases physician, Dr. Sandre, who's part of that group, if there is any requirement for consultation.

In terms of the network, we access the network for information. We access the network for education. Recently, we went through the Just Clean Your Hands training in March. They provide support on a variety of levels. They provide us with newsletters on upcoming educational opportunities across the northeast. We've been able to send staff to a variety of educational sessions as well as video conferencing. The person who's assigned as our infection control practitioner is going to be going through education to receive her designation or certification in infection control.

We do access the network often. It is a huge resource to us.

M^me^ France Gélinas: Did you want to talk about anything else that you would like or things that could work differently that would be helpful to your home or to homes in general?

Ms. Sandra Moroso: In terms of the regional infection control network, I don't see any other opportunities in terms of improvement, because they are meeting the needs that we have at our current time. Part of that—we've talked a little bit about C. difficile and some of the others, like VRE; those are conditions in our home. Fortunately, we haven't had cases for some time. So in terms of our challenges, it's really looking at common colds. We haven't had to access for those antibiotic-resistant organisms.

Ms. Christine Ozimek: My colleague Catherine Allison works closely with all of our homes, so I'm going to call on her to answer your question.

Ms. Catherine Allison: The regional infection control network in our area, we use primarily as a resource for educational support. We receive numerous educational materials from them. That's the primary use that we are doing right now. We also are hoping to get one of our staff to take the non-acute-care infection control practitioner course through that organization.

M^me^ France Gélinas: Have you have any outbreaks in your home? Could you go through the last one you had?

Ms. Catherine Allison: We recently had two small outbreaks. One was an enteric outbreak, and recently there was an respiratory outbreak. The infections were identified very quickly and the proper infection control measures were put in place, and we were able to contain them. We did receive a discharge report from our local public health area that listed that we had put everything in place quickly and were able to limit the spread of infection, and that there were no residents who suffered any ongoing complications as a result.

M^me^ France Gélinas: Did you know where those infections came in?

Ms. Catherine Allison: One was respiratory and one was enteric. It's very likely that they were brought into the home by someone in the community. It's usually how they first come. They don't start on their own. Somebody comes in and doesn't follow the proper procedures.

M^me^ France Gélinas: Okay.

Mr. David Zimmer: Could I just ask: What was that second infection?

Ms. Catherine Allison: Enteric, which is gastro-intestinal.

M^me^ France Gélinas: Talking about bugs being brought in—I will start with you but then I will go to Sandra as well—the auditor does talk in his report about immunization rates for residents and caregivers. Could you talk to me a bit about how this is handled? What are some of the barriers to reaching the ministry targets, both for clients—your residents—and your care providers?

Ms. Catherine Allison: Part of our influenza education program each fall entails providing education to our staff, our residents and our families regarding the benefits of immunization. We usually have a nurse from the public health unit come in and provide that education to our staff; we try and promote it that way.

In terms of barriers, people read things on the Internet that are myths, and we try and combat those myths with proper education.

We also have a policy that if we have an outbreak of confirmed influenza A or influenza B and a staff member is not immunized, they would not be allowed to work until they've taken Tamiflu and/or taken the immunization.

M^me^ France Gélinas: Would you know, at your home, what the rates are?

Ms. Catherine Allison: In terms of the—

M^me^ France Gélinas: Let's say, influenza immunization.

Ms. Catherine Allison: Sure. I have that here, if I can just find it. In terms of seasonal influenza this year, 37% of our staff took the pandemic vaccine and 21% of our

staff took the seasonal vaccine. In terms of residents, 86% took the seasonal and 48% took the H1N1.

M^me^ France Gélinas: We all realize that 21% of your staff taking the influenza vaccine is actually way below the general population. You have put in efforts, with the health unit coming in, with the education. Are there things that the government, the ministry—somebody—can do to help increase those?

Ms. Catherine Allison: I'd have to get back to you with a proper answer for that.

M^me^ France Gélinas: Sure.

Mr. Glen Moorhouse: I'd like to speak to that. In addition to staff training, for the last two years we have offered prizes to encourage staff to get the shot. I think one of the challenges this year has been that there have been so many mixed messages about H1N1. Frankly, staff are afraid of long-term implications.

