The Corporation of the County of Northumberland
Community Health Committee
Agenda

Tuesday, July 30, 2024, 9:00 a.m.
Council Chambers
555 Courthouse Road, Cobourg, ON K9A 5J6

Hybrid Meeting (In-Person and Virtual)
Zoom Information
Join Zoom Meeting
https://us06web.zoom.us/j/85250939748?pwd=0ytAabBrK4qTYYWhlnxugGcJAZGQTt.1
Meeting ID: 852 5093 9748
Passcode: 247210
Phone: 1-855-703-8985 Canada Toll-free

Pages

1. Notices

1.a Accessible Format

If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327.

1.b Meeting Format

This Committee meeting will be held using a hybrid meeting model. The public is invited to attend in-person in Council Chambers. Alternatively, the public may view the Committee meeting via live stream, join online, or join by phone using Zoom Conference technology. If you have any questions, please email matherm@northumberland.ca.

- Attend in-person in Council Chambers, located at 555 Courthouse Road, Cobourg
- Watch a livestream by visiting Northumberland.ca/Council
- Join online using Zoom
- Join by phone using Zoom

2. Call to Order

2.a Territorial Land Acknowledgement

3. Approval of the Agenda

Recommended Motion:
"That the agenda for the July 30, 2024 Community Health Committee be approved."

4. Disclosures of Interest

5. Delegations

5.a Delegation, Ontario Health Team of Northumberland (OHT-N) 'Proposal for a County-Wide Physician Recruitment Plan' 7 - 22

Andrea Groff, Executive Lead
Dr. Fraser Cameron, Primary Care Lead Physician

6. Business Arising from Last Meeting

7. Communications

7.a **Correspondence, Association of Municipalities of Ontario (AMO) & Ontario Medical Association (OMA) 'Joint Health Resolution Campaign'** 23 - 25

Recommended Motion:

"**Whereas** the state of health care in Ontario is in crisis, with 2.3 million Ontarians lacking access to a family doctor, emergency room closures across the province, patients being de-rostered and 40% of family doctors considering retirement over the next five years; and

Whereas it has becoming increasingly challenging to attract and retain an adequate healthcare workforce throughout the health sector across Ontario; and

Whereas Ontario municipal governments play an integral role in the health care system through responsibilities in public health, long-term care, paramedicine, and other investments; and

Whereas the percentage of family physicians practicing comprehensive family medicine has declined from 77 in 2008 to 65 percent in 2022; and

Whereas per capita health-care spending in Ontario is the lowest of all provinces in Canada, and

Whereas a robust workforce developed through a provincial, sector-wide health human resources strategy would significantly improve access to health services across the province;

Now Therefore Be It Resolved That the Community Health Committee, having considered the correspondence from the Association of Municipalities of Ontario (AMO) and the Ontario Medical Association (OMA), recommend that County Council support this correspondence and urge the Province of Ontario to recognize the physician shortage in Northumberland County and Ontario, to fund health care appropriately, and ensure every Ontarian has access to physician care; and

Further Be It Resolved That the Committee Health Committee recommend that County Council direct staff to send a copy of this resolution to key stakeholders, including the Honourable Doug Ford (Premier of Ontario), the Honourable Sylvia Jones (Deputy Premier and Minister of Health), the Honourable Paul Calandra (Minister of Municipal Affairs and Housing), the Honourable David Piccini (Minister of Labour, Immigration, Training and Skills Development and MPP for Northumberland - Peterborough South), AMO, OMA, the Ontario Health Team of Northumberland, and Northumberland County's seven Member Municipalities."

8. Staff Reports

8.a **Golden Plough Lodge - Quarter 2, 2024 Financial Analysis** 26 - 26
Matthew Nitsch, Director Finance / Treasurer

8.b **Northumberland Paramedics - Quarter 2, 2024 Financial Analysis** 27 - 27
Matthew Nitsch, Director Finance / Treasurer

Recommended Motion:
"**That** the Community Health Committee receive the Quarter 2, 2024 Financial Analyses of the Golden Plough Lodge and Northumberland Paramedics Departments for information; and

Further That the Committee recommend that County Council receive the Quarter 2, 2024 Financial Analyses for information."

8.c **Report 2024-085, 'Northumberland Paramedics - 2024 Semi-annual Report'** 28 - 35
Susan Brown, Chief Northumberland Paramedics
Keith Barrett, Deputy Chief of Operations

Recommended Motion:
“**That** the Community Health Committee receive Report 2024-085 'Northumberland Paramedics - 2024 Semi-annual Report’ for information; and

Further That the Committee recommend that County Council receive this report for information.”

8.d **Report 2024-086, 'Northumberland Community Paramedics - 2024 Semi-annual Report'** 36 - 68
Kim Wilkinson, Community Paramedic Coordinator

[Presentation was added to the agenda prior to the meeting]

Recommended Motion:
“**That** the Community Health Committee receive Report 2024-086 ‘Northumberland Community Paramedic - 2024 Semi-annual Report’ for information; and

Further That the Committee recommend that County Council receive this report for information.”

8.e **Report 2024-087 ‘2024 Ministry of Long-Term Care Inspection Reports Update'** 69 - 135
Alanna Clark, Administrator

Recommended Motion:
“**That** the Community Health Committee receive Report 2024-087 ‘2024 Ministry of Long-Term Care Inspection Reports Update’ for information; and

Further That the Committee recommend that County Council receive this report for information.”

9. Other Matters Considered by Committee

9.a Haliburton, Kawartha, Pine Ridge (HKPR) District Health Unit - Board of Directors' Minutes

136 - 158

Recommended Motion:
"**That** the Community Health Committee receive the minutes from the March 21, 2024, April 18, 2024 and May 16, 2024 HKPR District Health Unit Board of Health Meetings and May 16, 2024 and June 20, 2024 Summary Reports for information; and

Further That the Committee recommend that County Council receive the minutes and summary report for information."

10. Media Questions

11. Closed Session

Recommended Motion:
"**That** this Committee proceed with the next portion of the meeting being closed to the public at _____a.m.; and

Further That the meeting is closed to the public as permitted under the Municipal Act Section 239. (2.d) in order to address matters pertaining to labour relations or employee negotiations regarding 'OPSEU / SEFPO Local 381 – 2024 Collective Agreement Update (Northumberland Paramedics)', and that Jennifer Moore, Susan Brown, Lisa Ainsworth, Maddison Mather, and Cheryl Sanders remain present."

12. Motion to Rise and Results from Closed Session

Recommended Motion:
"**That** this Committee rise from Closed Session at _____ a.m.; and

Further That the confidential resolution moved in Closed Session regarding matters pertaining to labour relations or employee negotiations regarding 'OPSEU / SEFPO Local 381 – 2024 Collective Agreement (Northumberland Paramedics), is hereby referred to the Community Health Committee, which refers it to County Council for adoption."

