RESEARCH PAPER

Inspection Reports: The Canary in the Coal Mine

Rapports d'inspection : le canari dans la mine

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Abstract

Neglect in the Ontario long-term care (LTC) sector is defined under section 5 of *O. Reg. 79/10* of the *Long-Term Care Homes Act, 2007*. Allegations are monitored and investigated via inspections. Using an exploratory descriptive design, we analyzed reports of neglect in LTC homes from 2019 to 2020. The majority were in response to critical incidents, followed by complaints from family members or staff. Thematic analysis revealed four areas of neglect: (1) failure to provide treatment; (2) failure to provide care; (3) failure to attend to or assist residents; and (4) failure to investigate allegations. Study findings demonstrate that an accountability framework that includes consequences for institutions is needed.

Résumé

La négligence dans le secteur ontarien des soins de longue durée (SLD) est définie par l'article 5 du *Règl. 79/10* de la Loi de 2007 sur les foyers de soins de longue durée. Les allégations de négligence sont surveillées et font l'objet d'enquêtes au moyen d'inspections. À l'aide

d'une conception descriptive exploratoire, nous avons analysé les signalements de négligence dans les foyers de SLD de 2019 à 2020. La majorité portaient sur des incidents critiques, suivis de plaintes de membres de la famille ou du personnel. L'analyse thématique a révélé quatre domaines de négligence : (1) l'absence de traitement; (2) le défaut de fournir des soins; (3) le défaut de s'occuper ou d'aider les résidents; et (4) le défaut d'enquêter sur les allégations. Les conclusions de l'étude démontrent qu'un cadre de responsabilisation qui prévoit des conséquences pour les institutions est nécessaire.

Background

In Canada, the recent COVID-19 pandemic has exposed significant issues in the long-term care (LTC) sector, including cases of abuse and neglect. LTC homes are mandated under provincial legislation to protect residents from harm. Various approaches to quality improvement and accountability exist across the country. Inspections of LTC homes are used by all provinces. In Ontario, Canada's most populous province, inspections tied to legislation are used as a method of ensuring resident safety.

Neglect is defined under *O. Reg. 79/10*, section 5 of the *Long-Term Care Homes Act, 2007*, as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents" (Government of Ontario 2011: 70). There are limited data available on the prevalence of neglect in LTC homes. Most studies focus on elder abuse and include neglect as a sub-type of abuse found in institutional settings (Myhre et al. 2020; Pérez-Rojo et al. 2021). A meta-analysis by Yon et al. (2019) on the prevalence of abuse in LTC homes found that estimated prevalence reported by older residents was 11% for neglect, double the prevalence of neglect in the community (4.6%).

The Ontario government created the Long-Term Care Home Quality Inspection Program (LQIP) to "safeguard residents' well-being by continuously inspecting complaints and critical incidents" (Ontario Ministry of Health and Ministry of Long-Term Care 2019). Within the LQIP there are three ways an inspection occurs: (1) complaints reported by staff, family members or other visitors; (2) critical incidents identified through mandatory reporting; and (3) resident quality inspections conducted annually to ensure homes are meeting specific requirements of the *Long-Term Care Homes Act, 2007*. As part of the inspection process, inspectors use protocols to investigate issues and determine if a home is compliant with the *Long-Term Care Homes Act, 2007*, and its regulations.

We conducted a study to better understand the inspection process by analyzing reports on LTC homes in Ontario. The analysis focused on a two-year period (2019 to 2020), one year before COVID-19 and the first year of the pandemic. The study objectives were to (1) describe the inspection process; (2) describe the types of inspections conducted and the issues reported; and (3) describe and analyze reports specific to neglect. A better

understanding of reported cases of neglect can help inform policy changes needed to improve the quality of care for LTC residents across Canada.