In my opinion, really what's needed is that it has to be mandatory, from the ministry's point of view. Otherwise, I think it will be challenging to get to that 75%.

Ms. Sandra Moroso: In terms of our rates—and I agree with what has been said in terms of how we approach immunization—there's another immunization we do on admission as well, and that's pneumococcal immunization. Our rate is 91% within our home for residents accepting that immunization.

Every fall we do an entire blitz of the building. I agree: the residents' council and the family council are really key in terms of getting on board and understanding the purpose of immunization.

Our rate at Extendicare York for residents was 93% in 2008-09. It went down a little bit to 86% in 2009-10. For staff, we run around 85%.

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This past year was a little bit unique, and it was a little unique because of how the influenza and the H1 was released, and the quantities in which it was released. So many of our staff did take the vaccine, but did it externally, which was unusual in terms of a vaccination year. Normally, our staff take the vaccine on-site after education is provided.

What we do see, in terms of staff and resident rates, is that the remainder of the rate is because residents or staff have an allergy to the vaccine itself, and there are some residents who just don't believe in vaccination and don't receive the vaccine.

M^me^ France Gélinas: So could you give me your staff vaccination rate for influenza again?

Ms. Sandra Moroso: Staff vaccination for influenza in 2008-09 was 85%, and then in 2009-10 it went down to 49%. I think part of that was that our influenza vaccine was released in January; normally, it's in October/November. So many of our staff took it out into the community. And if I look back historically, we sit in the eighties, 80% to 86%, in terms of staff vaccination, up until this past year.

M^me^ France Gélinas: But wouldn't you also keep track—if they got their vaccination elsewhere, wouldn't they let you know?

Ms. Sandra Moroso: They do let us know. Part of the confusion this year, and I think Glen referred to it somewhat, is there were some staff who took the H1N1 vaccine, and because the influenza vaccine came out in January, they assumed that they didn't need it or chose not to take it because they had already been vaccinated with the H1N1.

M^me^ France Gélinas: Okay. There is a huge difference—and then I will go to the ministry—between 21% of your staff and 85% of your staff. Does that worry the ministry at all? Is this something that the ministry is commenting on?

Mr. Tim Burns: I think the homes themselves, who are most directly concerned—obviously we are there to support them—with their staff and residents are taking the measures that we would support. I think we have to learn more from them about what's working and what isn't, and have to consider measures that might further induce them—reporting on immunization rates in different homes and organizations could be something that we consider. I don't think it's something that lends itself to a heavy-handed policy push because of the individual staff choices and resident choices that are involved. So I think it's more a case of education and suasion.

M^me^ France Gélinas: And what sorts of education and suasion is the ministry involved with?

Mr. Tim Burns: We've got the immunization programming—I'm not close to it personally, but, Lyn, do you want to talk about it?

Ms. Lyn Fabricius: Most of the public health units run immunization campaigns. "Kill the bug, find the bug" season usually starts in September/October, so they're the real drivers behind it. I really have to speak to this year, because I was very involved with H1N1 with my position, and it did throw everything off this year. I think it's unusual, and 21% is unusual in most homes, but it's driven by public health. We just look for compliance and outcomes. But what I have seen through the province, and I have had the privilege to inspect all the way up to the north, is that public health had huge campaigns for immunization. So it usually comes driven from them.

M^me^ France Gélinas: I wanted to talk a little bit about urinary tract infections. Anybody who works in long-term-care—

The Chair (Mr. Norman W. Sterling): Excuse me. I think the auditor has something in terms of the immunization numbers.

Mr. Jim McCarter: I've got some stats, if you'd like, across the three homes. For residents, the ministry target is 95%, and the homes are generally all above 90%, with respect to flu for residents; for flu for staff, the ministry target is 70%, and the homes kind of range from 65% to 85%; and for pneumococcal immunization, the ministry target is 95%, and the homes range from sort of 65% to 80%. That would be kind of the range across the homes.

M^me^ France Gélinas: Maybe before I go to urinary tract infections, then, I'm going to go back to the pneumococcal immunization. I understand that whenever a resident is admitted, it would be one of the immuniza-

tions that would be offered. If you have the stats for your home, please share them and share any comments that would help get the rate, at 63%—I have the auditor's report in front of me; you don't, but it goes from 63% to 77%. We are a far way away from target. For your own home, how is it going, and can we do anything to help you?

