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Jeudi 1er mai 2008

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Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2007,
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ministère de la Santé et des Soins
de longue durée

Chair: Norman W. Sterling
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 1 May 2008

Jeudi 1er mai 2008

The committee met at 0940 in committee room 1, following a closed session.

2007 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

MINISTÈRE DE LA SANTÉ ET DES SOINS DE LONGUE DURÉE

Consideration of Section 3.10, long-term-care homes—medication management.

The Chair (Mr. Norman W. Sterling): Good morning. My name is Norman Sterling. I am the Chair of the public accounts committee. You can see that we have many members of the committee here.

This morning, we are dealing with the auditor's report, which became public in early December. We're dealing with the section on long-term-care homes and the management of the medication that's given to patients.

We're pleased to have with us today Ron Sapsford, Deputy Minister of the Ministry of Health and Long-Term Care, along with, I understand, Davie Cutler, who is the chief executive officer of Leisureworld Caregiving Centre, and Shelagh Nowlan, who is site administrator for Providence Continuing Care Centre in Kingston.

As well, the deputy minister has other people with him, so I will turn it over to you, Deputy Minister. I know you have some opening remarks, and then we'll probably go to questions after those opening remarks.

Mr. Ron Sapsford: Thank you, Chair. By way of introduction, sitting on my right is Mr. Tim Burns, who is the director of the performance improvement and compliance branch in the Ministry of Health and Long-Term Care.

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On behalf of the Ministry of Health and Long-Term Care, I thank the Standing Committee on Public Accounts for again giving me this opportunity to appear before the committee and on this occasion to discuss some of the important issues explored in the Auditor General's 2007 report on medication management in Ontario's long-term-care homes.

I also thank the Auditor General's office for identifying the key medication management issues facing the sector, where continued focus is crucial to ensure the best for the care and safety of Ontario's 75,000 long-term-care residents.

I'm pleased to update you on the ministry's work on these issues since last year's audit was conducted. The ministry is putting in place significant processes that will change the way medication management is approached in the sector.

At this time, I'd like to introduce the representatives from two of the three long-term-care homes that were audited for this report. On my immediate left, Mr. David Cutler is the chair, as I said, from Leisureworld, representing Leisureworld St. George, and Shelagh Nowlan is from Providence Manor.

The ministry, the three long-term-care homes involved in the audit and their associations, the Ontario Long-Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors worked together to respond to the Auditor General's report and to complete the status report that was forwarded to you prior to today. We have also been working with the associations and the homes on the initiatives that I'm going to report to you today.

I'm very pleased to report that this collaboration has been extremely positive, and the ministry looks forward to continuing to partner with the sector as these initiatives are implemented.

Before I begin this update, I want to note that the ministry was very encouraged by the Auditor General's positive references to the ways that the three long-term-care homes managed medications: "All three of the long-term-care homes we visited had procedures in place to ensure that they obtained physician-prescribed medications and administered them to residents in a safe and timely way."

We were also pleased to learn that the auditor found that all homes monitored all residents and that all the homes visited "had agreements with pharmacies that complied with the ministry requirements and described in general terms the pharmacy's responsibility to monitor potential drug interactions."

The auditor's report noted that all of the pharmacies maintained a medication profile for each resident that included the list of drugs and a medication profile that listed medical conditions that the pharmacist should be aware of. We also appreciated that the auditor recognized the roles and responsibilities of the professional providers—the doctors, the nurses and the pharmacists—and

acknowledged that all were aware of their respective colleges' requirements and were working within these obligations.

We thank the auditor for noting areas that can be improved. This is how the system will continue to improve to meet the needs of the residents of our long-term-care homes.

Before outlining the changes that are taking place to address the recommendations of the auditor, I would like to discuss the accountabilities and professional responsibilities for medication management within the long-term-care-home sector. As the Auditor General pointed out, this clearly falls within a number of areas.

Physicians prescribe medication for long-term-care-home residents and review patient-care plans based on their knowledge and skill and the clinical circumstances of the individual. Physicians, as you know, are accountable to their regulatory body, the College of Physicians and Surgeons of Ontario.

Pharmacists dispense medication for long-term-care-home residents on the basis of a physician's or other recognized health professional's prescription as well as the pharmacist's knowledge of the individual and the prescribed drug. It's the responsibility of pharmacists to work with the prescriber and home to identify potential drug interactions and to provide advice on the appropriate drug therapy.

Long-term-care homes contract with pharmacies to provide prescriptions and other medication ordered by physicians for residents, as well as advice on other medication-related issues. Pharmacists operate in accordance with both provincial and federal legislation and also the standards of practice of their regulatory body, the Ontario College of Pharmacists.

Nurses apply their knowledge of the resident and the medication when assessing and administering medicine, evaluating an individual's reaction to the drugs and planning and documenting the medication administration process. Nurses are guided by the medication practice standard of the College of Nurses of Ontario. They are the key link between the physician and pharmacist when it comes to medication management for each resident.

As of April 1, 2007, the province's 14 local health integration networks play a key role in the planning for and funding of long-term-care homes. Ontario's more than 600 long-term-care homes, both for-profit and not-for-profit, are regulated by the ministry and have a responsibility to provide the care to meet the needs of their residents. The ministry, as steward of the health system, is responsible for setting standards of care and conducting inspections of long-term-care homes to safeguard residents' rights, safety, security, quality of care and quality of life.

The government recently introduced Bill 140, the Long-Term Care Homes Act, 2007. I will not speak at length today about the legislation, which received royal assent last June, but I will say that the changes will improve care for residents and strengthen enforcement and the accountability of long-term-care homes.

As part of the mandatory annual inspection process of all long-term-care homes, compliance advisers review the medication administration practices and record-keeping for patient care plans, as well as narcotics management. The compliance advisers also ensure that the residents' response to medication and to treatments is assessed and documented, including medication provided to treat behaviours, pain and wounds. The long-term-care-home public reporting website provides information on the outcomes of inspections of individual homes and their record of care.

I now want to turn to the changes I mentioned at the beginning of my presentation—changes to address the issues that the Auditor General has raised, specifically related to the definition of medication errors; the number of, and potentially high-risk, medications prescribed for residents; the ministry's Ontario drug benefit program system alerts; the Ontario government pharmaceutical and medical supply service drugs; and environmentally responsible practices to dispose of medication.

In keeping with the ministry's role, the ministry is convening a task force on medication management. Membership will be made up of the long-term-care-home associations, the Institute for Safe Medication Practices and sector leaders. Additional sector representatives and the regulatory colleges will be engaged on a topic-specific basis. A letter dated November 2007 from the long-term-care-home associations and the ministry announced the formation of this task force and has been widely endorsed by the sector. The task force is expected to meet for the first time in the spring and will continue as long as is needed to complete its mandate.

The task force will address many of the issues identified by the Auditor General, as well as issues that are brought forward by sector members. Its mandate will be to engage the sector membership to identify issues and to utilize their expertise to propose opportunities for improvement. As such, the expectation is that the task force will identify targeted improvement opportunities that can be applied across the sector. The task force will consider issues such as the number of, and potentially high-risk, medications prescribed for residents, including psychotropics, standing orders and disposal of drugs.

However, let me assure the standing committee that the first priority for the task force will be a made-in-Ontario definition of "medication error" that is specific to the long-term-care sector. This is not as simple as it sounds. The College of Nurses of Ontario and the college of pharmacists each has a definition of "medication error" that their members must follow, and, to be clear, they're different. As well, other Canadian provinces have developed their own definitions of "medication error," but there is a recognition that a long-term-care sector-specific definition for "medication error" is needed to provide a consistent and coherent approach to what should be reported.

The ministry has recently enhanced and facilitated the reporting of incidents through a new critical incident system. I would like to add that the ministry committed

to doing this in its response to the Auditor General's report and has met this commitment.

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The critical incident system is a web-based initiative that is mandatory for homes to use to report and manage incidents. The current definition of an incident is set out in the long-term-care home manual and includes medication errors, misappropriation of medications and adverse reactions. When the new, and potentially broadened, definition of a medication error is developed, it will be incorporated into this critical incident reporting system. This computer system will provide more information than the former paper-driven format and in a more timely manner. Over time, this system will also enable early warnings of potential issues and risks and allow for links with different sectors of the ministry, such as public health, as well as other ministries, such as the Ministry of Labour, on matters that affect seniors.

The system is intended to provide enhanced data collection and root cause analysis, empowering homes, pharmacies and the ministry to use the information as part of their quality improvement process. This includes identifying patterns of medication errors and discussing the findings with the homes' physicians and pharmacists.

I'd like to speak briefly about the common assessment tool. The ministry is presently implementing the common assessment tool, and its technical jargon is RAI MDS 2.0, which is the actual tool that's used in all of Ontario's long-term-care homes. This tool is a standardized assessment that will be used for all long-term-care home residents to identify a resident's abilities, preferences and care needs and to develop individualized care plans. Until the common assessment tool came into use, there was a variety of care planning tools being used by homes, making it difficult to compare the quality of care across all long-term-care homes.

The common assessment tool will enable the ministry and long-term-care homes to benchmark results and monitor standards and quality of care. It includes drug-related quality indicators to support caregivers in identifying residents at higher risk for increased monitoring related to medication effects.

Resident outcome reports can also be generated by the system which would provide information on medication management for each resident. Currently, 217 homes are using this tool and it is anticipated that the entire sector will be using it by 2010-11. At the time the auditor was completing his review, 25% of homes were using the tool, and by June of this year, this will have increased to 45% of homes.