Research Design and Methods

An exploratory descriptive design was used to examine the inspection process in Ontario and analyze selected inspection reports over a two-year period. A review of grey literature, including government publications and the public reporting website,[1] was conducted to identify the stages involved in the inspection process. A Google search was conducted to identify relevant websites that included information about the LQIP. The findings were documented and reviewed for face and content validity by experts, including researchers and government officials working in the LTC sector. A database was created that categorized all inspections completed in LTC homes in Ontario between January 1, 2019, and December 31, 2020. The variables recorded included type of home (profit, not-for-profit or municipal), type of inspection (critical incident, internal or external complaints and resident quality inspection) and the relevant section or sub-section of legislation cited in the report. The reports varied in length and could include one incident or multiple incidents and outcomes.

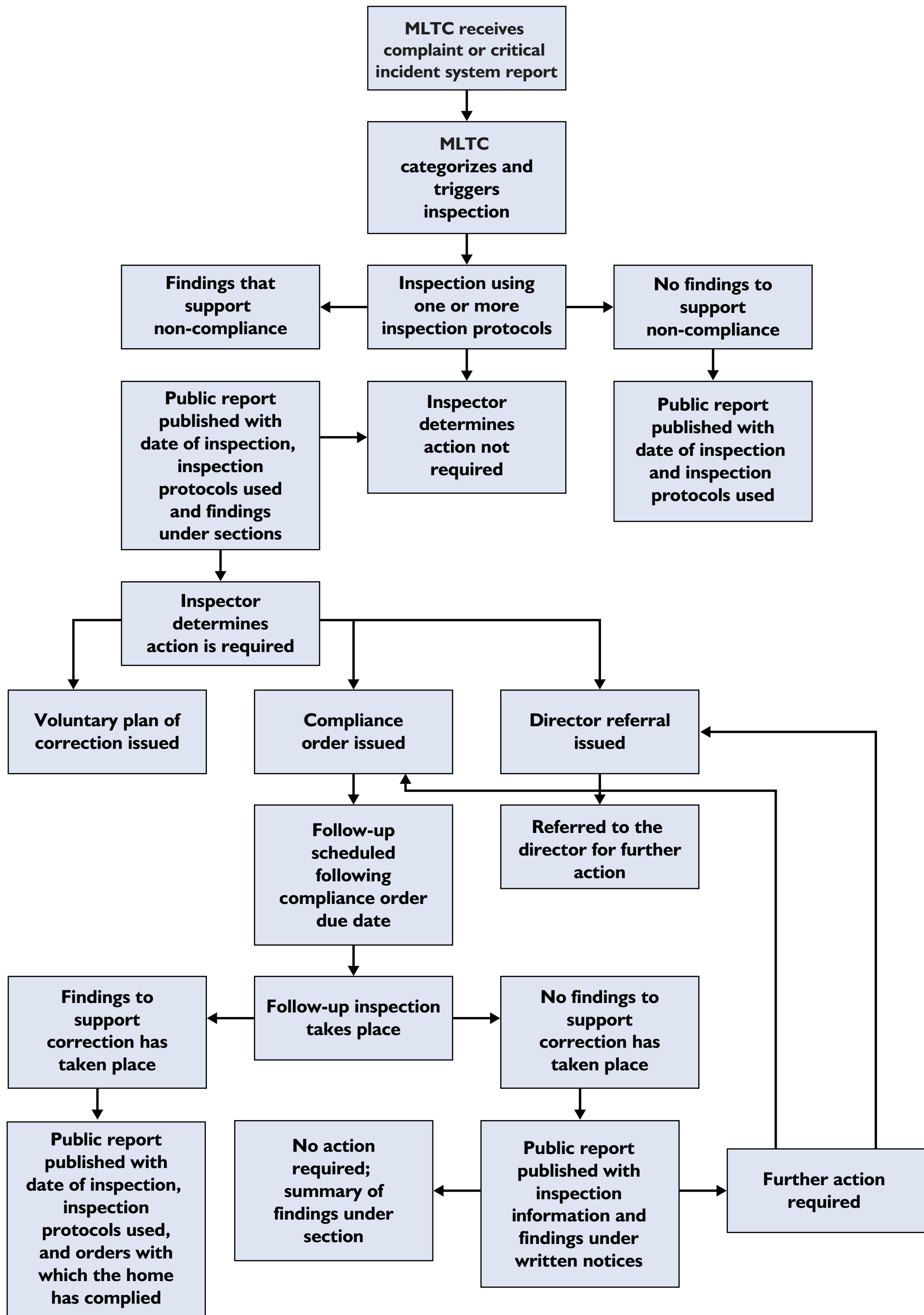
Descriptive analyses were conducted to identify the number and types of inspections reported and the recorded findings for each inspection. Count data were extracted from the reports to identify the characteristics of homes and incidences of neglect. Section 19, titled "Duty to Protect," and section 20, titled "Policy to Promote Zero Tolerance," of the *Long-Term Care Homes Act, 2007*, specifically address the prevention of abuse and neglect. Reports that included a finding of neglect under one of these sections were further analyzed. Texts were interpreted through thematic analysis and categories were developed using the *Long-Term Care Homes Act, 2007*, definition of neglect (Boyatzis 1998). During the preliminary coding, two members of the research team coded several texts independently. Team members then collaborated to develop a refined scheme to code the texts. Additional codes were assigned as new themes emerged. Major themes were highlighted and key findings were categorized under each thematic heading. Examples of cases of neglect with serious clinical consequences are reported in this paper.