Ms. Sandra Moroso: Our home was 63% in 2008 and we're 91% in 2009. Part of that is reflective of resident choice, whether or not residents choose to have the vaccine. This is a vaccine that's offered on admission and residents have the choice to refuse.

One of the strategies that we did put in place was to talk to residents' council and family council and to do a lot of education around the benefits of pneumococcal vaccine, but we also have a large turnover in terms of residents within our home. In 2008, we had 150 admissions. It's a lot of turnover. So with new residents, they made different choices and our rates went up.

Ms. Catherine Allison: In terms of our home, we do offer pneumococcal as well as a tetanus booster, influenza and TB testing—well, TB testing is mandatory—on admission. Again, I echo what Sandra says: It is resident choice, and some residents just absolutely don't believe in it. We try to provide that education to them on the benefits of it during the admission care conference, which is held within six weeks of admission. In addition, we do the benefits of immunization at our family council. That's one of the programs that is discussed.

M^me^ France Gélinas: Do you know your rate—

Ms. Catherine Allison: I don't have those numbers with me.

M^me^ France Gélinas: Would you know if there has been a change?

Ms. Catherine Allison: I think generally there's fairly good uptake. I think that we're improving; we continue to improve.

M^me^ France Gélinas: I guess my next question would be, why is there such a discrepancy between influenza immunization and pneumococcal immunization? To me, it's the same person. If they're opposed to immunization, why would they take one and not the other?

Ms. Sandra Moroso: One thing I failed to mention is that there's a little difference with your regular influenza immunization. You receive that on a yearly basis. With the pneumococcal immunization, in the past couple of years, it was given once. So you receive it only once, and it was supposed to last for a longer period of time. When you'd ask a resident, "Would you like your pneumococcal vaccine?" there were times when they couldn't remember if they had had it, so they refused it.

The thinking has changed behind pneumococcal, so in terms of our policies at Extendicare, we offer the pneumococcal vaccine on admission, and then we offer it again after five years, especially for those residents who have multiple diagnoses. That may be part of why we see a difference between the pneumococcal and the regular influenza immunization.

Ms. Catherine Allison: I'll just mention that the numbers that I reported in terms of influenza immunization were for this current year. I would say that because of the media information about H1N1 and the fear that was out amongst the public, that probably affected our numbers. I'd say that was an outlier year. I think normally our staff immunization uptake would be probably 60%. It's not what we would want, but it's up around the 60% range.

In terms of why some people take the influenza, or the pneumococcal and not the influenza, I would agree with what Sandra said. It is one time, and then repeat again within five to 10 years, so you only receive it twice. That could be part of it.

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M^me^ France Gélinas: Coming back to urinary tract infections: Anybody who works in long-term care knows the risks and knows how to prevent it. I'll start with you, Sandra. You sit closer. Can you talk to us about if you know the rates in your home? How come it's still such a battle?

Ms. Sandra Moroso: I have to say that in terms of our home, I wouldn't consider it a huge battle. Part of our approach—first I'll go to our data. We're able to pull quality indicators from that RAI MDS. As you do your clinical assessment, there are things that are generated behind the scenes that we can actually pull some of the information from, so that's one of the benefits of that entire system.

Urinary tract infections is one of those things that we can pull. Along with urinary tract infections is indwelling catheters, and they go hand in hand. In terms of indwelling catheters, our physicians, unless it's medically required, do not support the use of catheters. We have a very, very low number of urinary catheters within our home. It's 1.1% versus the province's 2.9%. In terms of urinary tract infections, at the last quarter we reported 4% and the province of Ontario is 5.7%. Our numbers—and it has been consistent from 2007 to 2009—are low and they're below the provincial average.

What are some of the things we do in order to prevent urinary tract infections? They're very simple things: having larger glasses at meal service, encouraging the intake of additional fluids, a move to having beverage carts in our dining room—we have a hot beverage cart and a cold beverage cart at all three meals—and we offer a variety of different types of fluids, which gives residents a lot of choice in terms of the fluid intake that they do have. As well, a higher fluid intake decreases the risk of urinary tract infections.