Right now, 10 homes are piloting a section of the common assessment tool for automated medication tracking. This section records medications in use for each resident, providing easily available information for caregivers. The use of this section of the tool will support better care planning related to medications and increase the ability of caregivers, as well as the ministry, to conduct analysis on a resident-specific or system-wide basis. This section of the assessment tool may also be able to identify the prevalence and outcomes of medication use across the system, including high-risk medications.

In addition to the critical incident system and the common assessment tool, the ministry has built information alerts for pharmacists into the ministry's Ontario drug benefit program computer system. The drug use review process is part of the online claims adjudication system and it's intended to enhance—not replace—professional judgement by pharmacists.

The Auditor General reported that there were 18,000 level one alerts in 2006, 91% of which were overridden and dispensed to residents. With more than 19 million prescriptions dispensed to long-term-care homes yearly, this represents 0.095% of total prescriptions. As well, as the auditor noted, of these 18,000 alerts, many are due to the same prescription being prescribed over and over to the same resident as part of care and treatment.

In any event, pharmacists must use their professional judgment to determine whether or not it's appropriate to dispense the drug. It's a standard of practice that if pharmacists identify any concerns regarding a prescription, they will contact the prescriber to verify the use and need for the prescription.

This led to the auditor's concerns over the number of medications in use by each resident and the reference to drugs that should be avoided. The Institute for Clinical Evaluative Sciences, in a soon-to-be released report, notes that the use of inappropriate drugs in long-term-care homes has decreased slowly, but steadily, over the last five years. Through the task force that I discussed earlier, the ministry will work with homes and regulated health professions to encourage and support discourse on this topic and on best prescribing practices.

To support pharmacists in working more closely with the homes, the ministry is reviewing the overall reimbursement structure for pharmacy professional services and dispensing services to long-term-care homes. To date, the review has identified more intense professional services that can be offered to long-term-care homes. In principle, this will be similar to the MedsCheck program, which was introduced last year through the Ontario drug benefit program. The ministry is now examining costing information to better understand the various options to amend the current reimbursement structure so that it includes professional services.

As to the Ontario government pharmaceutical and medication supply service, drugs that are provided free to the homes and potential wastage is generally limited to non-prescription drugs such as Gravol and Aspirin. The total funding for this, for the whole sector, is $3.4 million a year. The ministry is now providing these products through pharmacies to the homes. In terms of environmentally responsible practices to dispose of medication, this as well will be considered by the task force and as part of the regulations in support of Bill 140.

Finally, the ministry has also engaged the long-term-care sector and its partners in a dialogue on quality through five quality summits convened across the province since January 2008. There were a total of over

600 attendees from the long-term-care sector. A number of ideas were tabled for the ministry's consideration in ongoing efforts to improve quality in long-term-care homes.

On behalf of the homes, I would like to stress to the committee that, in my view, the homes have taken this audit extremely seriously. Each home has undertaken to review their protocols and processes around the issues discussed in the report.

With respect to the relationship with their pharmacists, each home has reviewed their current pharmacy contracts with a view toward improving the integration between the pharmacy and the home. This includes adding specific reporting requirements and monthly reviews to their contractual agreements.

With respect to consent, homes are actively seeking processes to obtain consent that enable the residents, their families and substitute decision-makers to feel informed and included in the residents' care. However, it is crucial that these efforts do not unnecessarily delay treatment of residents in emergency and urgent circumstances.

The homes noted that they and the regulated health professionals follow the guidelines set out in the Health Care Consent Act and by the professional colleges as part of their standards of practice. The homes did indicate that the compliance advisers review this requirement during on-site inspections.

In closing, let me say that many players in the long-term-care home system have a stake in—and are continuing to work hard to improve care in all its facets—long-term-care-home residents, including the critical area of medication management. We all want long-term-care residents to receive quality of care, just as we would want for our loved ones or ourselves.

Once again, I thank the committee for allowing me to address you on this important issue. We're happy to take questions at this point.

The Chair (Mr. Norman W. Sterling): Thank you very much, Mr. Sapsford. Mr. Cutler or Ms. Nowlan, if you wanted to say anything at this time, you could. If you don't, that's fully understandable and you can help answer questions. What is your choice?

Mr. David Cutler: My choice is not to say anything at this point in time.

The Chair (Mr. Norman W. Sterling): Okay, that's fine. Mr. Hardeman.

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Mr. Ernie Hardeman: I want to thank everyone for being here, and in particular the deputy for the great presentation. I want to start off by saying that I think all of us in the committee—I know, speaking for myself—agree with your last page. I think we're all in this to make the system work better, and it's in everyone's interests to make sure that it's done, recognizing the fact that everybody is doing a good job, as we're doing now. We're just looking to refine it.

The reason I'm bringing that up first is because my question really is going the other way. Obviously, this committee's responsibility is to look at the auditor's report, find out what he's reporting on, and then have the ministry come in and explain it and what they're going to do to fix it. Obviously, there was some concern or some questions about the auditor's report that the committee felt warranted asking this sector of the ministry to come in and talk to us—and I spoke to the deputy earlier; he's been here a number of times with different sections of the Ministry of Health. Every time I hear, "We're very happy that we got this auditor's report because it's going to be very helpful"—I can understand that. The Auditor General's office is a good group of people and they're very helpful. But I'm a little concerned.

The responsibility for the ministry is to regulate and inspect the long-term-care facilities. Serious things like not having proper records of the drugs people take and don't take, and making sure that it's all being done properly, and that there are not enough records, in the auditor's opinion: Why does that not turn up in the ministry's inspections? Why does it take an auditor to bring this forward and get all of this new process, which I think is a good idea, into play? If we do the inspection, wouldn't we notice something like this?

Mr. Ron Sapsford: Inevitably, it does show up from time to time during compliance inspections. Where it is noted that there need to be improvements, then recommendations are left with the home, and as part of the compliance process, homes are given a period of time to correct the issues. In some cases, it's a one-off; there's one example of it. In other cases, the inspection might lead to a more systematic problem, in which case the recommendations that are left with the home will vary, depending upon the number of circumstances. So that the auditor has gone in and looked at this particular part of a home's functioning and found areas of improvement, in a sense, is to be expected.

I think what we're trying to do as a ministry using the auditor's report is to look for more systematic solutions, as opposed to an individual home, and try to, in a more systematic way, find solutions that can be applied more broadly. So the ministry views the auditor's work as a quality improvement tool, and where we identify systematic issues that need to be corrected, move in that direction.

So I would hope you could see that in the minister's response—by looking at the critical incident reporting, by putting these things into automated form as opposed to paper records, by bringing the whole sector together, including the colleges, to improve the overall approach to it—is really what I want to focus your attention on today. But compliance inspectors on their inspections find issues that are dealt with all the time.

Mr. Ernie Hardeman: Thank you very much for that answer. I wasn't inferring that the auditor's report shouldn't be helpful in improving the system. I'm more concerned, taking from your presentation, that "the ministry, as steward of the health system, is responsible for setting standards of care and conducting inspections of long-term-care homes to safeguard residents' rights, safety, security, quality of care and quality of life."

I don't think there's anything that has a greater risk to the quality of care than the prescribing, giving and monitoring of medication. It's a wonderful thing in our society, but it also has ramifications—giving too much or too little and making sure the records are straight. So I'm quite concerned when the auditor comes in and finds there's a problem with that, that not all medication that's been given is being recorded properly, and I'm also concerned with the fact that in reporting when there's a problem, we don't have a definition of what requires reporting and what is considered a problem with medication—a critical problem or whatever it's called.

Mr. Ron Sapsford: Medication errors.

Mr. Ernie Hardeman: Medication error. I don't understand medications that well, but it seems to me it's either right or it's an error when you're administering medication. Shouldn't there be some way to record that and to make sure that was in place without having an auditor tell us that it's a problem? Is it something that we've overlooked too long?

Mr. Ron Sapsford: No, I don't believe that's the case. I think the issue we're confronting is what you actually consider an error to be. I'll give you some examples.

Error can occur because the wrong drug was given. That's a major issue. Some definitions include not only the right drug, the right route, the right dosage and the right time; each of these definitions has a definition. So the right time: If the prescription says at 2 o'clock in the afternoon and for a variety of reasons it wasn't given until 2:30, some definitions call that an error but other definitions simply look at the impact on the patient or the resident to whom it's been given. So if, yes, it was given 30 minutes late but it didn't have an appreciable effect on the care or the impact on the patient, other definitions don't include it. So depending upon which set of definitions you look at, you get a different set of things to actually keep track of, and as you've suggested, to record.

The definitions of the College of Nurses of Ontario, are different to the ones that the Ontario College of Pharmacists uses, principally because they are different professions and have different roles in the health care system. The challenge for us is to work with all of these definitions to come up with a consistent one that we can apply uniformly across the system.

Right now, there are definitions in use in homes, and my colleagues can perhaps speak to that, but the wrong drug is an error no matter how you look at it. The dose of a drug would be an error no matter how you look at. Whether it was given on time and those sorts of things are where we get into more vagueness. But safe medication management, irrespective of what the ministry says, is the responsibility of health professionals who are working in these facilities. To a degree, the ministry relies on professional practice standards as part of the mechanisms that are used to achieve quality of care. This isn't only about the ministry setting a standard and inspecting, but also our self-regulated professions and their responsibilities in providing safe care are part of how our health care system works.

Mr. Ernie Hardeman: In the definitions, is it required that there's a negative reaction to something happening before it's recorded as a mistake?

