

RECOMMENDATIONS TO THE JURY ON THE EL-ROUBI AND LOPEZ INQUEST ON BEHALF OF THE ONTARIO NURSES' ASSOCIATION

A. Need for Ministry of Health and Long Term Care to make Long Term Care a higher Priority

Repeated recommendations have been made to the Ministry of Health and Long Term Care (MOHLTC) to immediately develop both long term and short term strategies to manage elderly residents and in particular to plan and care for those with cognitive impairment and/or aggressive behaviours.

See: 1999 Annual Report of the Geriatric and Long Term Care Review Committee (GLTCRC) to the Office of the Chief Coroner for Ontario (Exhibit 66a)
2001 GLTCRC Annual Report (Exhibit 66b)
2001 PricewaterhouseCoopers, "Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators," (Exhibit 38 and 38A)
2004 GLTCRC Annual Report (Exhibit 66c)
2004 "Commitment to Care: A Plan for Long Term Care in Ontario", prepared by Monique Smith (Exhibit 57)
2005 Ontario Association of Non-profit Homes and Services for Seniors Report on Mental Health Issues and Long Term Care (Exhibit 67)
2005 Review of Homicides in Long Term Care Facilities by the GLTCRC (Exhibit 65)

Recommendation 1:

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

Recommendation 2:

It is recommended that the MOHLTC take immediate steps to implement the "Ten-Point Plan for Improving the Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario," (Ex 84). It is recommended that the MOHLTC recognize that due to health care restructuring LTC facilities have become "new Mental Health institutions" in Ontario, without the funding and resources necessary nor a recognition of the anticipated needs given the demographics in Ontario related to the

increased aging population with cognitive impairments.

See: *Evidence of Dr. K. LeClair*

B. Revision to Placement of individuals at risk of Harm to Self or Others

The present system sets out "harm to others" as an eligibility criterion for placement of an individual in a LTC facility. Long Term Care facilities have not been designed to handle these types of behaviours or levels of cognitive impairment. For instance there is no regulation or policy requiring an assessment of risk to other residents or staff, when placing the individual in the facility and no regulations or policies to ensure that the LTC facility manages that risk appropriately.

Moreover, there in fact are few or no alternatives to placement in the Long Term Care facility given the policy decision to close hospital beds, psychiatric facilities and the limited community resources.

See: *Placement Coordination Service Manual, 0503-02, p. 5-6 (Exhibit 18); Regulation 832, R.R.O. 1990, made under the Nursing Homes Act, R.S.O. 1990, c. N.7, s. 130(2)*

Recommendation 3:

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

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

Recommendation 4:

It is recommended that the MOHLTC and all CCACs change their policies to ensure that in cases of potential residents with cognitive impairment, with actual or potential aggressive behaviours, that the Community Care Access Centre health professionals should ensure that a comprehensive medical

assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry.

See: *Exhibit 70, Geriatric/Long Term Care Review Committee Case # 0217–0257 A & B, p. 14 (Exhibit 70: Review of the deaths of Lopez & Elroubi)*

Recommendation 5:

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

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

Recommendation 6:

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

C. Specialized Facilities and Units

i) Specialized Facilities

Recommendation 7:

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

Recommendation 8:

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

Recommendation 9:

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

See: *Review of Homicides in Long-Term Care Facilities by the GLTCRC, p. 6 (Exhibit 65)*
OANHSS Report "Mental Health Issues and Long-Term Care", p. 4 (Exhibit 67)
"Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility", p. 11, #1 (Exhibit 40)
Evidence of Dr. P. Clark and Dr. H. MacDonald

ii) Specialized Units

Recommendation 10:

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

- i) beds in appropriate physical spaces (ie private rooms located close to nursing stations etc) in which residents stay for a short period of time while they are assessed and an appropriate care plan is developed.
- ii) If appropriate, the resident once they are assessed and a care plan developed may be transferred to other units where the care plan will then be implemented. Attention must be paid to ensuring that the care plan is transferred completely, and that follow-up resources are available to the unit caring for the resident.

ii) Some of these units may also be set up based on a long term residential model where residents would live in these units for the entire duration of their behavioral complications.