We monitor our residents' fluid intake on a daily basis. Every 72 hours a registered staff member actually does a calculation to see if the resident has taken enough fluid in within those 72 hours. If there's concern that the resident has not taken in enough fluid, then there's a referral made to the dietician in order to visit with the resident to see how we can get the fluid increased for that particular resident.

M^me^ France Gélinas: Wow. Can you top that? Sorry.

Ms. Catherine Allison: No, I don't particularly want to follow that.

In terms of the number of urinary tract infections that we have in our home, we do count them individually. I

don't have a rate because we're just finishing the RAI process, so I'm not able to pull that data. Just in this year, there have been four urinary tract infections in our home. In terms of prevention measures—one thing I must say is that urinary tract infections are very common in the elderly. We try to minimize the use of indwelling catheters as much as possible. They're only used when they're medically necessary.

In terms of fluid intake, we have the same program in place that Sandra spoke about in terms of a hot fluid cart and a cold fluid cart, and that circulates throughout the dining room. We do provide water at each sitting in the dining room. In addition, we have thermal jugs of water at each resident's bedside so that they can take water on their own at will. We try to put individual interventions in place for residents who are determined to have a high risk of urinary tract infections, and that includes increasing their fluid intake, offering them cranberry juice etc.

M^me^ France Gélinas: Thank you. The next is on the use of antibiotics. I realize that it's a physician's decision to prescribe antibiotics. It is certainly something that homes usually monitor. Is there anything you have learned or want to share about the use of antibiotics in your home? Sandra, you seem to be willing and able to go first.

Ms. Sandra Moroso: We have a medical advisory committee. And I think one of the benefits of our home is that our physicians follow the resident to the hospital. They are practising physicians. They have privileges within the hospital sector as well.

Our physicians use the Ontario drug benefit program in terms of what kinds of medications they can prescribe, but they also try to follow best practice in terms of prescribing antibiotics. We just talked about urinary tract infections, so I'll use that as an example. What our physicians support in our home is that one may have bacteria growing in their bladder, but unless someone has symptoms related to that bacteria—you may have a change in your level of condition, you may have a variety of different things—they won't treat that bladder infection with antibiotics.

In terms of the actual committee, we do have access to the types of antibiotics that are prescribed. We do have access to the antibiotics that are prescribed per physician, and the physicians do have a discussion around types of antibiotics that they use for a particular condition—what is best to be used for someone who is elderly, who has pneumonia. So there is that kind of discussion that occurs at that particular level.

M^me^ France Gélinas: How many physicians do you have in your home?

Ms. Sandra Moroso: We have three who work in our home.

M^me^ France Gélinas: They've been there for a long time?

Ms. Sandra Moroso: They've been there for a very long time.

Ms. Catherine Allison: I don't think there's a lot I can add to that. We have one physician who primarily looks after the 60 residents in our home, and then there are two other physicians who look after two or three. We have a professional advisory meeting, as well, and our physician gets data from our pharmacy on the number of antibiotics that have been prescribed in the home.

As my colleague Christine spoke of earlier, we've talked to our pharmacy about developing a change to their database so that when an antibiotic is ordered, it is required to put in what the antibiotic is being ordered for, so that the information we get back is more meaningful. The physician follows the Ontario drug formulary and uses best practices to determine what antibiotic to use.

M^me^ France Gélinas: I'll continue with you. I take it that you have a designated infection control program leader/practitioner in your home.

Ms. Catherine Allison: Yes, we do.

M^me^ France Gélinas: How long has this person been in that position?

Ms. Catherine Allison: We just had a turnover of the director of care. It's the director of care who is responsible for this. This director of care is actually from the acute care sector, so she has specific training in infection control from acute care, which she's now using in long-term care. She has been in her position since November.

M^me^ France Gélinas: Is it common that the director of care is—I don't know who to ask this of—also the lead for infection control?

Ms. Catherine Allison: In a small home of our size, I would say it is common. We only have 60 beds.

Mr. Glen Moorhouse: We're a 103-bed home, and the infection control practitioner is separate from the director of care.

M^me^ France Gélinas: Has this person been in place for a long time?

Mr. Glen Moorhouse: She's a new hire.