Mr. Ron Sapsford: Well, there's a difference between a mistake and an adverse reaction. An error is something to do with an incorrect application of the prescription: the prescribing directions of the physician, dispensing by the pharmacist and administration by the nurse. An adverse reaction has to do with the drug itself. An adverse reaction because the wrong drug was given would be considered an error. An adverse reaction to the appropriate drug being prescribed, dispensed and administered is something to do with the physiological reaction to the drug. Yes, it would be noted, yes, the physician would be notified, yes, a change perhaps in the drug, but it wouldn't be considered an error.

Mr. Ernie Hardeman: Are there any definitions that would include or not include that the administration—like you said, "It was supposed to be at 3 o'clock. We missed the 3 o'clock one and we didn't give it until 6." Is there any definition of a drug error that would include that as having to be recorded as a drug error?

1020

Mr. Ron Sapsford: Yes, there are definitions that do include that.

Mr. Ernie Hardeman: So the administration of it is also a part of that.

Mr. Ron Sapsford: Yes.

Mr. Ernie Hardeman: But it doesn't deal with a wrong prescription. If a doctor makes an error in prescribing a drug, that wouldn't be classed as a drug error on behalf of the facility.

Mr. Ron Sapsford: Well, the homes and the ministry's inspection system have few ways to detect an error in the prescription. There is a relationship with the pharmacist, so the pharmacist is aware of the medical condition, the reason for the drugs and so on and so forth. If there are perhaps errors in dosage—the physician writes a prescription and, let's assume, makes an error in prescribing twice the normal dose of a drug, which would be an example—then the pharmacist's role in dispensing the drug would be to notice, "Well, this is twice the usual dosage of what I would normally prescribe. Is there something about this particular resident or is this in fact something I need to talk to the physician about?" Those kinds of prescribing issues are normally dealt with between the pharmacist and the physician.

Mr. Ernie Hardeman: All drugs administered in the facilities are monitored and recorded, so I could go in and find out what medicine my mother got today, tomorrow and yesterday?

Mr. David Cutler: Yes. Drugs that are administered in the homes are recorded and signed for. If you have to give a drug three times a day, it comes on a medication administration record sheet. It's documented there: the patient, the drug, the dosage, the strength. It has to be administered, and the person who administers it has to

identify the resident, the drug, and sign once it's given. So there is that record in the home.

Mr. Ernie Hardeman: Is that also true for the medication errors? Are they all recorded? Recognizing that each facility may have a different definition of it, whatever definition you use, are they recorded?

Mr. David Cutler: To the best of my knowledge, I believe that they are recorded. There are very standard definitions as well of what is considered to be a drug error, and the practice is that these are recorded. In fact, once they're recorded, they are also reported in an incident report to the ministry and to the home's administration.

Mr. Ernie Hardeman: I have just one more question and then we'll let somebody else have a turn. If all medications given are recorded and if every error is recorded, the only thing we're having a problem with is the definition of what an error is. Other provinces have developed their own definition. To the deputy: What's been holding us up? Obviously this problem didn't arise when the auditor did the audit; this problem has always been there. This is the first time it's been identified to this committee. We must have known before that we needed a common definition of what would be a drug error.

Mr. Ron Sapsford: I want to be very clear on this. There is a definition and there has been one in practice. What we're facing, partly based on the auditor's work, who did look at other jurisdictions, is that there's inconsistency in the definitions. What we're trying to do is to provide a common definition that covers, in general terms, all eventualities.

All homes have been using definitions of "errors." The question here is, are they adequate, and what's the best definition to use and apply in a systematic way?

Mr. Ernie Hardeman: This is the last one for sure: What we're saying is, then, that each home is recording the medication errors, and I could go into any home and they would tell me how they define that error?

Mr. Ron Sapsford: Yes.

Mr. Ernie Hardeman: Okay.

M^me^ France Gélinas: Can I direct my question to anybody, or do they decide among themselves who—

The Chair (Mr. Norman W. Sterling): No, you can direct it to anyone.

M^me^ France Gélinas: Shelagh, we'll start with you. I'm trying to understand the human element of what we're talking about. Does your home deal with one specific pharmacy?

Ms. Shelagh Nowlan: Yes, we do have a contract with a local pharmacy in Kingston.

M^me^ France Gélinas: How did you go about selecting that pharmacy?

Ms. Shelagh Nowlan: There are criteria within the long-term-care standards that pharmacy services are required to provide to a home. So our contract includes those criteria in the selection, in the contract.

M^me^ France Gélinas: Did you have a good selection of pharmacies you could have chosen from that were able to meet those criteria?

Ms. Shelagh Nowlan: We have a long-term relationship with a local pharmacy that has continued to provide us with services. There are a selection of pharmacies throughout the province that do have the ability to perform those duties.

M^me^ France Gélinas: I take it they provide services 24/7?

Ms. Shelagh Nowlan: Correct.

M^me^ France Gélinas: Do you have any way of ensuring that there's continuing education in long-term care, specifically dealing with long-term-care clients etc., happening with the professionals that you deal with at the pharmacy?

Ms. Shelagh Nowlan: Yes, that is part of our contract with our pharmacy. The pharmacist is actually in our home for half a day a week, where they are working with our staff, the physicians and the residents. So there is one pharmacist assigned to our home who builds a good working relationship with staff and with residents.

M^me^ France Gélinas: I'll move to another profession: physicians. How many physicians are associated with your home?

Ms. Shelagh Nowlan: At Providence Manor, we have 14 physicians who have attending physician agreements with our home, and we have one medical director. Our home is a 241-bed home.

M^me^ France Gélinas: Do most of the residents come in with their own family physicians, or are they assigned?

Ms. Shelagh Nowlan: That is happening less frequently as some changes occur. So if their family physician is not able to meet the service agreement requirements of the attending physician service agreement, then one of the physicians who are within the home accept the medical care for that resident.

M^me^ France Gélinas: Do you have any difficulty recruiting physicians to look after your residents?

Ms. Shelagh Nowlan: At this time, we are very fortunate. We have a team that has been in place for a long time—recognizing, across the system, there are some challenges ahead.

M^me^ France Gélinas: What kind of remuneration do you give to the physicians who work in your home?

Ms. Shelagh Nowlan: The attending physician bills for services through the OHIP billing system, so there is no remuneration directly from the home. The medical director of the home does receive remuneration for that role, which takes on additional duties than an attending physician.

M^me^ France Gélinas: Those are paid for by one of the envelopes that the Ministry of Health gives to you to fund the home?

Ms. Shelagh Nowlan: Correct.

M^me^ France Gélinas: Do you have any way to ensure that those physicians participate in continuing education, specifically to your area?

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Ms. Shelagh Nowlan: Again, in our home we are fortunate with our affiliation with Queen's University. We do have physicians, many of whom are part of an affiliation to the university. Continuing education is a component of what they have offered within our home, as well as through the university system.

Mme France Gélinas: Do you do performance appraisal of the physicians who provide services in your home?

Ms. Shelagh Nowlan: No, we do not. We do have a service agreement. If they are not meeting the expectations of the agreement, then our medical director and I work to resolve the issues that are being presented. They are required to show their proof of registration as part of that agreement, as well.

Mme France Gélinas: Moving on, do you have nurse practitioners?

Ms. Shelagh Nowlan: Not at Providence Manor.

Mme France Gélinas: You have them someplace else?

Ms. Shelagh Nowlan: Certainly, some other homes do have nurse practitioners involved in the role. At this point, at Providence Manor, we have not been able to have the position.

Mme France Gélinas: I take it you have a number of nurses. I don't know if you know the number. Do you have any problem recruiting nurses to your home?

Ms. Shelagh Nowlan: Yes. I think, again, it's not unique to Providence Manor. There are issues around recruitment of both registered nurses and registered practical nurses in the Kingston area.

Mme France Gélinas: What would you see as solutions for you to be more competitive in recruiting nurses and RPNs?

Ms. Shelagh Nowlan: Providence Manor is participating in one of the health human resources strategies that the ministry has funded to look at recruitment and retention of nurses. There are four projects that seven homes plus our association are working on for the next year, trying to identify what would make the biggest difference to recruitment of nurses to the long-term-care sector. There are lots of options available, and we're trying to look at what will make the biggest difference.

Mme France Gélinas: Aside from RNs and RPNs, do you have anybody else who dispenses medication? Do your PSWs do it?

Ms. Shelagh Nowlan: No, they do not.

Mme France Gélinas: Do you have anything in-house that works on developing an interdisciplinary team working relationship with the people who are involved with drugs—prescription management, dispensing?

Ms. Shelagh Nowlan: Yes, we do have a couple of committees. The pharmacy and therapeutics committee is an interdisciplinary team that meets within our home. As well, the professional advisory committee is an interdisciplinary team, where we bring practices and changes forward to those two committees. We are fortunate that we are one of the phase 5 adopters of the RAI long-term-care programs, which means we are just beginning down that road. But what we're seeing is, that in itself will promote our interdisciplinary approach to care planning. It will improve our ability to get input from the front-line workers, the personal support workers, into the care planning. Medications would obviously be part of looking at the effect of those, as well.

Mme France Gélinas: We hear a lot in the long-term-care sector about the need for more hands-on care, more hours of care per home, average hours of care per resident etc. As legislators, when we look at the report from the auditor and the opening statement that Mr. Sapsford has done for us, we all want things to improve. I think the auditor's report shows that there is a bit of room for improvement. Some say there would be lots of room for improvement. Is there anything that we can do that would help you meet the requirements that the Auditor General has set out?