Results

Inspection process

It demonstrates the outcomes of an inspection, such as voluntary plan of correction, compliance order or director referral (Figure 1). The latter two result in a follow-up inspection that potentially leads to further consequences. Inspection reports are publicly available from the Ministry of Health and the Ministry of Long-Term Care.[1]

FIGURE 1. LTC home inspection process



MLTC = Ministry of Long-Term Care.

Inspection reports: Types and outcomes

At the time of the study, there were 626 LTC homes in Ontario. Between January 1, 2019, and December 31, 2020, there were 5,101 inspection reports across these homes. The majority of inspections were critical incidents, followed by complaints (see Figure 2). Reports ranged from three to 125 pages and included an average of 3.7 issues per report.

Of 626 homes, 538 (86%) had violations under the *Long-Term Care Homes Act, 2007,* which comprises 10 parts and 399 sections and sub-sections. Over the two-year period, 18,240 violations were identified. Table 1 shows the most frequent violations identified in the inspection reports.

FIGURE 2. Types of inspections completed in Ontario LTC homes, 2019–2020

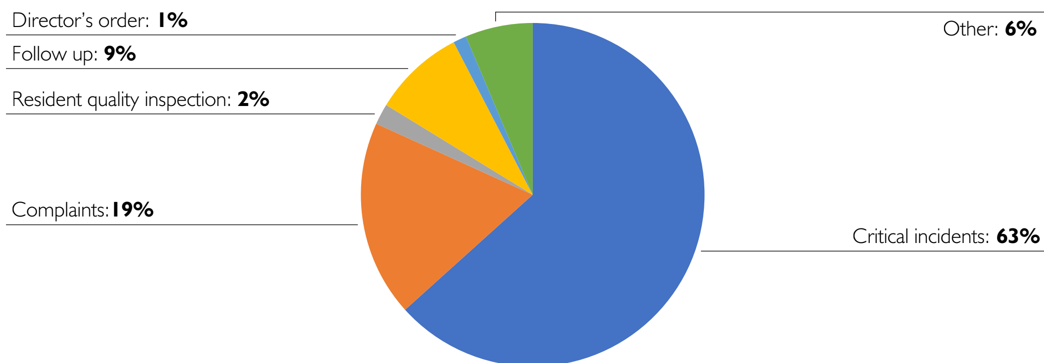


TABLE 1. Ontario LTC home inspection reports, 2019–2020

LTCHA, 2007, sub-sections	Section	Number	Percent
Plan of care	2007, c.8, s.6	3,661	20%
Policies and records	*O. Reg. 79/10*, s.8	1,207	7%
Reporting certain matters to the director	2007, c.8, s.24	830	5%
Prevention of abuse and neglect	2007, c.8, s.19	873	5%
Policy to promote zero tolerance	2007, c.8, s.20	655	4%
Administration of drugs	*O. Reg. 79/10*, s.131	659	4%
Skin and wound care	*O. Reg. 79/10*, s.50	573	3%
Transferring and positioning techniques	*O. Reg. 79/10*, s.36	539	3%
Report regarding critical incidents	*O. Reg. 79/10*, s.107	455	2%
General requirement programs	*O. Reg. 79/10*, s30	349	2%
Infection prevention and control program	*O. Reg. 79/10*, s.229	328	2%
Other*		8,309	46%
Total		**18,240**	**100%**

*Includes a combination of other sections of the *LTCHA, 2007,* cited in reports.
LTCHA, 2007 = Long-Term Care Homes Act, 2007.

Selected reports of abuse and neglect

There were 628 reports of abuse and neglect. Of these, 438 identified incidents of abuse and 190 identified incidents of neglect. We focused our analysis on the latter, which included 231 separate incidents of neglect that were categorized into four thematic areas (see Table 2). These areas are not necessarily mutually exclusive, and they were chosen for the purposes of discussion and illustration.

TABLE 2. Thematic areas of neglect in LTC homes in Ontario in 2019 and 2020*

Thematic area	Sum	Percentage (%)