M^me^ France Gélinas: Was the person in the lead role before in her role for a long time?

Mr. Glen Moorhouse: About two years.

M^me^ France Gélinas: How often would you say this person held meetings? How did this person do her work in your home?

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Mr. Glen Moorhouse: The previous person was very involved. We were getting ready for accreditation, so she chaired several committees related to medication and infection control.

Ms. Catherine Allison: Our infection control committee meets quarterly; and then, during outbreaks, they would meet daily to review the practices that are in place.

M^me^ France Gélinas: Of the people on the committee, who are the people on the committee that meets quarterly?

Ms. Catherine Allison: It would be the infection control practitioner/director of care, the administrator, the managers of food service and environmental, the physician and the public health nurse assigned to our home.

M^me^ France Gélinas: And how do their recommendations or ideas get trickled down to the people delivering the care?

Ms. Catherine Allison: That would be through our communication system, either through communication books, stand-up meetings at shift report—

M^me^ France Gélinas: Can you give me an example of something that they did recently?

Ms. Catherine Allison: During our recent outbreak, the DOC would go to each shift report, discuss what was going on in terms of the outbreak, how many residents were ill and what practices were in place in terms of trying to maintain the residents isolated in their room and what practice to put in place. That was done at each shift report. When the DOC was not in the building, those items were communicated through the charge nurse.

M^me^ France Gélinas: That was during the outbreak?

Ms. Catherine Allison: That's right. For daily, any changes that are implemented as a result of the infection surveillance and the infection control meeting would be communicated through communications systems, our communication books and shift report.

M^me^ France Gélinas: Could you give me an example of something that came out through those regular quarterly meetings that was circulating and communicated?

Ms. Catherine Allison: I'd have to get back to you on that.

M^me^ France Gélinas: How about—sorry, I forgot your name.

Mr. Glen Moorhouse: Glen.

M^me^ France Gélinas: Could you give me an example of something that was picked up in one of your quarterly reports and acted upon in your home?

Mr. Glen Moorhouse: I think I'll call on our director of care to speak to that, if that's okay.

The Chair (Mr. Norman W. Sterling): Ms. Gélinas, we're going to go over here.

Ms. Ama Amoa-Williams: What I would say is that most of the time, infection in the home, like if it is a wound infection, the infection control practitioner will communicate with the charge nurses, and the same thing: Do a report. The charge nurse will communicate this to the PSW for them to know what is happening. So we do this through daily reports.

M^me^ France Gélinas: I'm not interested on the chain of communication; I'm interested in the content. Could you give me an example of something that this committee has done?

Ms. Ama Amoa-Williams: That we communicate through the building?

M^me^ France Gélinas: Sure.

Ms. Ama Amoa-Williams: When there is a quarterly meeting, what we do is the same as communication. What we do is, they communicate through the whole group and then the infection control practitioner is the one who carries the report down to the floor. Then they put things in place. If a resident has got an infection and the infection is not being taken care of, that's what the infection practitioner will communicate to the staff, and then get this right in the proper way. That's how the meeting goes, the quarterly meeting that we do.

Ms. Catherine Allison: I was just going back over the last professional advisory committee meeting that we had. We did talk about hand hygiene and the results of the hand hygiene audits and any corrective action that was required. So that would be an example of something that we would communicate to the shift report, that hand-hygiene audits have been completed, what the results were and what our recommendations were to everybody in terms of what they needed to do in terms of washing their hands. I believe in this case, although I'm not 100% sure, that it was discussing washing their hands after contact with the environment. They were washing their hands before and after care and before and after removing gloves, but it wasn't after they had touched the environment of the resident's room. That was just an example of something that would be communicated after an infection control meeting.

The Chair (Mr. Norman W. Sterling): Ms. Van Bommel.

Mrs. Maria Van Bommel: I want to just pick up on Ms. Gélinas's point around antibiotic use. One of the things we assume when we talk about infection control is the fact that you can develop antibiotic resistance, and as much as you clean and try to stay on top of things, the organisms can develop.

One of the recommendations from the Auditor General was around that whole issue of prevention of antibiotic resistance. In the ministry's response in terms of what they were doing, they talk about the joint task force on medication management at long-term-care homes. Your response says that the report was given in November of last year, but it doesn't really say very much about what the recommendations were other than to say it has recommendations. Could you fill us in on what recommendations came out of that particular task force?