Ms. Shelagh Nowlan: Certainly, what we are trying to do is work with the changing complex-care needs of residents and look at the support within the registered staff. I would say that our main focus is the resident and the time we have to provide the care that each one of our staff is wanting to provide. So I think time with people—as the system looks at time with people—will make the differences we're all seeking.

Mme France Gélinas: As legislators, if we were to implement minimum average care, based on the case index, would that be helpful to you?

Ms. Shelagh Nowlan: It's a complex issue because it determines the right person and the right skill set, and how to create an average length-of-care time needs some looking at. But, yes, I think if we work together to look at the right mix of staff within a home, it would benefit the resident care.

Mme France Gélinas: Thank you.

Mrs. Liz Sandals: Perhaps that leads into the question that I was interested in. When I talk to my local long-term-care operators, what I hear is that a larger and larger proportion of the residents have dementia issues in one way or another. I'm from Guelph and the community mental health centre has been doing a lot of work with my long-term-cares in terms of working with the staff to give them better patient management strategies and better knowledge around how to manage residents with dementia issues.

I wonder if perhaps the deputy could comment on whether that's something we're seeing across the province, and, then, if the long-term-care operators could talk about how that's playing out for them locally and whether that has a positive influence on the amount of medications that are actually required, if you have other management strategies other than just medication.

Then, I wanted to follow up with another dementia issue, which is really the substitute decision-maker issue, which, again, is a dementia-related issue, if I may.

Mr. Ron Sapsford: Yes, aging brings dementia and as our population ages and we have more people in that category, yes, it becomes a growing problem. So it is a phenomenon across the province; it isn't an isolated

issue. It's an ongoing area of program development as to how to manage patients with varying levels of dementia and behavioural problems in long-term-care homes.

There are principles of treatment around minimum intervention. The whole issue of how one manages residents with these kinds of problems is an ongoing treatment and management issue. There are a variety of techniques, which my colleagues will be able to talk about.

Resorting to drugs is not the first intervention. There are many other ways that people can be managed without resorting to medication, although, at the end of the day, that is one of the options that physicians have, in terms of assisting. In the past, the ministry has made investments in education and training in a variety of locations, and I'm sure you'll hear some information about that.

Mr. David Cutler: I talk on behalf of Leisureworld St. George and our organization. I can tell you, at St. George we've had training for our staff on a program called U-First!—nine members have gone through that—and PIECES training. As an organization, we implemented behavioural management training and education and 241 employees at St. George have been through that. That's teaching them how to deal with and treat residents who exhibit these behaviours at different times. That is about how you handle them, how you may distract them, put in place processes to distract them, rather than going toward looking for medication. We try, as an organization, only to use medication, and call a physician for that when we need it, as a last resort, when it's extremely difficult or maybe dangerous to the safety of other residents. But we do use the other steps that I've indicated as our first priority.

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Ms. Shelagh Nowlan: Thank you. As well, at Providence Manor we have extensive training programs. We are also addressing some of the issues that are facing staff and residents with what is called the gentle persuasion approach, which is the behavioural management program that the psycho-geriatric resource consultants across the province are supporting in homes, and giving our staff the skills they need to work with individuals.

Certainly, medication is one option that is looked at, at the end of all the other approaches, and it's an interdisciplinary approach that is taken. So again, it's not one person looking and coming up with a solution. It's 24 hours a day, seven days a week the people who are working with the residents coming up with strategies that are helping the residents to live life to their fullest in the home.

We have also benefited from the U-First! training and the PIECES training that is funded through the province and many of our staff around the clock have taken those courses as well.

Mrs. Liz Sandals: Thank you. The auditor noted some difficulty, where there are issues of dementia, in getting substitute decision-makers to make timely contact. The deputy, in his remarks, spoke about homes actively seeking processes to obtain consent without getting unduly overregulated so that you actually end up delaying treatment. I wonder, because that's an issue the committee may be interested in, if you, as operators, have any practical suggestions around approaches we might consider. How do you manage that problem? It's obviously a huge problem for you, not having your substitute decision-maker readily available, yet you've got a medical emergency. Could you give us any insight into practical ways that you might be able to handle that?

Ms. Shelagh Nowlan: I'll start. Certainly, we don't have all the answers. We are encouraged by the task force that is being brought together through the ministry to look at consent to treatment, because it is a complicated issue that has a shared responsibility—physicians, nurses and pharmacists all share a responsibility to seek informed consent. In our home, we certainly have opportunities to work with families at the annual review of a care plan; medications are reviewed at that time. We look at any high-risk medications very carefully and ensure that it's the right decision for the client.

It is a challenge in our communication age, where voice mail and e-mail are the main—when you're seeking consent and voice mail is there and you leave a message and then you are expecting to close the loop. We are working with the system to identify the problem that I think we have all identified in the system. I'm encouraged that the task force will come together and get the discussion going around the professions on how we can do this, because it is important to our residents and families.

Mrs. Liz Sandals: Do you wish to comment too?

Mr. David Cutler: As has been indicated, it is a difficult situation, but there are specific conditions under which it is acceptable to proceed without consent: obviously, in an emergency situation when no substitute is available. We also practise mandatory follow-up with the substitute decision-maker by inclusion of family conferences and highlighting the medications and trying to get their permission. But if something changes dramatically, obviously with the assistance of the physicians, the nurses and the pharmacy, our goal is not to let a resident suffer. We have the legislation that will allow us to use that in emergency circumstances, but normally on the everyday run-of-the-mill stuff, the consent that you originally get at the time of admission should stand you in good stead until the next meeting.

Mrs. Liz Sandals: Okay. If you could help us understand this, I think it would be helpful, and the deputy may wish to jump in. What I think I'm hearing you say is that there are already some regulatory structures in place where the substitute decision-makers can hand off some authority to their interdisciplinary team at the nursing home. Certainly in emergency situations you've got the authority to make the decision and then come back and inform the substitute decision-maker. The fact that you don't always have that signed off in advance doesn't mean that you're breaking the rules; it may mean that you're following the rules that are already there. Am I hearing you properly?

Mr. Ron Sapsford: Yes, you are. When one is in a care milieu, applying an absolute rule to every condition and every resident in all circumstances is impossible to achieve, and I think the area of consent is one example. We assume that all residents are able to understand; they're not. We assume that all families are very attentive and immediately available and in the home at reasonable times; they're not. Some residents are alone, and we have to refer to substitute decision-making processes, but even there sometimes the substitute decision-maker is in Vancouver. You leave the voicemail and nothing happens, nothing happens, but this resident has acute respiratory distress. Are you going to get a consent to administer perhaps an antibiotic, which is going to immediately improve the physical condition? If I were in that case, I'd say no. Have I violated the letter of—well, I didn't have a signed or—maybe. Have I violated the spirit of what getting consent is about? I would argue not. So consent is applied to the level of the risk of proceeding with the administration. If it's aspirin, it's quite different than if it's a very high-level heart treatment.

Consent is not, in my view, absolute. It requires an evaluation of how you apply the rules to the circumstance that you're in, and that's again where we rely on our professionals to use their best judgment, because this is about making sure that the health and safety of the resident is the prime importance. I would argue that that's even more important than the documentation of the fulfillment of a rule.

I think that's the spirit at least that we're using as a ministry. Let us try to focus now on what the key elements of it are and make sure that as the system responds, it's responding in the interest of the resident and their health and well-being and then fit the documentation in as we go along. As long as the basic principles are what are guiding people, it can be handled in most cases.

But I know homes, on admission, establishing the wishes of family and substitute decision-makers based on mother's or father's condition—at what level do you want us to intervene? How do you want us to respond when someone is at the end of their life and not likely to get better? There has to be an active discussion. And those discussions do take place and the homes pay attention to it. Part of that consideration is how it applies to medication: How do you want us to respond? Those discussions are taking place, by and large. I think it's in the exceptional circumstances where we need a separate consent, and then we have to go through that process.

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Mrs. Liz Sandals: Okay, thank you very much. That's very helpful.

The Chair (Mr. Norman W. Sterling): Is the task force dealing with the consent issue?

Mr. Ron Sapsford: Yes. It gets into questions that I think the auditor referred to—issues around standing orders—and asked for a review of the ministry. So the consent issue touches on issues of standing orders because the standing order says, "If this happens, give the medication." There's an implied consent question there, so if they get a respiratory infection, you apply an antibiotic. Standing orders don't go into that, but there needs to be some discussion and redefinition about consent and its application to some of the routine procedures that go on in homes.

The Chair (Mr. Norman W. Sterling): There are a few Liberal members, but we're in the rotation, so I'm going to go to Mr. Hardeman.

Mr. Ernie Hardeman: If I could go back to your presentation, Deputy, and the common assessment tool. I just need a little understanding of what the common assessment tool is, and secondly, why it would take until 2010-11 to get everyone to use it. If 217 homes are already using it, how come it takes so long to implement that in the other homes?

Mr. Ron Sapsford: I think I'll ask Tim Burns to respond to that question.

Mr. Tim Burns: If I'm allowed to suggest a follow-up, I think the homes in the process of implementing it could probably add quite a bit to what I'm about to say.