Failure to provide treatment	90	39
Failure to provide care	73	32
Failure to attend or assist	36	15
Failure to investigate allegations	32	14
Total	**231**	**100**

*Some reports included only a single incident, while others included multiple incidents.

FAILURE TO PROVIDE TREATMENT

This theme reflected the failure of the home to provide specialized medical care or assessment required for treatment of illness or injury. Thirty-eight percent ($n = 90$) of neglect incidents involved failure to provide treatment, which includes medications and specialized care. In one case, a home had failed to provide a resident with necessary care that included nutrition and hydration, wound care and medications. The inspector noted that on multiple occasions the resident was not given appropriate hydration and was often left unattended for 12 to 14 hours with no documented care. The inspector also noted that upon admission, the initial assessment failed to identify skin integrity issues; consequently, the plan of care did not include wound care for altered skin integrity. Furthermore, it was observed that "[d]rugs were not administered to residents in accordance with the directions for use prescribed by the prescriber" (Inspection Report A: August 25, 2020).

In another case, a complaint was issued against a home for failing to provide skin and wound care. According to the inspection report, a resident with "significant alteration in skin integrity" had been neglected by direct care staff for an extended period. The inspector interviewed the wound care lead, a registered staff member, who indicated they relied on direct care staff to assess residents during their regular weekly bathing. Yet the care worker had not alerted anyone regarding the resident's skin issues. By the time "the wounds were assessed … [it was evident that] they had been present for some time." The inspector documented that the physician had made a note in the resident's chart that read: "THIS IS NOT ACCEPTABLE … THIS WAS PREVENTABLE AND SHOULD NOT HAPPEN" (Inspection Report B: August 13, 2020; physician's emphasis).

In another instance of neglect, a resident fell onto the floor while under the supervision of a registered staff member. The resident was not assessed or provided treatment at the time

of the fall. They were later transferred to hospital where the injury was identified and the resident eventually died. The inspector interviewed the registered staff involved and commented, "They were not sure if they were required to report and document this incident, and therefore, they search[ed] the internet and decided not to report and document the incident" (Inspection Report C: October 21, 2020).