Mr. Tim Burns: Yes, I can. I'm not going to get all of the recommendations—I'm sorry; I don't have them committed to memory—but in the main, they concerned equipping homes to take a systematic approach to optimizing all medications and all medication-related processes and activities. It would, by extension, improve—

Interjection.

Mr. Tim Burns: Oh, now I've got them with my team here. I bought a vowel.

I'll just recap. The recommendations were incident reporting; improved medication reconciliation, so it's a good known history; better processes concerning potentially high-risk drugs in the elderly; and technology supports. The committee took a very broad, systematic approach: looking at the whole home as a system and the interaction between pharmacists, physicians and the care teams in homes as a system.

We received the report. It was a joint report with the ministry and the provider associations. In terms of what has been done with it, it would be most fair to say that the partners, continuing to collaborate, have taken pieces of it and are starting to move toward implementation.

For example, with the collaboration of the Institute for Safe Medication Practices, a partner to the report, and the Ontario Health Quality Council, we're working through

the residents-first initiative in applying continuous improvement methods within homes; so, for example, to improve homes' familiarity with continuous improvement techniques, and improvement facilitators. The goal there is to provide the homes with specific curriculum—reducing falls, reducing the incidents of wounds and so forth. What's being worked on now is a curriculum around improving medication reconciliation, which we would see introduced through that program with the Ontario Health Quality Council. That's an example of an outcome of the report.

Another example of an outcome is that under the leadership of the Ontario Long Term Care Association, there's work going on with the Ontario Long Term Care Physicians association, physicians practising in homes, to get a good—there's good literature and good examples around. You may have heard of the Beers list, the high-risk drugs. There's work going on to educate all players and to adapt that list to the Ontario context. We can expect to see an education initiative coming out of the Ontario Long Term Care Association.

Those are examples of where—it started with the audit; a joint task force was convened. It's not a single implementation plan or action plan per se; it's a series of steps that are using that report as an impetus for improvement.

Mrs. Maria Van Bommel: You went through one part really quickly there, and I just want you to backtrack into the recommendations. You talked about the physicians and the pharmacists. I didn't quite follow what you said was going to happen there.

Mr. Tim Burns: As an example, on high-alert drugs, the best practice would be to make sure that the prescribing physicians, the care teams in homes and the pharmacists serving the homes meet on a regular basis to examine utilization patterns and incremental steps that might be done to improve upon them. The methods and educational supports and so forth to do that are being developed through the various partners to that report.

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Mrs. Maria Van Bommel: At one time, in a previous auditor's report, we talked about the whole issue of prescriptions and over-prescribing for seniors, especially in long-term care. How does that link into what this task force is doing?

Mr. Tim Burns: I think it does, because the task force looked at all aspects of optimizing medication, including high-risk drugs, med error, med error reporting, utilization patterns and so forth. It took a holistic view, if you will, so there are now supports. For example, tools coming out of it would include medication safety self-assessment. We had very good uptake. I believe 65% or 70% of all homes went through a methodical self-assessment of their fundamental processes for medication delivery: Do they meet regularly with their pharmacist, do they have these features in their contract—very concrete contributors to safety. That self-assessment, which went widely through the sector—perhaps the homes could comment on it—was a prompt to homes to make sure they have the right structures in place to support safety.

Another example would be, as a best practice, specific prompts about how they're working with their pharmacy, what information they're looking at, how they conduct those quarterly reviews.

Those would be examples of tools and supports that are under development as a result of that task force work.

Mrs. Maria Van Bommel: You said that you were doing this in sort of a staging. It wasn't just an implementation of a recommendation. You're staging this to a certain extent. I'd like to ask if any of the others here want to talk about how this task force and its recommendations have been—if you've started to implement those recommendations; how you've started. Do you feel that they're practical, in your cases?

Ms. Christine Ozimek: Speaking for Regency Manor and all five of our homes, I can say that we have participated in the self-assessment process Tim Burns has described and found it to be very valuable. We work very closely with our pharmacies and the doctors on the issue of safe medication practices. We're very fond of ISMP bulletins that provide us with errors that are made, and we really work hard to disseminate that information.