I think the common assessment instrument is very valuable to the system, first and foremost because it's a series of questions and items which have been proven through research to be very important to the course of care for our residents: the critical questions for the team to ask to put together the plan of care for the resident. It's extremely important both for what it does to bring the team together to document what's in the best interests of the resident, to get that plan of care, and then from the data that's derived in the follow-up in delivering the plan of care, you get the rest of the measurements that we're seeking in a performance and quality improvement light. So it gets the right teamwork, the right questions asked, the right plan together and then the right measures coming off as the thing matures into full use.

As to your question with respect to why it's taking so long, I think the homes could help answer this question. But it has to be recognized that for a home that may have had a variety of different processes, may not have been computerized, may not have had the disciplines in place for whatever reason to bring the care team together, it's a profound change in how they do their business. It is not something that you can come in over the weekend and do a swap over. We're learning to get it in place, learning how to assess, getting the data correct, getting the supporting processes, the software and everything correct. It can be anywhere from 12 to 15 months to really get up to full and complete proficiency in everything that the tool has to offer.

I think the answer to that question, in short, is that it is such a profound improvement in those fundamental processes that it takes that long for an individual home to go through, and then we have a project at the ministry that works with homes to train everybody and help them understand the data and so forth. They have a certain capacity constraint there, so we think we can do about 70 homes per quarter at full speed. If you take 600 homes and how far we are today, that suggests the time scale.

Mr. Ernie Hardeman: So the time delay is more from the ministry being able to move through it and help people—

Mr. Tim Burns: It's both—

Mr. Ernie Hardeman: —rather than the homes' hold-up?

Mr. Tim Burns: The answer to that question is we're getting a very good response from the system in terms of homes putting themselves forward. Each time we open the front desk and say, "Who wants to start," we're over-subscribed, and we can do about 70 well. We want to do intakes at a rate that we can do well, and that's about our rate. I would ask the homes to comment, if that's within my purview. I think homes need the time to go through. We don't want to rush people through it because we want it to be about the residents and the care plans.

Mr. Ernie Hardeman: Before we let the homes answer, the reason for the question is, if it's the wave of the future, if it's the most effective way to deal with patient care in the system, it would seem to me that every home would be anxious to get on with doing it the best way possible. So the question really is, are we waiting on the ministry or are we waiting on homes to buy in?

Mr. Tim Burns: We started this initiative at scale, I guess it's going back about two years. If you want to look at the history of the program, there was an early adopter phase, where we were doing 10 homes at a time. We have to learn how to work with homes to do it. Seventy homes a quarter would be 240 homes a year, and in our first year we did 20 homes. So we're actually coming up a learning curve of our own, and there are some changes on the ministry side that we have to get through.

In short, I guess there are some capacity constraints, but our capacity to support homes is coming up quite quickly.

Mr. Ron Sapsford: I just wanted to add two points to Tim's comments. One is the focus in the home for standardizing the assessment of residents and developing care plans. On the other end, this information is available to the ministry in a consolidated form, where we can begin to take the care requirements across the whole system and apply that to costing methodologies, which will help the ministry in terms of the resource requirements needed to support the levels of care in homes in a more consistent and more measurable way than we've been able to do in the past. So there are two points to this: first, to help homes in terms of determining what care is required; and secondly, to give the ministry consistent information on resource requirements into the future.

Mr. Ernie Hardeman: Could we get an answer from the homes? Are you waiting for it to happen, or do both of the homes already have it?

Mr. David Cutler: I can talk for Leisureworld. We own and operate 26 homes in the province at the moment, and I believe, if I can just check, up to 20 of our homes are on the system already. Now, it is a complicated process in that extensive training of staff is required. We've had to add resources. The ministry has provided additional resources and training. The particular home that was audited is not on the system yet, but that is a function of application and selection. It will happen. The ministry is systematically selecting homes and it is a much better system of assessment. It's complicated because the nurses have to learn and understand it. So to do the initial admission assessment, when they first do it, it's taking them upwards of two hours per resident. As they become more familiar with the tool, because it looks at so many different aspects of the care levels, they are managing to get that down to about an hour and a half. So it is a learning tool, but it provides much better outcomes and much better information to assist the needs of the residents.

Ms. Shelagh Nowlan: Perhaps, if I could add, as I had mentioned, we are just embarking on this. It started in February. We're very encouraged. It is a huge change, and if you follow change, especially in a home of our size, the personal support workers also have to change every way that they are doing or documenting or reporting things. So it's a huge change that requires the staff to understand what difference it's going to make in the quality of life of the residents in order to keep it sustained. It is so important that we get accurate information so that residents' care-planning reflects the person—who they are. In the past, we had documentation after documentation; we had all sorts of information that we weren't able to pull together in a way that people could use to provide the care. I'm optimistic that this is going to provide the information to the people who are providing the care in a way that they can use it. It is also focusing on what's of value to the resident, which is their activities of daily living and promoting independence. Rather than looking at what we do for a resident, it's focusing more on what we do with a resident, so that they get the time again—I know I used the word—to have an opportunity to live a life of quality. So we're encouraged by it, but it is very labour-intensive.

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Mr. Ernie Hardeman: The other question was the issue of the 18,000 level 1 alerts that were overridden. The auditor mentioned that. Deputy, I get from what you said in your presentation that, based on some percentage of all the prescriptions, it's not a big deal. Is that what it says? And if it is a big deal, what are we doing to fix it?

Mr. Ron Sapsford: Simply to put some perspective around the number itself, that a drug is on a list that one needs to be cautious about does not obviate the need to prescribe and dispense the drug. This is what the flags are about. When a prescription is written for that, the flag goes up in the system so that the professionals can provide additional scrutiny and remember, "Oh, yes, this is one of those drugs. Having said that, are we still going to give this resident the drug?" When the answer is yes, they're still going to prescribe and administer the drug, the flag is overridden. So if a physician makes the decision that, yes, this resident is going to have this drug on an ongoing basis, each time the pharmacist dispenses the

drug, which could be once a week or once a month, another flag goes up in the system. It doesn't change the fact that the drug will be dispensed, but it does mean the number of overrides goes up because it's constantly being overridden. It's that perspective that I wanted to explain.

Mr. Ernie Hardeman: I'm right, then. I don't need to be worried about that.

Mr. Ron Sapsford: Well, I think it's an indicator. It's an appropriate flag. Clinicians do need to be cautious around the use of certain drugs. I don't dispute any of that. But you should take some comfort that these flags are in the system and that they do go off, and as they go off, people apply their minds to whether they're going to continue to dispense or not. That's the purpose of them. These, in a sense, are audit flags.

Mme France Gélinas: Right now, Mr. Sapsford, we've asked for reports that come from mandatory reporting from long-term-care homes to the Ministry of Health. When we get those reports, there's often a line that says, "We had 85% compliance." It's never 100%. Is the new system we're putting in place going to give us 100% compliance of all of the homes?

Mr. Ron Sapsford: For the critical incident piece?

Mme France Gélinas: No, for the new R—whatever we're rolling out.

Mr. Ron Sapsford: For the assessment tool—RAI. Maybe Mr. Burns could follow up.

Mr. Tim Burns: There could be a few answers to that.

One of the issues is that when we report, we may have a higher compliance rate than the data we put forward. On mandatory reporting, to the best of my knowledge, we have very high compliance rates because it is taken seriously. What you may have seen is that there are data tests done on it, so that in a global report that we might put forward, in the interests of accuracy and in having a report be representative, some data points may have been selected out for data quality reasons, and therefore we report the numbers based on 85% of the total sample. That's one explanation.

The other one is on some of the stuff with respect to common assessment. One of the key things that's both intriguing and really a challenge about this system is it's designed to have the care teams ask the question in a way in which two different professionals would get the same answer back. It's called inter-rater reliability. We try to get homes above 90% inter-rater reliability on that data before we—it covers the threshold of usability. It's one of the reasons it takes so long to get homes up. That could be another answer to your question, not knowing exactly what you're referring to.

Mme France Gélinas: Good enough. You cleared up my worries.

I guess I'd like to ask my question of Mr. Cutler. If you have a good memory, it's about the same line of questioning I did with your colleague. Let's start with the pharmacy that you deal with. Does your home deal with a single pharmacy?

Mr. David Cutler: This particular home does deal with a single pharmacy.

Mme France Gélinas: That's St. George?

Mr. David Cutler: At St. George; yes.

Mme France Gélinas: Have you been with this pharmacy for a long time?

Mr. David Cutler: We did change about four years ago.

Mme France Gélinas: The reason for the change?

Mr. David Cutler: The reason for the change was that we were not happy with the services provided by the prior pharmacy.

Mme France Gélinas: Do you issue RFPs to select a new pharmacy? How does that go?

Mr. David Cutler: Yes, we do. We would have sent out an RFP saying, "These are the services and these are the standards"—of course, we would follow as well the ministry standards that come out of their manuals of what we have to achieve—and then set up a committee, had presentations and selected a provider. In fact, because we did it across the chain, we selected several providers so as not to put all our eggs in one basket.

Mme France Gélinas: Certainly the auditor reported on the price of the dispensing fees from the pharmacy. Was this something that was taken into account in your RFP?

Mr. David Cutler: We have nothing to do with the dispensing fees. We have no role in that at all.

Mme France Gélinas: So when you did your selection, you did not take this criterion into account?

Mr. David Cutler: From my information, I did not take that into account. But I believe that they are prescribed in defined rates by regulation that have nothing to do with long-term care.

Mme France Gélinas: So you've had the same pharmacy. Do you have the same arrangement where the same pharmacist comes to your home to review?

Mr. David Cutler: Yes, they do have an appointed pharmacist who will come in and do auditing, education and training and attend committees. So we have the very same arrangements.