FAILURE TO PROVIDE CARE

This theme included cases where a home failed to provide adequate care to residents in order to maintain good health and well-being. There were 73 reports of neglect in this category. They covered various aspects of care, such as continence care, mobility and nutrition. It was documented in one critical incident that a resident had been left without proper continence care for a protracted amount of time. During a changeover in shift, staff discovered the resident was "saturated in urine" and upon assessment "determined that [they] had specified alterations in skin integrity to identified areas of the body" (Inspection Report D: November 8, 2019). The inspector's findings indicated that the home failed to ensure the resident received immediate care to promote healing as required.

A different case involved residents missing meals on multiple occasions. In one example, the inspector noted that residents who required extra assistance or a higher level of care remained in bed during meal times because the personal support worker did not have time to get the residents up. The home was short-staffed and it was reported that staff did not wake the residents for their morning meals. Additional documentation reflected a lack of clarity regarding whether residents were given nutritional supplements in place of missing meals.

In another incident, a resident who had been identified as a nutritional risk was not being fed sufficiently. The resident required total assistance during meals and was to be provided with "high energy, high protein meals." Upon investigation, it was found that the resident had experienced significant weight loss over five months because they had not been receiving their meals regularly (Inspection Report E: November 21, 2019).

FAILURE TO ATTEND OR ASSIST

This theme reflected the failure of the home to ensure residents were provided with adequate assistance and supervision to maintain safety and well-being. It includes failing to respond to calls for assistance (by call bells) or conducting regular safety checks. In 36 cases of neglect, residents were left unattended or without assistance for extended periods. In one example, a staff member had transferred a resident to a new room but did not apprise other staff. It was not until the next shift that the home was searched and the resident was found. It was noted that this incident led to the resident "not receiving care or repositioning for an identified period of time and very late medications and meal" (Inspection Report F: July 29, 2020).

Other examples involved staff failing to check on residents as required. In one case, a resident was left unattended and without care, despite documentation indicating care had been provided. Video footage revealed the resident had been left alone for five hours and

was found unresponsive. The resident was later pronounced dead (Inspection Report G: October 16, 2020). Another report described residents suffering serious injuries due to being left unattended and in one such case the resident passed away unexpectedly (Inspection Report H: February 11, 2020). In one of the more severe cases, a resident "was found with their sweater sleeves tied in knots and was sitting in the wheelchair [with their body] tilted" (Inspection Report I: July 2, 2020). The report indicated that the resident was left for approximately five hours before being found by housekeeping.

FAILURE TO INVESTIGATE ALLEGATIONS

This theme included cases where the home failed to investigate allegations of neglect including failure of the home to conduct internal investigations and failure of the home to report neglect cases to the ministry. Thirty-two reports described a lack of attention to incidents that subsequently led to inspections. In one example, staff at all levels advised management over a five-year period (2016–2020) that a registered staff member was abusing narcotics and provided residents with medication "when they did not need it" (Inspection Report J: December 21, 2020). A family member had complained that their loved one was being given narcotics without cause and asked that it be discontinued immediately. The report indicated, "There were multiple allegations of narcotic diversion by the same staff member and the allegations were ongoing since 2016" (Inspection Report J: December 21, 2020).

Residents in a different case did not receive their medications. Nine unopened pouches of medications were found in the waste disposal. However, staff had documented that the medications had been administered. The staff member who failed to provide the medication continued to work at the home after this incident. It was later identified that another 28 residents were not given their medications (Inspection Report K: June 25, 2020).

In another case, management failed to investigate or act after receiving numerous reports of abuse and neglect of residents from staff, family members and visitors. The inspector indicated, "Despite the multiple allegations of abuse and neglect … the DOC [director of care] denied taking any management actions to correct their lack of reporting, such as education or discipline as outlined in the home's Zero Tolerance of Abuse and Neglect policy" (Inspection Report L: September 1, 2020).