13. Next Meeting - Tuesday, September 3, 2024 at 9:00 a.m.

14. Adjournment

Unified County-Wide Physician Recruitment

Presented to Northumberland County, Community Health Committee

Presented by Dr. Fraser Cameron, OHT-N, lead physician PCN Physician Group and Andrea Groff, Executive Lead, OHT-N on behalf of the Physician Recruitment Working Group

July 30, 2024

The Problem

- Northumberland County is losing physicians faster than we can replace them
- Physician recruitment is via three (3) separate physician recruitment committees:
  - The West Northumberland Physician Recruitment Committee (WNPRC)
  - Campbellford Memorial Hospital (CMH)
  - Docs by the Bay who serve the East Region/Trenton and Quinte

This problem is wide-spread and physician shortage in Ontario is becoming critical

Why does the population of Northumberland County need to have access to physicians?

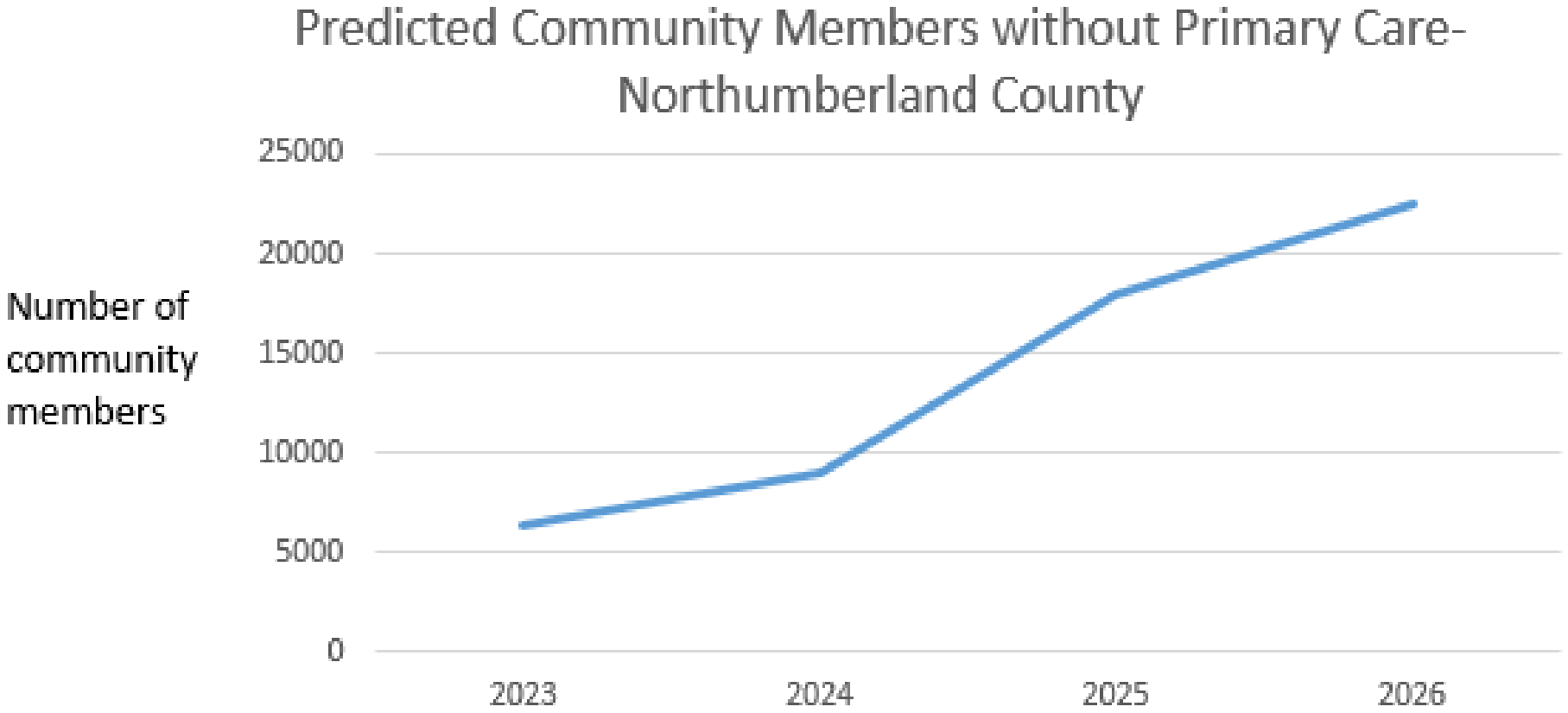
Preventative treatment

Cancer screening

Allows appropriate use of emergency depts

Staff hospitals

Provide specialist care



If we continue with the same approach, 8,000 unattached patients could become over 20,000 by 2026

(OCFP predictions applied to Northumberland population)

Problem-Framing

- Access to primary care was identified as a priority in OHT-N's strategic plan 2022-2026
- Northumberland Hills Hospital and OHT-N worked with Toronto Metropolitan University (TMU) on a Design Thinking project with 19 interest holders and partners entitled "*Rethinking Health Human Resources Recruitment and Retention through Design Thinking*"
- Direct engagement from patient, family and caregiver members of OHT-N's Experience Partner Council
- Involved interviews, environmental scan and two facilitated problem-framing sessions

Results of the Problem-Framing Sessions

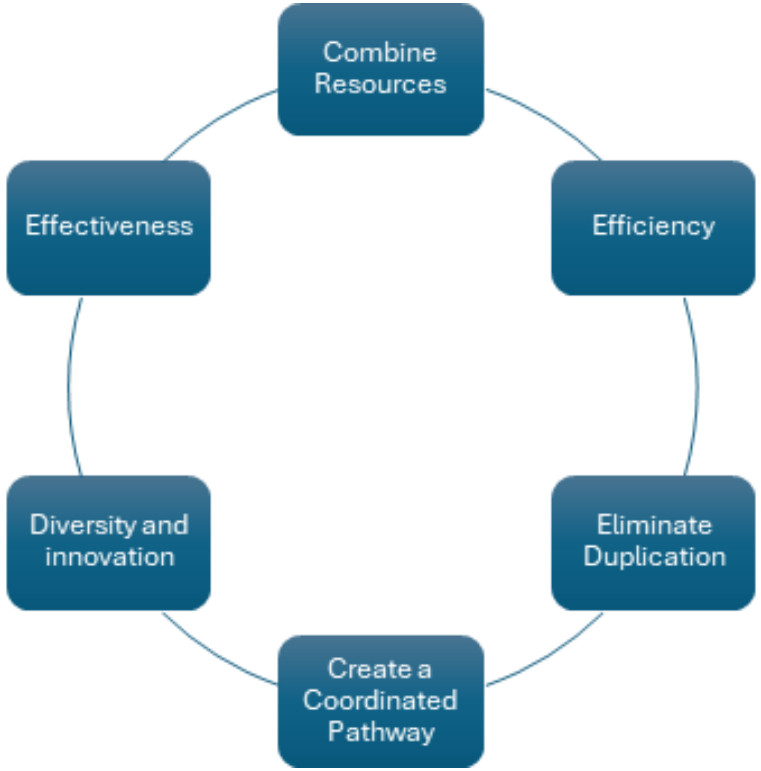
Result of the initial problem-framing session,
five (5) key areas of focus