Mme France Gélinas: Do they come regularly?

Mr. David Cutler: Yes, monthly.

Mme France Gélinas: They come once a month?

Mr. David Cutler: Not once a month; several times a month they come.

Mme France Gélinas: Do you do any kind of performance appraisal of the pharmacy services you get?

Mr. David Cutler: What we do is, we rely on our staff. When a pharmacy delivers the medication, it's up to the registered nurses to make sure it matches with what the doctors have prescribed and ordered and to bring to our attention if there are any errors that have come in. We do that. We also review their education, training and attendances and the services they provide. And yes, we do meet and discuss it with them if there are issues.

M^me^ France Gélinas: So, four years ago, when you were not happy with the pharmacy, is this how it unfolded: the nurses came to management and told them?

Mr. David Cutler: That is correct, and I personally had several meetings with the pharmacy, told them what they had to fix and gave them a 30-day time frame. It didn't work out, so I went and RFP'd for a new pharmacist.

M^me^ France Gélinas: Going to physicians that assist your home, how many physicians work in your home?

Mr. David Cutler: In St. George three, and they are there seven days a week.

M^me^ France Gélinas: They provide 24/7?

Mr. David Cutler: Yes, 24/7.

M^me^ France Gélinas: Of the three?

Mr. David Cutler: They take turns. There's a rotation.

M^me^ France Gélinas: That's a heavy call, is it not, one week out of three?

Mr. David Cutler: No. It's different days of the week. They rotate among themselves. They decide, "I'm going to do Monday, Tuesday, Wednesday, Thursday," whatever they choose, but we have coverage. We also have emergency coverage. If we can't get hold of one, we have the pagers for the others, and they will respond.

M^me^ France Gélinas: Do you do performance appraisals or performance appreciation of the physicians who work in your home?

Mr. David Cutler: Obviously, we do have discussions with them if issues come up, and we raise these with them. I'm pleased to say that we have very good physicians in this home.

M^me^ France Gélinas: Did you have any difficulty recruiting physicians to work in your home?

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Mr. David Cutler: No, we did not. We've had some of these physicians working with us for a long time.

M^me^ France Gélinas: Do you ask for a copy of their continuing education so that they stay up to date?

Mr. David Cutler: The home does that. They check their registration and they also provide information on the continuing education and advise us of the conferences or education sessions that they are attending.

M^me^ France Gélinas: But do you know which physician attended which continuing education?

Mr. David Cutler: Yes, the home would know that.

M^me^ France Gélinas: The home would know that. Okay. Do you have a nurse practitioner in your home?

Mr. David Cutler: Unfortunately, no.

M^me^ France Gélinas: But you have nurses and RPNs?

Mr. David Cutler: We have nurses and RPNs.

M^me^ France Gélinas: Just give me an idea how recruitment is going in your home.

Mr. David Cutler: We do have sufficient coverage. It is a stretch at times. It's a universal problem, I believe, across the country. But we are able to cope with what we have, not without its difficulties.

M^me^ France Gélinas: Do you offer continuing education to the nursing staff?

Mr. David Cutler: Oh, absolutely. It's mandatory. I highlighted to you that not only our nurses but our PSWs—241 have been through this behaviour management training. That's a Leisureworld initiative itself. So we do that on an ongoing basis. We'll even pay for them to attend education sessions.

M^me^ France Gélinas: Do you do performance appraisals or performance appreciation of your nursing staff?

Mr. David Cutler: Every employee in Leisureworld will not get a pay increase unless they have a written performance appraisal. So I rely on my HR to report to us. We have that system in place.

M^me^ France Gélinas: That's an incentive.

Mr. David Cutler: We do have a staff appreciation as well.

M^me^ France Gélinas: Again, my question: We are legislators. We realize that there are some needs for improvement. Is there anything specific that comes to you that would help you if we move forward on different pieces of legislation?

Mr. David Cutler: I think that continuing education and upgrading of skills is very necessary. I think that if there were a way to entice more people to go into nursing, that would be great. If there were a methodology to do this, that would be really worthwhile.

One just has to look at the numbers of people who are aging and what's going to happen. In 2025, over 25% of Ontario's population will be over the age of 65. So we need to provide for the future.

M^me^ France Gélinas: In your community, is your home competitive toward recruiting nursing staff, if you compare with other people that have nursing? I'm thinking health units, hospitals, community health centres etc. Are you able to be competitive in the recruitment or do you feel you have a harder time recruiting than other sectors do?

Mr. David Cutler: Different people—I think you need a different mindset to work in long-term care than if you want to be an emergency room nurse, for example. It's a question of profiling long-term care and the benefits. It is an exciting sector to be in. In some respects, yes, it's more difficult. But I believe that every sector will have its own unique challenges. It's really making your sector appealing to the nurses so they want to join. It's tough all around.

M^me^ France Gélinas: I take it that PSWs don't dispense drugs in your home, or do they?

Mr. David Cutler: No, not at all.

M^me^ France Gélinas: So it's the RN and the RPN.

Mr. David Cutler: That's correct

M^me^ France Gélinas: When I talked to your colleague about mandatory or average—based on the case mix index of hours of hands-on care—would that be something that would help with the challenges that the auditor has highlighted?

Mr. David Cutler: Can I understand your question better? Can I frame it?

M^me^ France Gélinas: Sure.

Mr. David Cutler: Is your question that an average minimum number of hours of care is what should be mandated?

Mme France Gélinas: As one idea.

Mr. David Cutler: Obviously, homes could always have more care, and the government has addressed that in this last budget, and that is going to be rolled out. But I think to prescribe that everybody is provided with X number of hours of care per day is not the right methodology to adopt.

Mme France Gélinas: I wasn't thinking per person; I was talking about more of an average. I know that 3.5 hours of hands-on care is something that has been talked about by your association. They came and lobbied us, anyway.

Mr. David Cutler: No, I think what we've talked about is the tool that measures the level of care that is needed and whether that can be improved. But to prescribe an average for everybody is really just painting everyone with the same brush. I don't think a standard average is the way to go; I think it's individualized need.

Mme France Gélinas: So how would you see this linked to the case mix index?

Mr. David Cutler: It's absolutely linked to the case mix index. The case mix index looks at the charting, looks at the needs of the resident. Especially out of the new MDS-RAI, you will be able to more clearly define the needs and the resources required to care for these residents, and from that you determine the total number of hours, based on your resident population in a particular home. Some homes may need four and others may need two. So, to give the one that needs two 3.5 hours of care is not applying the resources in the right place at the right time.

Mme France Gélinas: So you would like it to be based on the case mix index at the home?

Mr. David Cutler: Yes.

Mme France Gélinas: Thank you.

The Chair (Mr. Norman W. Sterling): Mr. Sapsford, coming out of the line of questioning earlier, are there regulations around the contract between the long-term-care home and the pharmacy? For instance, can the pharmacy pay the long-term-care home money in order to obtain that contract, and are there conflict-of-interest bars between the pharmacy and the long-term-care home?

Mr. Ron Sapsford: I don't believe there's a regulatory framework around that. The payment of the pharmacist's services is through billings to ODB, by and large. So the dispensing fees, I think as someone else mentioned, are part of the agreement between the ministry and the pharmacist on the payment.

As to the services that go into that contract, I think they vary home by home. To some extent, I think there's a negotiation over what services a pharmacist would supply to a specific home. But there's not a specific regulatory framework around that issue. Perhaps Mr. Burns can add to that.

Mr. Tim Burns: I can't say anything specifically with respect to the pharmacy contract. I just wanted to assure you that within the service agreement and the manual, there are general provisions for conflict of interest following typical public practice, because you want the resources in the system to work for the benefit of residents. So there's a general provision. How specifically that applies to the pharmacy contract, I can't answer right now. But be assured there's a general provision on conflict of interest.

The Chair (Mr. Norman W. Sterling): So we don't know, because the Ministry of Health is not privy to these contracts. They would be private arrangements. Are they—

Mr. Tim Burns: They are examined. There are standards in the manual, and that's what the compliance advisors rely on when they do their annual inspections. So in the course of the annual inspection, an examination is done of the contract to make sure that it meets the requirements, in terms of evaluation and reconciliation, and the standards of practice that you would hope of pharmacists.

With respect to the economics of the transaction, I don't think we look at that routinely. I don't know if one of the homes wants to talk about how the safeguards would be in place on the economics of the contract with their pharmacist. But we do look at the contract to make sure that it meets the requirements specified in the manual.

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The Chair (Mr. Norman W. Sterling): So there can be money paid by the pharmacy to the long-term-care home, in order to obtain the contract?

Mr. David Cutler: I don't believe that is the case. What the pharmacist will provide in return for the contract is the additional education, the in-services, the training, and those types of services which obviously would come out of their profitability because they would have to hire educators, send in pharmacists, and do that kind of thing. Their remuneration comes out of their arrangement with the ODB or whatever their regulatory body is that defines the fees on dispensing.

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

Ms. Laurel C. Broten: Maybe I'll pick up somewhere where the Chair was talking with respect to the pharmacists. I want to focus on the work that's being done right now to support pharmacists in having a closer relationship and a more integrated role, maybe, with respect to long-term-care homes. I know mention was made in your deputy's comments with respect to this somewhat paralleling a MedsCheck program.

I wanted to just ask about that relationship between pharmacists and long-term-care homes and whether, within the examination of that issue, they would be looking to a differentiation between internal and external providers of pharmacy support, and whether, within the long-term-care-home community, there would be long-term-care homes that would have a pharmacist in-house?