See: *Review of Homicides in Long-Term Care Facilities by the GLTCRC, p. 6 (Exhibit 65)*
“Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility”, p. 11, # 1 (Exhibit 40)
Evidence of Dr. P. Clark and Dr. H. MacDonald

D. Revision to the Long Term Care Funding Model

The evidence is that the present system (the “CMI” or Case Mix Index based on the former Alberta model) needs fundamental revision as it is "problematic", in numerous ways.

This will require implementing both short term recommendations and long term recommendations including adopting Monique Smith's recommendation that the MOHLTC "revisit the entire funding system in the next fiscal year": ("Commitment to Care", Smith report 2004, ex 57; p. 26)

The long term care industry recognizes staffing as the means of ensuring quality care therefore requiring focus on having sufficient skilled staff, in sufficient numbers, to ensure a safe resident to staff ratio. Cognitively impaired individuals, particularly those prone to aggressive behaviours must be managed by the appropriate professionals (Registered Nurses, physicians, and in particular those with expertise in psychogeriatrics) who have the education, training and skill set to manage the unpredictable behaviours known to be associated with such cognitive impairment. These professionals must be available in the facilities in sufficient numbers and with sufficient time designated to safely manage the care.

See: *“Commitment to Care”, prepared by Monique Smith, 2004, pp. 23, 26.*

Recommendation 11:

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

Recommendation 12:

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

Recommendation 13:

That the MOHLTC retain PricewaterhouseCoopers, or a similar consultant, to update the January 2001 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, (Exhibit 38 and 38A) and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario Long Term Care facilities given the significant number of Ontario residents with cognitive impairment and complex care needs in LTC facilities. This would include determining the appropriate amount of direct RN care that is required, the indirect RN care and the total hours per resident per day of overall Nursing and Personal Care (RN, RPN and HCA), on average.

Recommendation 14:

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

Recommendation 15:

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

Recommendation 16:

Pending the remodeling of the funding system, the MOHLTC immediately review and revise the present CMI system to ensure cognitive impairment and behavioural problems are sufficiently weighted in the CMI system to ensure sufficient funding for appropriate skilled staff for assessment,

monitoring and management of residents prone to these behaviours.

See: *"Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility", p. 12 # 5 (Exhibit 40)*

Recommendation 17:

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

Recommendation 18:

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

E. Working Conditions

It is well recognized the long term care is severely understaffed and in particular is understaffed with Registered Nurses, the professionals who are designated under the *Regulated Health Professions Act* to have the scope of practice to manage complex care and unpredictable behaviors.

Monique Smith's report (Exhibit 57), the PricewaterhouseCoopers Report (Exhibits 38 & 38A), the Provincial Auditor's report (Exhibit 75), the Sigma 3 survey report (Exhibit 76) and the evidence of witnesses, indicates that this problem must be adequately addressed in Ontario. As Smith recommends: "strategic efforts need to be developed to promote the long-term care sector as a desirable career option as staff shortages and pay inequities are constant challenges".

See also: *Evidence of M. Haase, RN*

Recommendation 19:

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

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

F. Professional Standards of Regulatory Colleges to Protect the Public

Recommendation 20:

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

See: *Chart - "Profile of Practice Expectations for RNs and RPNs" (Exhibit 34) College of Nurses of Ontario Practice Guideline, "Utilization of Unregulated Care Providers (UCPs)" (Exhibit 80)*
Evidence of M. Haase, RN

Recommendation 21:

The MOHLTC staffing standards and the implementation of the staffing standards by the LTC facilities must ensure that the RN has sufficient time to ensure that she\he has time for collaboration with physicians, RPNs and Psychogeriatric Resource Consultants and sufficient time to adequately supervise, teach and delegate to the unregulated workers.

G. Accountability

Concerns have been repeatedly expressed by various bodies that the MOHLTC has insufficient accountability mechanisms to ensure that public money is being spent appropriately and in the way intended. In particular, when the Ministry predicted that a funding injection in 2002 would create 2400 new jobs in LTC, a survey that they commissioned revealed that 1782.5 Full Time Equivalent positions were created.