Discussion

Researchers have identified neglect of LTC residents as a critical policy issue that requires immediate reform to improve care (Jolly 2020; Storey 2020). Reader and Gillespie (2013) provided a comprehensive description of the incidence and nature of neglect in their concept analysis. Neglect causes significant deterioration in health status that leads to deleterious outcomes such as decubitus ulcers, dehydration, urinary tract infections and increased prevalence of falls (Bunn et al. 2019; Clarysse et al. 2018). All of these were identified in the inspection reports we reviewed, highlighting the need for accountability measures that enforce corrective action on the part of LTC homes.

The inspection process in LTC has changed over time. Historically, the government of Ontario conducted mandatory annual Resident Quality Inspections using methodology adapted from a Quality Indicator Survey. The inspections were amended in 2018 to occur only in response to specific complaints or incidents as required under the *Long-Term Care Homes Act, 2007*. The complaint process for LTC homes includes non-urgent and urgent complaints. The first are considered "less serious … [and] are related to diet, activities or care," while the second "include cases of harm, neglect or danger to residents" (Government of Ontario 2021a). Although our analysis focused on neglect, the inspection reports also included issues that the provincial government considers less serious. It is important to recognize that these issues can compound neglect and increase the potential for adverse outcomes for LTC residents.

The Ontario government recently made a significant investment over three years to increase the number of inspectors and reintroduce the annual proactive inspections program (Government of Ontario 2021b). The new funding will result in a ratio of one inspector for every two homes. The government is also introducing new legislation that will provide "stronger enforcement and compliance tools to hold poor performing long-term care homes to account" (Government of Ontario 2021b). Provincial legislation should be supplemented with mandatory accreditation that would incorporate the National Standards of Care for Long-Term Care (HSO 2021). This would close the loop on a continuous quality improvement model that includes mandatory accreditation that builds on the national standards in long-term care.

COVID-19 exposed the decades-old crisis in the LTC sector. Public response to the lack of answers and accountability has given rise to class action lawsuits. The allegations are numerous: disregard for the health and safety of residents; lack of infection prevention and control, resources and personnel; and failure to respond properly, comply with public health guidance, communicate with family members or report deaths (Katawazi 2020a, 2020b; Morris 2021; Perkel 2021).

Findings from our study provide additional evidence of the need to improve accountability, enforcement and transparency in the LTC sector. The persistent cycle of "Neglect, Abuse, Crisis, Review, Repeat" in LTC must be broken (Lantz 2020). As long as the situation remains unchanged, the consequences will continue to be borne by the vulnerable residents of LTC homes and their families rather than by the homes and their operators.

Limitations

The variation in inspection reports was a significant limitation in the study. Lack of standardized reporting made it difficult to identify and extract relevant data. Additionally, the COVID-19 pandemic introduced disruptions to the inspection process. First, inspections were suspended in March and April 2020, resulting in a significant drop in the number of reports during this time. Second, visitor restrictions were imposed in LTC homes for a four–month period. This may have reduced the number of complaints issued by family members or other visitors.

Conclusion

There are systemic issues in LTC that must be addressed at the provincial level. Inspections have been perceived as punitive but they do provide useful information about issues in the sector as a whole. In order to be effective, inspections should be related to continuous quality improvement. We reviewed inspection reports one year before and during the first year of the COVID-19 pandemic. The number and severity of neglect cases within the two-year period suggest that the current accountability measures in LTC are not enough. Cases should be analyzed and synthesized annually within an accountability framework with clear consequences for individuals and organizations. A shorter timeline with explicit expectations for quality improvement is also required. Although policy goals are clear, there are definite signs of longstanding inaction in the LTC sector. National standards have been developed by a committee of Canadian experts to guide quality improvement in LTC. The standards are a useful framework for LTC institutions but they require a plan for monitoring and evaluation. In order to improve the quality of care provided to LTC residents, standards should be implemented provincially and integrated into legislation across jurisdictions. Accountability mechanisms must be strengthened and investments should include staffing, improved training and comprehensive documentation and reporting.

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Note

1. Reports on Long-Term Care Homes can be found here: http://publicreporting.ltchomes.net/en-ca/default.aspx.

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