Mr. Ron Sapsford: I wouldn't be aware of any, no. The traditional or the typical arrangement is that the services are provided by local independent pharmacies, generally located in the community. There are some pharmacy companies, though, that provide exclusive service, or a large part of their business, to multiple nursing homes and have become expert, perhaps, to really focus on the needs of long-term-care homes. But, actually having an in-house pharmacist—I'm not aware of a home that would have that service.

Ms. Laurel C. Broten: So, as the task force looks at the model, what type of analysis are they going to be undertaking, or directed to undertake, with respect to reviewing the reimbursement structure and the dispensing services?

Mr. Ron Sapsford: Well, the ministry is going to be undertaking that—the economic review. As we've done in the general population, the MedsCheck program is where there's a specific fee paid for the clinical consultation services of a pharmacist. So, through a half-hour interview, where citizens have drug profiles with more than three medications, I think it is, they can sit down with a pharmacist and review their history, their use of the drug, the indications, contraindications, and answer questions that the patient may have.

It's that particular model that we're looking at including as part of the service contract in the long-term-care homes, so that there would be a more comprehensive clinical service available to residents of long-term-care homes. So, that's the piece of it that we're looking at to see if there's a similar application for the long-term-care population.

Ms. Laurel C. Broten: Any comment in that respect from the long-term-care home experts to indicate whether that is something that would be of assistance, as something that you look to down the road?

Mr. David Cutler: I'm certain that any assistance that we can get in that regard will heighten areas of concern, raise issues a lot sooner and give us better information to work with through our professional staff.

Ms. Shelagh Nowlan: Also, if I could add as well, I think our residents and families would greatly appreciate an opportunity to review medications in a way that gives them the chance to ask the questions of the experts around medications. So I think it could be a real additional benefit to residents and families.

Ms. Laurel C. Broten: Great. Thanks.

With respect to expired medications, the auditor spoke about perhaps a need to tackle that issue head-on and approach it in a somewhat different way. I wanted to ask two questions in that regard. As we develop the regulations on the Long-Term Care Home Act, is that something that you think will be examined in the context of long-term-care homes and pharmacy providers? Even before that's done, what kind of work is currently being done between pharmacists and residents? The pharmacy association, for example, has an ad campaign with respect to the return of expired medication for disposal. I'm just wondering if you can comment with respect to the highlighting of this issue and what steps are in the course of being taken to improve the disposal.

Ms. Shelagh Nowlan: There are steps in place in our home to regularly review medications. Our home is a large home, and we have an area away from the resident home area where the medications are kept that are not currently in use. So there's a double screening that goes on to make sure, if some of those medications end up going past due, that we have a way to clear that area for the larger drugs.

Our pharmacist is doing a regular review of medications with our nurses, and we have systems in place to check the date of expiry of all medications as part of the check that nurses are expected to do before giving medications.

There are always opportunities for improvement when you're dealing with large volumes of medication. There are always opportunities to look at improving processes to get medications that aren't being used anymore, whether they're in your own home or whether they're in a long-term-care home, disposed of properly in an environmentally friendly manner.

Ms. Laurel C. Broten: And what is your current practice with respect to disposal?

Ms. Shelagh Nowlan: We have a contract with a biohazard removal company that comes in weekly and disposes of all our medications.

Ms. Laurel C. Broten: Is there any different approach in terms of the way this business is conducted at Leisureworld?

Mr. David Cutler: It is not dissimilar. What happens at Leisureworld is that excess drugs from the floors are sent down to the director of care. The pharmacist reconciles them on drug forms against the actual drugs received and renders them unusable. The drugs are then placed in a box and taped shut, and a biohazard company comes and collects it, labels the box, barcodes it, scans it and removes it from the premises.

Ms. Laurel C. Broten: Thank you. Those are all my questions. I think Mr. McNeely might have some questions.

The Chair (Mr. Norman W. Sterling): Could I just ask: What would the average cost of a contract be for the disposal service of these drugs? I was interested, before you came into the room, in hearing from the auditor that other provinces capture these drugs and share them with Third World countries, where they might use some of them. What is the rough cost? Do you have any idea?

Interjection.

Mr. David Cutler: I have my administrator here, and he said to me that the pharmacy pays for that. So I have no idea.

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

Mr. Phil McNeely: I want to congratulate you on getting that new tool in to measure—what is it called?—the assessment tool, so that you'd be able to compare apples to apples across the province.

There was something in the report that you presented this morning: 19 million prescriptions a year for 75,000 patients comes out to about five per week per patient. What is a prescription in the long-term-care homes? Why would we be up to five prescriptions per resident per week? That seems like a lot.

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Mr. Ron Sapsford: That's the way the numbers work, I suppose. As I've said, a lot of residents in long-term-care homes have a number of physical issues that are dealt with through medication. Don't forget, these prescriptions can be anything from aspirin to sophisticated drugs. They could be drugs that are routine—in other words, four times a day every day—to prescriptions that are as needed. So it's not something that's given every day, but as the patient exhibits a certain symptom or a certain condition, then the drug is administered. The system counts all of these, all 19 million of them. It doesn't mean, and one shouldn't interpret, that every resident's getting a minimum of five drugs every day, because that's not what the number is about.

I think the issue of how many prescriptions are given to residents is an issue that's on the table. As I mentioned in my remarks, the clinical institute has been doing some work on medications in long-term-care homes, and their evidence is that there is a downward trend. Is there more room for improvement? Probably, but that comes from an engagement of discussion with physicians, who are responsible for writing them in the first place, and making sure that the physicians who spend time in long-term-care homes are looking at things like best practice.

The task force I referred to is to begin to address those issues as well. We've been in discussion with the College of Physicians and Surgeons of Ontario, and they're willing to engage in that dialogue to assist in making sure that physicians who practise in this area are aware of best practice and that medication management is a major part of their responsibilities for long-term-care-home residents.

Mr. Phil McNeely: Thank you. That's all, Chair.

Mrs. Laura Albanese: I wanted to ask about long-term-care homes. The auditor noted that some of the medication was expired, especially in emergency room supply. How do you know you're not giving any expired medication to residents? How do you make sure of that?

Ms. Shelagh Nowlan: That is one of the checks that the nurse does before giving medication. The expiry date is noted. We also now have an audit monthly of our emergency-stock drugs by our pharmacist, who removes anything that will be expired within the month. The stock is being regularly audited to ensure that the stock is current, but a nurse, as part of her five-hour checks that are done around medication administration, looks for an expiry date on medications.

Mrs. Laura Albanese: Is that the same procedure that is implemented at Leisureworld?

Mr. David Cutler: Yes, it is.

Mrs. Laura Albanese: Is this as a consequence of the auditor's report? Because he did find some expired medication in some departments.

Mr. David Cutler: The auditor's report has highlighted things for us that we've rolled out across all of our homes to make sure that it's not happening. I can't tell you where it was, but we're using that to our advantage and as a learning tool to make sure these things don't occur.

Mrs. Laura Albanese: I also had some questions regarding the orders from the government supply depot, the ones that are free. How do you know how much to order?

Mr. David Cutler: As you heard today, the process has changed. The process is that the order is made and it's delivered to the pharmacy, which then packages it and sends it out to us. They will keep an inventory, so they will be the gatekeeper now.

Mrs. Laura Albanese: So they're the gatekeeper, and not the long-term-care home anymore.

Mr. Ron Sapsford: On that point, it links to the wastage question as well, and expiry. The process has changed so that we don't ship in bulk to the home but now use the pharmacy as the vehicle so that we're not dispensing large lots from the government pharmacy. That should help manage the expiry and reduce the amount of wastage. We've tried to deal with it from that perspective.

Mrs. Laura Albanese: Thank you very much.

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

Mme France Gélinas: Coming back to high-risk drugs, those are drugs that are generally more harmful than beneficial to older adults. It's troubling me to read that these drugs were dispensed to at least 20% of residents in 30 homes.

I'll start with you, Mr. Cutler. When do those discussions take place in your home? How do they take place when you're about to give a drug that is more harmful than beneficial to a resident?

Mrs. Liz Sandals: Point of order, Mr. Chair: I'm not clear that it was in these homes that you found that, so I'm not sure whether it's—

Interjection.

Mme France Gélinas: Forget about the 20%. Where would those types of conversations take place?

Mr. David Cutler: Understand that we are dealing with professionals, consisting of the physicians, the registered nurses and the pharmacy. The doctor is the person who makes the diagnosis and says, "This is how we're going to treat." If it's flagged as a high risk, there would be a discussion. The pharmacist would call the doctor directly; if they couldn't get the doctor, they would call the home and speak to the registered nurse, who would make sure that they got hold of the physician first to verify the order. So it would be at that point that that would take place.

Mme France Gélinas: There are no interdisciplinary meetings where those people are there live on location to have those discussions?

Mr. David Cutler: If it coincides with a conference, absolutely, they would be, but if a doctor was called in today to deal with something and prescribed the medication, the pharmacist would get the order this afternoon, and he may try to call the doctor this afternoon or tonight and not get him, call the home, and we would follow up. There would be a few hours' delay, but there would absolutely be—it's an interdisciplinary discussion between the physician; the nurse; the resident, if they're able, or the substitute decision-maker; and then you would get approval to proceed or not.

The Chair (Mr. Norman W. Sterling): On a point of clarification: You're talking about the drug alert, and I think the member is talking about these drugs that are on the Beers criteria, that are high-risk. Are we on two different issues here?