I think what we are seeing from this report is that individual homes and organizations are looking at opportunities to improve practices. One area that we looked at specifically was the prescription of certain narcotics to residents. In particular, I've been taught that you need to look at the idea of starting low and going slow. But we found that on occasion, physicians were prescribing very strong narcotics. Fentanyl is one that comes to mind. Our nurses were being put in the position of having to say, "Are you sure this is the proper drug?" What we did in that case is, again, we went to our partner pharmacy, MediSystem, and said, "We think you need to look at your system. You have the entire medication history for that resident since they've been with us on file. Can you put into your coding system an alert so that when a drug like that is prescribed, the system reviews the history on file and if it finds that it's the wrong level or the wrong drug—the person hasn't had other drugs before that are opiates—it sends an alert to the pharmacy and there is communication between the pharmacy and the doctor?"

In fact, MediSystem did implement a change to their code and they expanded on the idea and put in a list of approximately 20 high-risk drugs. I checked with them recently and that system is in place, it's working, it's producing alerts. They actually had an occasion where a physician wrote back to say thank you, because he was happy to have received the information back and did alter the prescription for the resident in question.

Ms. Sandra Moroso: We also completed the assessment, which gave us, I think, really wonderful results. It gave us areas that we were very strong in and areas where we felt we needed to do some improvements.

We established a multidisciplinary team primarily made up of staff who work on the nursing units that are actually delivering medications or taking medication

orders. We also looked at the Auditor General's report on medication use in long-term care, because there were some recommendations that came out of that report as well.

What we did was we looked at a variety of different areas. One was the high-risk, high-alert medications. Another area is medication reconciliation, which is a very important area, and that is when a resident comes to us and they're admitted, we verify what medications they're on. If they're coming from a hospital, we get a list from the hospital and we ensure that that list is complete. Part of that reconciliation is actually talking to the resident and their family and saying, "This is the list that we've received from the hospital. Are these all the medications that you were taking at home prior to going to the hospital?" If the resident can't answer, quite often we'll go to a community pharmacist who they were dealing with in the community. We're trying to verify the list of drugs prior to ordering drugs. We do that on admission and we do that on readmission to the hospital if a resident goes back out to the hospital.

We have implemented, a few months ago, eMARs, which is an electronic medication delivery system and which has, I think, improved our ability to give medication safely. All the medications are listed there electronically. They've verified on a variety of different fronts. They're verified with the nurse and the physician, they're verified at the pharmacy prior to us giving it, and there's documentation right at the point, at the resident's room. There are a lot of different things that we've put into place.

We went through accreditation in February. Accreditation Canada actually acknowledged all the work that we had done in terms of medication and did not find one outstanding standard related to medication in our home.

Ms. Ama Amoa-Williams: For Nisbet, we are not part of the medication task force, but we're looking forward to joining. We practise medication reconciliation the same way. If we have a resident coming back from hospital or coming from home, or a new admission, we check the medication the same way—what the resident was on before—with what the hospital sends to us. We compare that. Then if a resident goes to hospital and comes back, we still do a medication reconciliation. If we have to change the medication—sometimes they change the medication in the hospital. When they come in, they increase the dose, or they decrease the dose, so we go back and check what the resident was on before, and then we get that and send it to the pharmacy and get everything going. We're looking forward to being a member of the medication task force.

Also, we're exploring eMAR. We want to get into eMAR really badly because we know how good eMAR is. It's something that we're looking forward to joining.

Mr. Paul Tuttle: The only thing I'd add to that is that on top of all these improvements that are being implemented, generally if you look in the literature throughout North America and elsewhere too, actually, when a person comes into a long-term-care home post-admission, in their first pharmacy review, there's often a drastic reduction in the number of medications. There's already an improvement, and all this is on top of that, so there's real progress being made.

Mrs. Maria Van Bommel: Thank you. I take it from the Chair that my time is up.

The Chair (Mr. Norman W. Sterling): Thank you very much for coming to our committee. I'll ask members of the committee to stay for a few minutes after so we can instruct our researcher as to some ideas we might have for the report.

I thank everyone here.

The committee continued in closed session at 1430.

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