1. Lack of unified/county-wide focus on recruitment,
2. Need better ways to market unique regional features, amenities and lifestyle benefits,
3. Administrative burden and burnout of doctors,
4. Better housing and financial incentives and
5. Need to make doctors feel valued, recognized and supported

Result of the second problem-framing session focused on solutions related to a lack of unified-wide focus on recruitment:
three (3) priority actions:

1. Consolidated strategy and unified oversight for physician recruitment in Northumberland County
2. Articulate a clear value proposition for the collaborative approach
3. Affirming the necessity for OHT-N involvement in this process

Recommendations



- The Physician Recruitment Working Group was formed in response to the TMU Design Thinking sessions
- Working Group is recommending a unified approach to physician recruitment that will:

The Ask

The Physician Recruitment Working Group is requesting funding for a shared Project Resource

- 50% County/50% OHT-N

Project Resource:

- Full-time, 6-month contract, up to $90,000 shared
- Hired through OHT-N's fund holder Northumberland Hills Hospital
- Steering Committee (formally Physician Recruitment Working Group) will provide oversight

Deliverables from this investment:

- Creation of a county-wide playbook for a unified physician recruitment strategy for Northumberland County including but not limited to:
  - Key performance indicators including supply and demand analysis
  - Single marketing strategy
  - Aligned and coordinated incentives
  - Identification of core recruitment processes

Thank you for your consideration.

PRIMARY CARE & PHYSICIAN RECRUITMENT

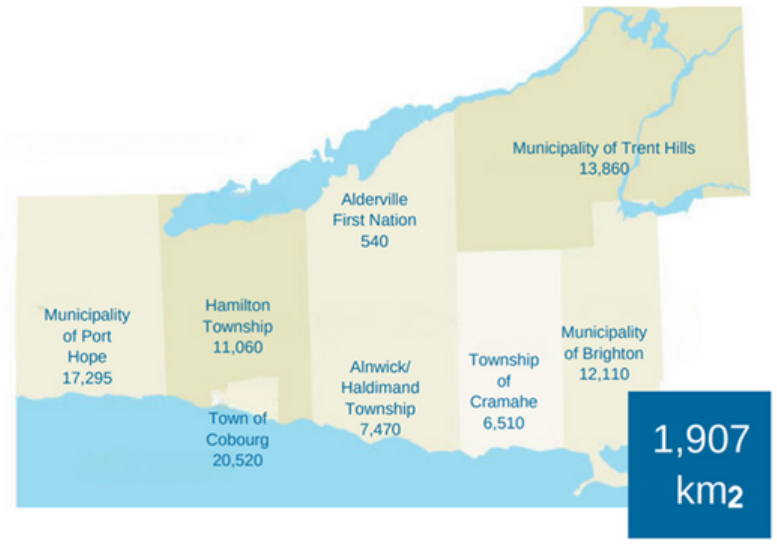
County-wide physician recruitment and retention strategy to unify efforts, combine resources, eliminate duplication and create a coordinated pathway.

Northumberland County Population

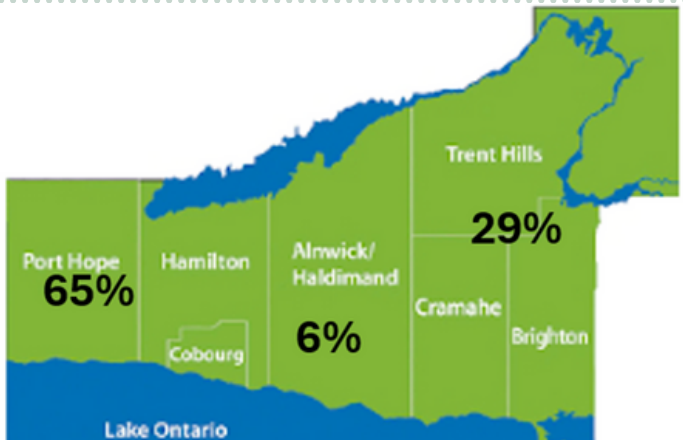
89,365

TOTAL POPULATION

Increased 8.8% between 2011 and 2021



Primary Care in Northumberland County



29% in Eastern Northumberland
6% in Central Northumberland
65% in Western Northumberland