M^me^ France Gélinas: No, I'm happy with his response. The same logic would apply. Shelagh?

Ms. Shelagh Nowlan: Yes, I think the interaction between the physician who's prescribing the drug and the pharmacist who is dispensing the drug is critical. In family practice, a community-based physician and a pharmacist discuss if there are issues. The same practice takes place at Providence Manor, so there would be a connection if there was a question around the appropriateness of a prescription. There would be clarification between a pharmacist and a physician.

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

Mrs. Liz Sandals: Yes, just a clarification. It would seem to be that on both of these topics, if you've got a drug that is being frequently prescribed for an elderly patient when it's contraindicated or you've got a high number of drug interactions, that's really for the pharmacist and the doctor. You may be reporting that there's a problem with the reaction to the drug; your nurses would do that. But the original prescribing overriding appropriateness of the prescription—that's back to the pharmacist and the doctor, surely.

Mr. Jim McCarter: That would be my understanding, that the issue with the prescription of, say, one of the higher-risk drugs that is on the Beers criteria—that's really the doctor's decision to prescribe that drug. Once it's prescribed, the pharmacist would fill the prescription. That wouldn't generate a contraindication drug alert; it would just be prescribed. It would come to the home; it would be in the strip package.

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The point we were making—and we understand that these high-risk drugs, on occasion, would be prescribed. The doctor would make that decision. I'm aware that I'm still going to prescribe it, but based on the data in the system, we found that a very high percentage of the residents—20%, in certain homes—were being prescribed a high-risk drug. The point we were making is that we just thought that was a very high percentage. Maybe that was information that either the college of pharmacists or in this case the College of Physicians and Surgeons should be aware of, just more along the lines of education, to get back to the doctor and say, "Dr. Jones, we just want to make you aware that this is a high-risk drug on the Beers criteria. Are you sure that it should be prescribed to 20% of the residents?" That's the issue that we were making.

Mr. Ron Sapsford: I would agree with that assessment. Are you talking at the level of an individual patient versus the whole system?

M^me^ France Gélinas: I was going to take it to the system after I had their answer.

Mr. Ron Sapsford: I think you've heard that, for an individual resident, it's a discussion. For the system: Some of the systems that we've talked about, the assessment tool, the discussion with the task force around best practice in medication management—these are some of the broader questions that we intend to table so that the profession itself is seized with the issue of drug and medication management.

The information that will come out of the ICES review, the discussion in the task force around best practices, would be the tables where we would intend to raise these sorts of issues. Are there better ways, as the auditor suggested, to manage with this high-risk group of medications? Sometimes it's an issue of, "Is there a better drug, or is there a less risky drug that could accomplish the same clinical outcome?" So it's a series of questions around the use of the drugs, as opposed to, "You shouldn't ever use these drugs," to make sure that those kinds of "use" questions are being asked.

M^me^ France Gélinas: Is the ministry in a position to share that information from the auditor's report directly with the College of Physicians and Surgeons, which is the body that physicians are accountable to?

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: How does that work?

Mr. Ron Sapsford: If we have a systemic issue or that kind of information, we would call them in, sit down and talk about how they would respond to that kind of issue, and take their advice on it. We don't get involved with individual physicians. That would simply be referred to them for their own purposes.

M^me^ France Gélinas: So has this phone call and this meeting taken place for the high-risk drugs that the auditor's report brought forward to our attention?

Mr. Ron Sapsford: No. We've dealt with it in terms of, "We need to get together and talk about the whole report and the issues that affect the profession and deal with them in a comprehensive way," this being one of them.

M^me^ France Gélinas: So it will get done.

Mr. Ron Sapsford: Yes.

M^me^ France Gélinas: My next one is that we've learned, through this new tool that is being rolled out, that there will be more of a focus on interdisciplinary practice. In the homes that I know best—the ones in Sudbury—they often mention the fact that the physician being fee-for-service is not conducive for him or her to take part in interdisciplinary practice team meetings, those types of activities, because you can't bill fee-for-

service for interdisciplinary practice meetings. How are you handling that part of it? I'll start with Shelagh.

Ms. Shelagh Nowlan: I'm not actually sure how we're handling that. I can certainly get you the information. We don't have a problem with physicians attending interdisciplinary conferences. We schedule them to their schedule, which may add complexity for a family member to attend. So that's one of the ways we've dealt with it. But there's certainly a fee structure for long-term care attending physicians that enables them to bill for their services at a certain number of visits a month to our home. So I would expect that that's how we are dealing with it at Providence Manor.

Mme France Gélinas: How about Leisureworld?

Mr. David Cutler: In a very similar manner; it's spelled out right in the beginning, when they sign their contract, that there's an expectation. So it's a contractual commitment.

Mme France Gélinas: Moving to you, Mr. Sapsford, with the introduction of family health teams and more physicians being interested in that type of practice, I take it that there would be provisions for family physicians who are interested in practising in family health teams to also attend at nursing homes. How are the fees—they're not fees anymore; whatever they are—being looked into to facilitate interdisciplinary activities?

Mr. Ron Sapsford: Some family health teams have, in fact, expressed an interest in offering that as part of their comprehensive service. So that would be put forward as part of their proposal to the ministry, and then we would negotiate the agreement with that particular family health team. So that would be one opportunity.

As far as the rules governing physician attendance in long-term-care homes, that's a subject for discussion between the Ontario Medical Association and the ministry when we do our contract negotiations. Physicians who spend a fair amount of time in long-term-care homes are organized as a group and provide that advice to the OMA, so often we're negotiating that as part of the physician agreement in the province.

Mme France Gélinas: Both of the homes have talked about the importance of education and upgrading for their staff. How are the homes being reimbursed, or are they being reimbursed by the ministry for those types of activities that are not necessarily patient-care-related, but they've both identified as something important to the health of their clients?

Mr. Ron Sapsford: There's an expectation in the remuneration for the homes in the current costing model that continuing education for staff is part of their obligation. So we expect homes to provide sufficient education, to keep the performance of the home and care levels at the standards established in our service agreements.

There are, from time to time, though, special requirements. I think you heard today about some of the behavioural programs that have been funded in the past that the ministry has provided special funding to support. It's an ongoing evaluation on the part of the ministry as to whether resources are needed. I think the questions around adequacy of staffing levels that you've raised today, as well as a question, partly, of education—where do we add resources into the mix of staffing? Is it on the front line? Is it providing more educational resources and expertise or specialized support? These are the kinds of questions that factor into the overall questions of staff levels.

But clearly, as we've asked questions in the system—I referred to some of the quality summits that we've had—education of staff is an issue that comes up time and time again on different areas of practice. So as we're looking at regulatory reform, policy and funding, education is one that we're always concerned about supporting.

Mme France Gélinas: I'll start with Mr. Cutler. What line do you use to do continuing education with your staff?

Mr. David Cutler: It depends. If it's for nurses, it'll be out of the nursing envelope, if it's for programs, it's out of the program envelope, and if it's dietary, housekeeping or infection control, it's out of the accommodation envelope.

Mme France Gélinas: Same thing with you, Shelagh?

Ms. Shelagh Nowlan: Yes.

Mme France Gélinas: Thank you.

The Chair (Mr. Norman W. Sterling): Can I just clarify a couple of points here? Is there any difference in the compensation to the pharmacy between what they receive when they get a prescription by a nursing home and somebody just walking in the front door? Is there any difference in the compensation the pharmacy receives?

Mr. Ron Sapsford: No. Well, some pharmacists in certain communities will forgo fees. We've seen that happen for Ontario drug benefit recipients, but the amount that they're able to charge for a dispensing fee is a regulated amount.

The Chair (Mr. Norman W. Sterling): Okay. The other one is on the consent issue, Deputy. From your response to my previous question on the consent issue, I take it that the task force is dealing with a very narrow part of the consent issue as they go forward. Am I correct in interpreting your remarks?

Mr. Ron Sapsford: No. The consent issue that the auditor referred to was the standing order issue. So we will be looking at that for sure, but looking more broadly at the question as well.

The Chair (Mr. Norman W. Sterling): I think every member of this committee, including me, understands the extreme difficulty of dealing with this issue in this environment. I think we all would like to see the best job done, but our first and my first concern would be the patient getting the needed medication at the appropriate time.

My concern would be the consistency across the system. In other words, I don't think nursing home A should have a different policy than nursing home T, or whatever it is. It's the consistency of the application or the burden upon each and every institution to have the same requirement as the next, so that you have a so-

called level playing field. Will the task force be dealing with trying to develop workable policies in terms of that?

Mr. Ron Sapsford: Yes. It's not restricted just to the standing order question.

The Chair (Mr. Norman W. Sterling): Any further questions? If not, first I would like to thank both Mr. Cutler and Ms. Nowlan for coming to the committee. You have added a great deal to our committee deliberations, in providing us with the practical knowledge of what actually happens on the ground. We all know that these are challenging times in terms of long-term care in our province, and all of us work with a number of our long-term-care facilities in each and every one of our ridings. So thank you very much for making the trip—particularly you, Ms. Nowlan, from Kingston.

I think all members of the committee realize that the criticisms that were brought forward in the auditor's report don't point to any single home and that they are generic in their scope.

Mr. Sapsford and Mr. Burns, thank you very much for appearing before the committee today.

The committee will take a short break and then we'll reconvene to try to give some instructions to our researcher for the preparation of the report. Thanks, all, for coming to the committee today. With that, we will adjourn the committee.

The committee continued in closed session at 1153.

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