*See: 2004 Annual Report of the Provincial Auditor, 4.04 - Long-Term Care Facilities Activity, Follow-up to VFM Section 3.04, 2002 Annual Report, (Exhibit 75)
Evidence of Tim Burns*

Recommendation 22:

To ensure that the funding provided to long-term-care facilities is sufficient to provide the level of care required by residents and that the assessed needs of residents are being met, the MOHLTC should, in keeping with the recommendations of the Office of the Provincial Auditor (Ex 75, page 385):

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

*See: PricewaterhouseCoopers Report (Exhibits 38, 38A)
"Commitment to Care", prepared by Monique Smith, pp. 21, 23 (Exhibit 57)*

H. Immediate High Needs Funding for Cognitively Impaired/Aggressive Residents

The MOHLTC has referred to their "High Intensive Needs program" as a means for LTC facilities to access immediate funding to ensure appropriate staffing for high needs residents; the program should be immediately revised to ensure that the program is adequately funded, known to the administrators and staff at LTC facilities to be available for high needs cognitively impaired residents and is used for funding regulated health professions.

Recommendation 23:

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

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

See: OANHSS, "Mental Health Issues and Long Term Care," p. 4 (Exhibit 67)
Evidence of H. Khapadia
Evidence of M. Haase, RN

I. Speciality Training

Recommendation 24:

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

See: PIECES Manual (Exhibit 83)
Evidence of Dr. K. LeClair
"Commitment to Care," prepared by Monique Smith, p. 23
Evidence of M. Haase, RN

Recommendation 25:

More specifically it is recommended, that the MOHLTC create and enforce standards requiring all RNs working in LTC to be PIECES trained as a priority. Such standards should set out timelines, such as ensuring that all RNs presently on staff are PIECES trained within one year, and shall include PIECES training as part of the orientation for new staff. The MOHLTC shall ensure that there are adequate classes in each region to address the waiting lists and have all RNs trained within one year.

Recommendation 26:

That the MOHLTC create and enforce standards requiring all administrative and management staff who are involved in admissions decisions and staffing decisions regarding the In-house Psychogeriatric Resource Person, as well as all members of the “admissions team” to be trained in either the full PIECES course or the Enabler course.

Recommendation 27:

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

Recommendation 28:

In the interim, pending full training of all staff, that within the next six months the MOHLTC set standards, monitor and enforce such standards to ensure that all facilities have at least one Registered Nurses’ with PIECES training on staff on all shifts and available to do PIECES assessments.

Recommendation 29:

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

Recommendation 30:

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

Recommendation 31:

That the MOHLTC create and enforce standards, in addition to requiring all LTC facilities to have PIECES trained Registered Nurses on all shifts, that at facility there is a minimum of least one current PIECES In-house Psychogeriatric Resource Person and that ultimately there is a team of in-house resource persons. These In-house Psychogeriatric Resource Persons shall be linked to the Regional In-house Psychogeriatric Resource Team as part of their duties at each LTC facility.

The MOHLTC standard should require LTC Facilities to designate dedicated time for the RN to complete assessments, both initial assessments at the time of admission and all necessary repeat assessments. This person shall also have time designated to conduct PIECES in-service training, and attend the ongoing PIECES update sessions. For all LTC Facilities with over eighty residents, who admit significant numbers of cognitively impaired clients, the In-house Psychogeriatric Resource Person shall be full-time.

See: *Evidence of Tim Burns, Director of Long-Term Care and Homes Branch, MOHLTC*
Evidence of M. Haase, RN

J. Psychogeriatric Assessors and Consultants: Links to the Facilities

Recommendation 32:

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

See: *PIECES Manual (Exhibit 83)*
Evidence of Dr. K. LeClair
Evidence of M. Haase, RN

Recommendation 33:

That the MOHLTC create and enforce standards requiring all LTC Facilities to have an In-house Psychogeriatric Resource Team that is linked to the Regional In-house Psychogeriatric Resource Team, to ensure that staff are closely linked to community resources and updated on changes in assessment tools etc.