Approx. 55 primary care physicians

On average primary care physicians enroll 800-1,200 patients

Aging Population

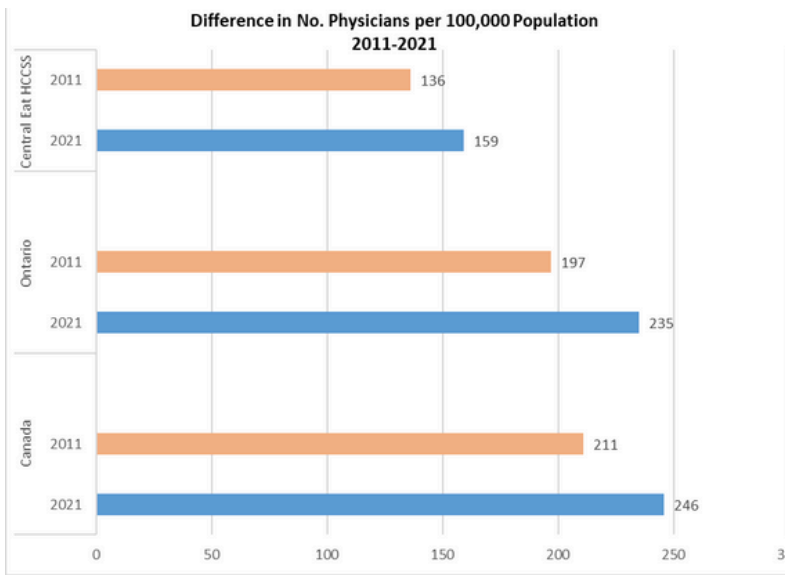
52.4

MEDIAN AGE

More than 10 years older than provincial and national counterparts

Over 65 years old

Access to Primary Care

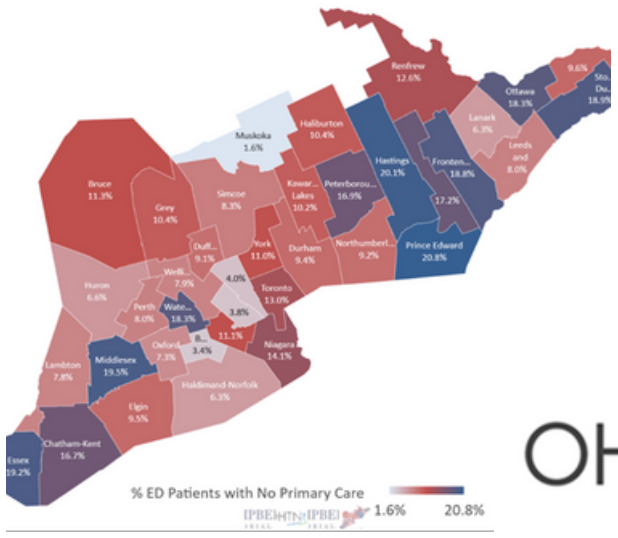


Number of Physicians per 100,000

Lower ratio of physicians to population than Ontario and Canadian averages

HIGHEST % WITHOUT ACCESS TO PRIMARY CARE

Eastern Northumberland borders on the region with the highest number of ED patients with **NO** Primary Care in S. Ont.



OHTN

About Ontario Health Team of Northumberland

The Ontario Health Team of Northumberland is a county-wide collaboration of patients, caregivers, health, and community care providers, working together to improve patient, caregiver, and provider experience. The goal of the OHT is to build a connected and sustainable health care system, centred around the needs of patients.

PRIMARY CARE & PHYSICIAN RECRUITMENT

County-wide physician recruitment and retention strategy to unify efforts, combine resources, eliminate duplication and create a coordinated pathway.

Primary Care in a Rural Setting

Rural Ontarians are losing physicians at a rate of **12%** per year

4 x higher than in urban settings

It takes

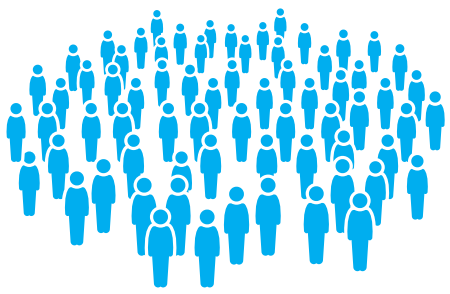
3

New primary care physicians to replace **one** retiring physician

Primary Care in Ontario

2,500,000

In Ontario without a family doctor



Projected to increase to at least

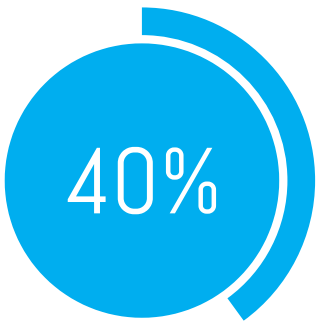
4,400,000

By 2026

Physicians Leaving Practice

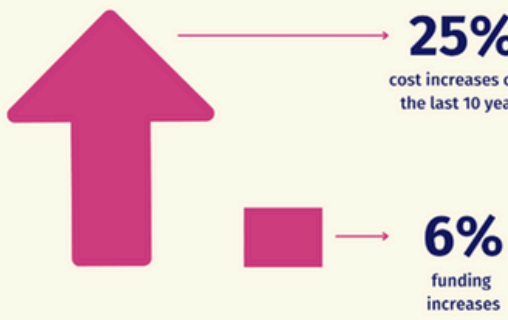
RETIREMENT

#1 reason primary care providers are leaving Northumberland County



Ontario physicians considering retiring in next **five years**

Family Physicians struggling with rising costs



Rising costs include:

- Staffing costs
- Equipment & tech
- Office rental

Physician Retention

Family physicians say they can spend up to **25%** of their week on administrative work

SUPPORT RETENTION

1. Ensure family doctors are attached to team-based care

2. Improve amount of time family physicians can spend with patients by supporting "Patient before Paperwork"

OHTN

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Topic:	Unified County-Wide Primary Care/Physician Recruitment
Date:	July 30, 2024
Prepared by:	Physician Recruitment Working Group

Briefing Note for the Northumberland County Community Health Committee

ISSUE

Recruitment efforts across Northumberland County are unable to meet the escalating demand for primary care providers. While this is not a unique problem to Northumberland, the response requires a collaborative unified approach, consolidating resources, talents and efforts to improve the recruitment outcomes.

Presently, Northumberland County lacks a unified, County-wide primary care provider recruitment and retention strategy. Instead, three (3) distinct independent committees, each with its own budget and operating in isolation are responsible for attracting talent into the local municipalities:

The West Northumberland Physician Recruitment Committee (WNPRC), Campbellford Memorial Hospital (CMH) and Docs by the Bay who serve the East Region/Trenton and Quinte.

BACKGROUND/SITUATION ANALYSIS

Physician Shortage in Ontario

Ontario is facing a significant physician shortage. Currently 2.5 million Ontarians do not have access to a primary care provider and that number is predicted to grow to more than 4.4 million in the next few years (Ontario College of Family Physicians). By 2025, the Ontario College of Family Physicians reports that 1 in 5 Ontarians may not have access to a family physician. This alarming projection underscores the impending shortage of primary healthcare providers, which will have widespread implications for public health, such as: strain on the existing healthcare infrastructure, leading to increased wait times, overburdened emergency services, and potential declines in preventative care and chronic disease management.

40% of Ontario primary care physicians are reporting plans to retire in the next few years (Ontario Medical Association). To compound that, rural municipalities are losing primary care providers at a rate of 12% per year, four times higher than in urban centres (Rural Ontario Municipal Association). Northumberland County is experiencing significant challenges to fill vacant physician roles and is on the brink of a severe resource crisis.

Unattached Patients in Northumberland County

Currently, there are more than 20 primary care physician vacancies in Northumberland County. The shortage of physicians adversely impacts the health and well-being of residents in Northumberland. Recent statistics indicate that 7% of community members in Northumberland do not have access to a primary care physician today (Inspire); according to forecasts, this number could increase to 20% due to physician retirement and dissatisfied primary care providers leaving practice. This issue necessitates urgent attention and strategic intervention to ensure the healthcare needs of Northumberland County's

population can be met. As such, improving access to primary care and specialty physician services is a key area of focus for the Ontario Health Team of Northumberland (OHT-N).

RESULT OF COLLECTIVE ENGAGEMENT

Problem-Solving Physician Recruitment in Northumberland County

Toronto Metropolitan University (TMU) facilitated a Design Thinking event with Northumberland Hills Hospital and OHT-N to co-design a problem-solving framework focused on physician recruitment. They conducted research with many interest holders, partners, including local physicians, and facilitated the first engagement session, inclusive of patient/caregiver representation, in March 2024. The session resulted in a consensus identifying **five (5) key challenges impeding local primary care and specialty physician recruitment and retention**:

1. Lack of a unified, County-wide approach to recruitment;
2. Insufficient strategies for collaboratively marketing the region's unique, amenities and lifestyle benefits;
3. Administrative burden and burnout of doctors;
4. Inadequate housing options and financial incentives; and
5. Necessary measures to ensure providers feel valued, recognized and supported.

During a follow up Design Thinking session with TMU in June 2024, the session concluded with **three (3) priority actions:**

1. Consolidated strategy and unified oversight for primary care and specialty physician recruitment in Northumberland County
2. Articulate a clear value proposition for the collaborative approach
3. Affirming the necessity for OHT-N involvement in this process

Following the TMU Design Thinking sessions, a Physician Recruitment Working Group was formed to advance those priorities, including: Jeff Hohenkerk, President and CEO, Campbellford Memorial Hospital; Susan Walsh, President and CEO, NHH and Co-Lead, OHT-N; Andrea Groff, OHT-N Executive Lead; Chloe Craig, Experience Partner Council member; Dr Erin Pepper, Family Physician; Taryn Rennicks, Executive Director, CHCN and Co-Lead OHT-N, Glenn Dees, Director Health and Human Resources, Northumberland County; and Lynda Kay, Physician Recruiter. This group collaborated on the development of this proposal.

ACTION REQUIRED/RECOMMENDATIONS

Develop a Unified County-Wide Physician Recruitment Strategy

To optimize the efficiency and effectiveness of resources for physician recruitment in Northumberland County, a coordinated approach is essential, and will facilitate the sharing of resources and unite the efforts to recruit and retain physicians. This will leverage the successes of existing recruitment efforts and amplify the allocation of resources to attract physician talent to the County.

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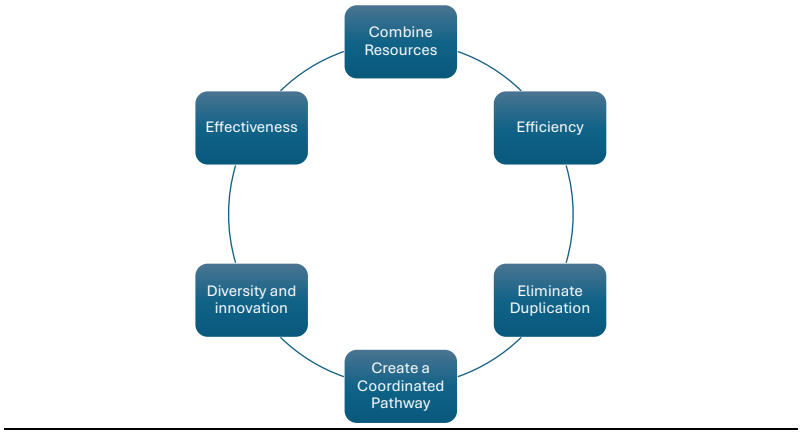
Coordinate Recruitment Efforts



To Accomplish This Goal

The Physician Recruitment Working Group is requesting funding for a shared project resource

- 50% County/50% OHT-N

Project Resource:

- Full-time, 6-month contract, up to $90,000 shared
- Hired through OHT-N's fund holder, Northumberland Hills Hospital
- Steering Committee (formally Physician Recruitment Working Group) oversight

Deliverables from this investment:

- Create a unified primary care/physician specialist recruitment strategy for Northumberland County
- Coordinate efforts across the County
- Develop key performance indicators
- Establish a single marketing strategy
- Coordinate incentives

NEXT STEPS/CONCLUSION

Physician recruitment for Northumberland County has proven to be challenging and this will only get increasingly difficult as the health and human resource situation becomes more dire. Adopting a coordinated approach will enable Northumberland County to more efficiently and effectively recruit and retain physicians. This united approach will allow county-wide recruitment efforts to pool resources, eliminate redundancies and optimize efforts to attract and retain physician talent into the County. To initiate this process, dedicated coordination effort is required to build the coordinated path forward and more effectively compete with communities outside our region.

About Ontario Health Team of Northumberland

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REFERENCES

Health Force Ontario (HFO). HFO Jobs. July 12, 2024.

Ontario College of Family Physicians. (2024, March 5). Without urgent action, nearly 1 million in Toronto could be without a family doctor by 2026. Ontario College of Family Physicians. https://ontariofamilyphysicians.caOntario Medical Association. (2023, May 31). Ontario's doctors say primary care is in crisis, burnout at record levels. Ontario Medical Association. https://www.oma.org

Primary Care Metrics. Inspire-PHC. inspire-phc.org

Rural Ontario Municipal Association [ROMA]. (2024). Fill the Gaps Closer to Home Improving Access to Health Services for Rural Ontario. https://www.roma.on.ca

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F: 416.533.9309
E: info@oma.org

oma.org

July 4, 2024

[Mayor's Name]
[Mayor's Address]
[City, Province, Postal Code]

Dear Mayor [Last Name],

Communities across Ontario have been facing critical health-care challenges, including long waitlists for primary care, shortages of doctors and other health care workers; and emergency room closures. These cracks in Ontario's health care system are impacting economic development, health, and well-being at the local level.

In response, the Ontario Medical Association (OMA) and the Association of Municipalities of Ontario (AMO) are working collaboratively to advocate for a better healthcare system for Ontario's residents and communities.

We have jointly developed the attached draft council resolution (Appendix A), urging the provincial government to recognize the physician shortage in your municipality and the rest of Ontario. By adopting this resolution, your municipality can play a crucial role in highlighting the urgent need for more healthcare resources and support.

AMO is excited to welcome everyone to Ottawa for our annual conference from August 18-21, 2024. We are pleased to inform you that the OMA will be participating at this year's conference . Along with sponsoring the Rural Caucus Lunch on August 20, the OMA has reserved meeting room at the Fairmont Château Laurier for both August 20 and 21 to meet directly with municipal leaders. During these meetings, we would like to hear what you are seeing on the ground and discuss opportunities to work closer with you. We believe that collaboration between Ontario's doctors and all 444 municipalities is essential in addressing the health-care needs of your community.

To set up a meeting with the OMA, please reach out to Tarun.Saroya@OMA.org (senior advisor for government relations and advocacy) to book a 15-30 minute time slot at your earliest convenience.

We look forward to your positive response and to working together towards a healthier future for all Ontarians.