K. Placement and Admissions

The MOHLTC is responsible for both the legislative requirements, policy and standards surrounding the admission process to LTC facilities. The admissions process, including the policy issues of where individuals should be cared for in the system and the present CCAC process for dealing with individual cases indicates systems problems at various points.

Recommendation 34:

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

Recommendation 35:

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

Recommendation 36:

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

unit etc.) as part of the CCAC process and the determination of whether the resident is eligible for admission to LTC and should be placed in that particular LTC facility.

See: *Placement Coordination Service Manual, 0503-03, p. 7 (Exhibit 18)*

Recommendation 37:

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

Recommendation 38:

That at the same time as these policies and regulations are reviewed, the MOHLTC should review the resources available with respect to psychogeriatric assessments in each region to ensure that the CCAC can obtain timely psychogeriatric assessments for all applicants, including crisis placements.

Recommendation 39:

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

See: *"Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility," p. 11 # 3 (Exhibit 40)*
OANHSS, "Mental Health Issues and Long Term Care", p. 4 # 5 (Exhibit 67)

Recommendation 40:

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

Recommendation 41:

That weekend admissions should be avoided in LTC facilities. If weekend admissions are necessary, they should only occur at facilities with full staffing related to admissions at the time of admission, including both an In-house Psychogeriatric Resource Person, a physician and access to facility's pharmacy.

Recommendation 42:

In light of the known effect of a change in environment on residents suffering from cognitive impairment, it is recommended that additional staffing be arranged for, at a minimum, the first 72 hours after admission to ensure that these new residents are appropriately monitored and managed. Given the unpredictability of behaviours, this monitoring should be by a PIECES trained RN, and the MOHLTC should recognize the need for such monitoring in their funding programs.

Recommendation 43:

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

Recommendation 44:

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

Recommendation 45:

That the RAI-HC assessment tool be reviewed and revised to ensure that it adequately assesses cognitive impairments, in particular behaviours that indicate a propensity for aggression, and to ensure that it reviews behaviours for an adequate period of time (as apposed to a three day period)

L. Assessment Tools

Recommendation 46:

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

See: Evidence of Dr. P. Clark and Dr. H. MacDonald

Recommendation 47:

The MOHLTC, in consultation with the health care professions working in the long term care industry, should ensure that all assessment tools in this area are kept current. This would require updating PIECES training and incorporating new tools into mandatory training.

Recommendation 48:

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

M. Communication

Communication issues repeatedly came up in this inquest in a number of ways that suggest the need for system wide improvements:

Recommendation 49:

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

- i) the appropriate regulated health professionals, who are trained in both a holistic approach and have probing assessment skills and interview techniques, are responsible for obtaining the information from all relevant members of the families, physicians, hospitals, other health and community sources, and criminal information where appropriate;
- ii) the CCACs structure is reviewed to ensure an integrated model to ensure the resident is being followed by a single case manager who has responsibility to ensure the information is consistent, comprehensive thorough; and
- iii) any issues, real or perceived, regarding consent to releasing relevant information is addressed systemically to ensure that all relevant medical, social, cultural, criminal, and environmental information is available to the health care team both making decisions regarding eligibility, placement and providing management of care of cognitively impaired residents with aggressive behaviours.

Recommendation 50:

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

- i) review whether there are appropriate translation services available to CCACs and LTC facilities in each region;
- ii) ensure that policies and training reflect the heightened need for clear communications in cases of potential aggression, including cultural sensitivity to the issue of domestic assault or placement of elderly in institutions;
- iii) ensure that language issues do not increase alienation or trigger aggressive behaviours when individuals become residents of facilities where staff do not speak their language or that language issues not be a barrier to staff adequately assessing and managing such behaviours; and,

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

N. Publication of the Circumstances of the Deaths of P. Lopez and E. Elroubi:

Recommendation 51:

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

Recommendation 52

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

**Submitted By Kate A. Hughes
CAVALLUZZO HAYES SHILTON
McINTYRE & CORNISH LLP**

**On Behalf of the Ontario Nurses
Association**

April 4, 2005