Yours sincerely,

Kimberly Moran
CEO, Ontario Medical Association

Colin Best
President
Association of Municipalities of Ontario

Appendix A:

WHEREAS the state of health care in Ontario is in crisis, with 2.3 million Ontarians lacking access to a family doctor, emergency room closures across the province, patients being de-rostered and 40% of family doctors considering retirement over the next five years; and

WHEREAS it has becoming increasingly challenging to attract and retain an adequate healthcare workforce throughout the health sector across Ontario; and

WHEREAS the Northern Ontario School of Medicine University says communities in northern Ontario are short more than 350 physicians, including more than 200 family doctors; and half of the physicians working in northern Ontario expected to retire in the next five years; and (Northern Ontario only)

WHERAS Ontario municipal governments play an integral role in the health care system through responsibilities in public health, long-term care, paramedicine, and other investments.

WHEREAS the percentage of family physicians practicing comprehensive family medicine has declined from 77 in 2008 to 65 percent in 2022; and

WHEREAS per capita health-care spending in Ontario is the lowest of all provinces in Canada, and

WHEREAS a robust workforce developed through a provincial, sector-wide health human resources strategy would significantly improve access to health services across the province;

- NOW THEREFORE BE IT RESOLVED THAT the Council of (the name of municipality) urge the Province of Ontario to recognize the physician shortage in (name of municipality) and Ontario, to fund health care appropriately and ensure every Ontarian has access to physician care.

	YEAR-TO-DATE			ANNUAL BUDGET	
	Actual	Budget	Variance		Comments
Cash Based Revenue					
Taxation	$3,491,017	$3,491,017		$6,982,034	
Grants & Subsidies	$8,446,235	$6,656,414	$1,789,822	$13,312,827	Prior year adjustments 876K, Operating subsidy increase 384K, HIN claims 436K
Interest Revenue	$100		$100		
Resident Revenue	$1,707,075	$1,764,656	($57,581)	$3,529,313	Below target
Other Revenue	$74,467	$60,650	$13,817	$121,300	
Total Revenue	$13,718,894	$11,972,737	$1,746,157	$23,945,474	
Expenditures					
Salaries & Wages	$6,281,315	$6,662,392	($381,077)	$13,445,950	RPNs (375K), PSW regular salaries under budget but offset by OT
Benefits	$1,917,486	$2,158,922	($241,436)	$4,150,128	RPN, PSW
Travel & Training	$46,507	$41,045	$5,462	$82,090	
Materials & Supplies	$44,659	$22,575	$22,084	$45,150	
Health Care Supplies	$1,125,901	$793,300	$332,601	$1,586,600	HIN costs 337K
Raw Food	$317,617	$324,600	($6,983)	$649,200	
Insurance	$88,549	$80,135	$8,414	$160,270	
Information Technology	$13,661	$15,050	($1,389)	$30,100	
External Services	$719,883	$440,299	$279,584	$812,598	Staffing agency costs (RN, RPN)
Utilities & Fuel	$203,173	$169,900	$33,273	$339,800	Natural Gas 24K, Water/Sewer 10K
Repairs & Maintenance	$323,012	$183,850	$139,162	$367,700	Security 115K
TCAs under Threshold	$95,953	$56,250	$39,703	$112,500	Timing
Internal Chargebacks	$972,505	$972,505	($0)	$1,945,010	
Financial Services	$34,489	$36,989	($2,500)	$73,978	
Total Expenditures	$12,184,710	$11,957,813	$226,898	$23,801,074	
Investments					
TCAs over Threshold	$5,811	$61,200	($55,389)	$122,400	Timing
Transfers to Reserves	$25,000	$25,000	$0	$50,000	
Total Investments	$30,811	$86,200	($55,389)	$172,400	
Financing					
Transfer from Reserve	($14,000)	($14,000)		($28,000)	
Total Financing	($14,000)	($14,000)		($28,000)	
Surplus/(Deficit)	$1,517,373	($57,275)	$1,574,648		

	YEAR-TO-DATE			ANNUAL BUDGET	
	Actual	Budget	Variance		Comments
Cash Based Revenue					
Taxation	$4,805,021	$4,805,021	($0)	$9,610,041	
Grants & Subsidies	$5,235,425	$5,298,008	($62,583)	$11,317,758	Community Paramedicine
Permits & Fees				$260,000	
County Revenue				$25,200	
Other Revenue	$84,997	$50,000	$34,997	$200,000	Recoveries
Total Revenue	$10,125,442	$10,153,028	($27,586)	$21,412,999	
Expenditures					
Salaries & Wages	$5,528,740	$5,969,159	($440,418)	$12,316,474	Gapping, vacation payout
Benefits	$2,181,253	$1,894,267	$286,986	$3,788,534	WSIB claims
Travel & Training	$23,599	$69,347	($45,748)	$138,694	Timing
Materials & Supplies	$104,472	$56,343	$48,129	$112,686	Timing
Health Care Supplies	$274,286	$170,158	$104,128	$340,316	Medical supplies - timing
Insurance	$24,838	$21,570	$3,267	$43,141	
Licences	$325	$3,586	($3,261)	$7,171	
Information Technology	$131,070	$28,841	$102,229	$57,683	Technology support
External Services	$305,716	$106,367	$199,349	$212,733	Off-load nursing (funded)
Utilities & Fuel	$178,701	$194,000	($15,299)	$413,031	
Rent & Property Tax	$13,984	$15,659	($1,675)	$31,318	
Repairs & Maintenance	$173,322	$87,528	$85,794	$183,526	Vehicle repairs higher than anticipated
TCAs under Threshold	$83,339	$101,212	($17,873)	$202,424	
Internal Chargebacks	$977,634	$977,634	$0	$1,955,268	
Total Expenditures	$10,001,280	$9,695,671	$305,609	$19,802,999	
Investments					
TCAs over Threshold	$398,948	$140,000	$258,948	$1,240,000	Timing - vehicles and equipment
Transfers to Reserves	$645,000	$645,000		$1,290,000	
Total Investments	$1,043,948	$785,000	$258,948	$2,530,000	
Financing					
Transfer from Reserve	($140,000)	($140,000)		($920,000)	
Total Financing	($140,000)	($140,000)		($920,000)	
Surplus/(Deficit)	($779,786)	($187,643)	($592,144)		

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Report 2024-085

Report Title: **Northumberland Paramedics, 2024 Semi-annual Report**

Committee Name: Community Health

Committee Meeting Date: July 30, 2024

Prepared by: Keith Barrett
Deputy Chief of Operations
Northumberland Paramedics

Reviewed by: Susan Brown
Chief – Northumberland Paramedics
Northumberland Paramedics

Approved by: Jennifer Moore, CAO

Council Meeting Date: August 14, 2024

Strategic Plan Priorities:
☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☒ Foster a Thriving Community
☐ Propel Sustainable Growth
☐Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2024-085 Northumberland Paramedics '2024 Semi-annual Report' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

The purpose of this report is to provide a semi-annual review of Northumberland Paramedic Services inclusive of the Operations and Quality Assurance and Training departments for information purposes. All data and statistics presented are inclusive of the period of January 1 to June 30, 2024.

Background

Northumberland County with a land area of 1,905 sq Km. provides emergency responses from six (6) ambulance stations that are strategically located throughout the County in the following locations:

- Cobourg (1) 24 - hour and (1) 12- hour ambulance,
- Port Hope (1) 24 – hour and (1) 12- hour ambulance,
- Colborne (1) 24 - hour ambulance (1) 12-hour ambulance * Q2
- Roseneath, (1) 24- hour Ambulance, (1) 12- hour first response unit,
- Campbellford, (1) 24- hour ambulance,
- Brighton (1) 24 -hour ambulance.

Call Volume

The total responses for service requests for the first half of 2024 were 12,365 calls. Included in this figure are requests for emergency and life-threatening calls (Code 3 and Code 4), interfacility transfers and assessments (Code 1,2,3, and 4), standby for emergency coverage and incidents. This currently is trending slightly below the call volume compared to the first 6 months of 2023 where it was 15,575 and the full year 29,162 call responses.

To respond to these calls Northumberland Paramedics, drove 494,971 km per vehicle in the first half of 2024. To help put this into perspective, the Earths circumference is 40,075 kilometers. Northumberland Paramedics would have driven around the earth twelve (12) times. This distance required approximately 139,774 litres of fuel in first half of 2024.

Northumberland Paramedics deploys one (1) first response - Emergency Response Vehicle (ERV) throughout Northumberland County each day. The first response vehicle is available to respond to calls in each of the lower tier municipalities within Northumberland County, however the focus is in the central rural area of the County where we experience increased response times due to the geographical distance. In the first half of 2024 the first response vehicle responded to a total of 195 calls and arrived prior to the dispatched transporting ambulance 131 times. The deployment of the ERV saved a total of 1,502 minutes and 16 secs in response times and began an earlier assessment and treatment by the responding Paramedic. This data is congruent to the 2023 ERV responses of 218 calls mid-year with the full year of 439 responses in total.

Northumberland Paramedics total call volume includes all responses from within our County and to external municipalities due to seamless coverage for all code 4 – Life threatening calls. Seamless coverage ensures that the closest vehicle to a code 4 (Life Threatening) call is sent regardless of the operating municipality. Northumberland Paramedics continues to respond to most neighboring services more frequently than external responses to our area. (APPENDIX 2) In the first half of 2024 Northumberland Paramedics responded to 293 calls in Peterborugh compared to their total responses within our county of 179. Also, Northumberland Paramedics responded to Hastings County for 330 calls compared to their response of 121 calls within our County. This effects our deployment in several ways as it takes Northumberland ambulances out of our county and in most cases places us in off load delays at hospitals outside of our catchment area.

Off load delays are still being experienced in the first half of 2024 (APPENDIX 3). The four (4) main hospitals we transport to are: Northumberland Hills (NHH), Campbellford Memorial

Hospital (CMH), Peterborough Health Center (PRHC), and Trenton Memorial Hospital (TMH). The common pre-hospital measure of an off-load delay begins to count after 30 minutes on arrival at the hospital. This 30-minute delay has been accepted as a 'normal time to arrive at the hospital, register the patient with triage nurse, be provided direction to the stretcher/ room, transfer the patient over and give a report to the nurse/doctor, clean their stretcher and equipment, return to state of readiness, and begin the required documentation for the patient. Currently Paramedics are experiencing off-load times beyond the "accepted" 30 minutes. In the first half of 2024 the total off-load time was 382 hours for the four (4) hospitals we routinely transport to. If the off loads continue in the same trajectory, we project a total off load delay of 758 hours compared to 899 hours experienced in 2023.

Northumberland Paramedics once again have applied for Off-load nurse funding from the Ministry of Health and Long-Term care and have utilized the "Fit to Sit" programs to help with off-load delays at Northumberland Hills and Campbellford Memorial Hospitals in 2024.

Quality Assurance and Education 2023-year end

Education

In the spring of 2024, we actively recruited and onboarded eighteen (18) new Paramedics. These new Paramedics attended an orientation that included topics such as: driver training, legislative requirements, policies & procedures, County culture and values, equipment training for the provision of patient care, mental wellness and resilience.

Each year Paramedics must attend training for the maintenance of skills and knowledge for delegated medical acts (medications and procedures) as well as training on new directives and medications. This training is provided by the Central East Prehospital Care Program (CEPCP) which is a part of Lakeridge Health. To date each Paramedic has received 8 hours of training on these topics. CEPCP also provides training to Paramedics that are returning from extended leaves to ensure that they are comfortable and able to provide patient's care with any of the delegated medical acts. Thus far we have returned 5 paramedics from various leaves back to their frontline duties.

In addition to the CEPCP training Northumberland Paramedics provide 16 hours of training to each paramedic to ensure that the paramedics are meeting the legislative standards. This includes the Basic Life Support Patient Care Standards (BLS-PCS), Ontario Ambulance Documentation Standards, and others. Thus far in 2024 each paramedic has received 8 hours of in-service training. Training has included updates regarding the changes to the standards, Multi Casualty Incidents (MCI), oxygen delivery systems, pregnancy and neonatal standards, and skills maintenance on equipment that is not frequently used to ensure competency.

Working with our partners we have trained 6 medics in the first half of 2024 for IV starts to become IV autonomous. Training also took place, for all medics on the new digital radio system Public Safety Radio Network System (PSRN) for the ambulances.

We provided the opportunity for three (3) classes to visit our Cobourg station and three (3) school visits where the students were able to tour the ambulance, view the equipment and discuss the situations and incidents that may require them to call 911 for an ambulance. We also had opportunities over the spring to visit primary and Secondary age schools and meet with the children to let them know what to expect if they were to be in an ambulance and when to call 911.

Quality Assurance

In 2024 we have manually audited over 2,600 call reports completed by paramedics in addition to the software audits completed in real time when the Paramedics are documenting their reports.

Paramedic Supervisors also completed over 50 evaluations on calls they attended with paramedics. These evaluations provide feedback on paramedic performance during the real applications of their skills and compliance with BLS-PCS standards.

Call Data 2024

Thus far in 2024 Northumberland Paramedics have responded to 135 Cardiac Arrest where they were able to provide care. Of the 135 cardiac arrests, 9 of these patients resulted in the return of spontaneous circulation (ROSC- resulting in a return of the heartbeat) restored by the Paramedics with a defibrillator during their response.

In October of 2024 we will be holding our annual survivor night to celebrate those patients where the Paramedics were able to restore heartbeats from 2023. This year we will be honoring 19 survivors of cardiac arrests along with those first responders that were part of the chain of survival including the Paramedics, Ambulance Communications Officers and Firefighters that were a part of the survival stories.

For certain types of heart attacks (STEMI's), Paramedics by-pass the local hospital emergency department and take these patients for definitive care directly to the Catheter lab for angioplasty treatment at Peterborough Regional Health Centre (PRHC). This far in 2024 Northumberland Paramedics have identified and utilized the bypass criteria eleven (11) times. The Cath lab is deemed to be the definitive care "gold standard" for myocardial infarctions, as time is heart muscle; the quicker the blockage is physically restored by direct catheterization of the vessel occluded the less heart damage occurs.

Patients suffering from an acute stroke (within 6 hours of onset) were transported by paramedics to regional stroke centers for definitive treatment. Thus far in 2024 seventeen (17) patients have been transported to a regional stroke center under the stroke protocol bypass agreement.

These specialized bypass protocols have made significant improvements of the patient's quality of life within Northumberland County

Consultations

ESO – Interdev Analytics

Ambulance Dispatch Data Systems (ADDS)

Legislative Authority / Risk Considerations

N/A

Discussion / Options

N/A for information only

Financial Impact

N/A

Member Municipality Impacts

Data presented is a mid -year report inclusive of Northumberland County

Conclusion / Outcomes

Staff request that the Community Health Committee receive report 2024-085, Northumberland Paramedics ‘2024 Semi-annual Report’ for information.

Attachments

1. Report 2024-085, ATTACH 1 ‘2024 Paramedic Services Mid-Year Report’
2. Report 2024-085, ATTACH 2 ‘Cross Border Calls’
3. Report 2024-085, ATTACH 3 ‘OFF load Delays – January 1 to June 30, 2024’

Northumberland County Paramedics 2024 Mid-Year Report January-June 2024

Total Call Volume : 12,365

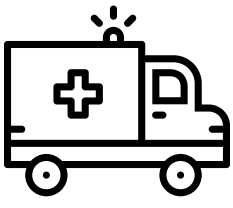
Cardiac Arrest

Total number of cardiac arrest calls Jan-June 2024: 135

of the 135 treatable cardiac arrest calls, 9 (7%) resulted in return of spontaneous circulation (ROSC)

Bypass

Bypass protocol allows an ambulance to bypass a local hospital for definitive care.



Number of patients taken directly to regional stroke centre: 17

Number of patients taken directly to cardiac care centre for emergency angioplasty: 11

First Response

Responded to **195** calls

First on scene to **131** calls

1502 minutes, 16 seconds

Response time saved by deployment of Emergency Response Vehicle (ERV)

Hospital Offload Delays

379 hours, 16 minutes

Total amount of off-load time for the four main hospitals Northumberland Paramedics routinely transports to

Training

18 New Paramedics

8 hours each with Base Hospital - Central East Prehospital Care Program (CEPCP)

Training Highlights

- Certification by physician
- Review/train medical directives

8 hours each with Northumberland Paramedics education staff

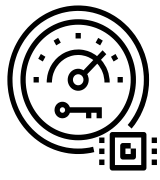
Training Highlights

- Legislative training on updated standards
- Multi-Casuality Incidents (MCI)
- Oxygen delivery systems
- Pregnancy and neonatal standards
- Skills maintenance on infrequently-used equipment

Travel

139,774

Total litres of fuel uses by vehicles in 2024 so far.



494,971

Total Kilometers travelled by vehicles in 2024 so far.

That's equivalent to circling the Earth **12** times!

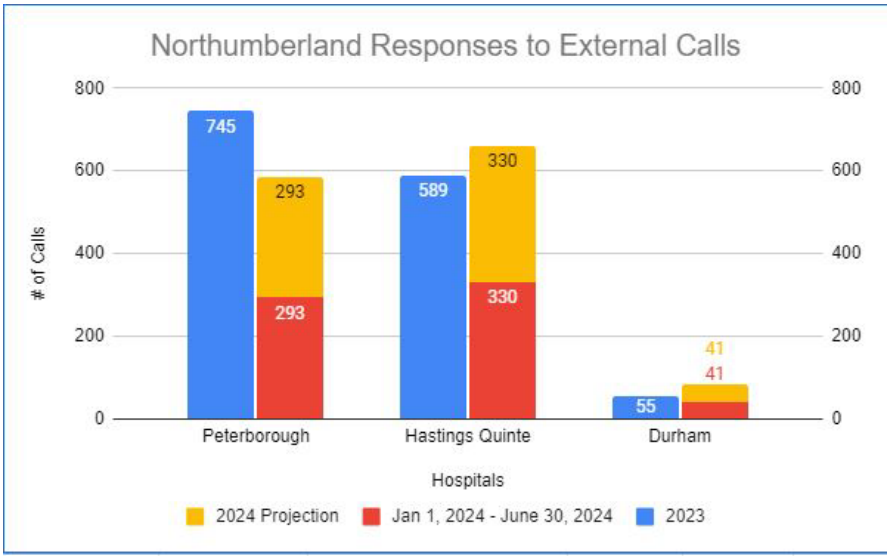
Quality Assurance

Manually audited over **2,600** call reports by paramedics

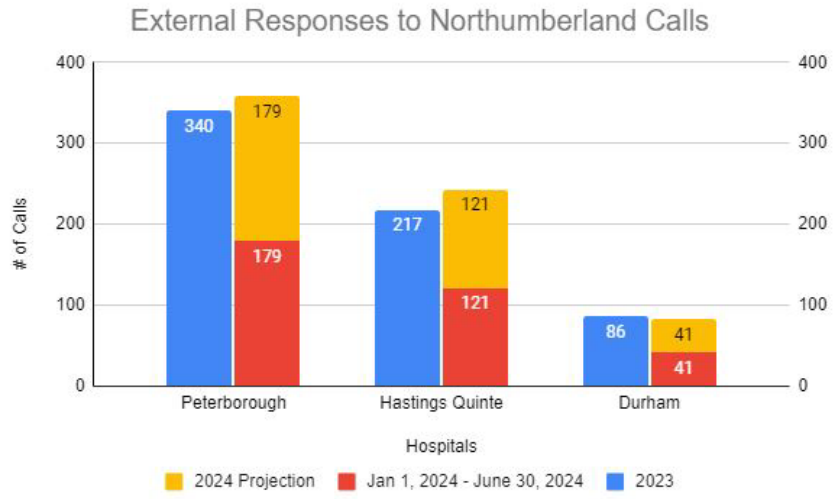
Paramedic Supervisors completed over **50** evaluations on calls attended with paramedics

APPENDIX 2

2024 Northumberland Responses to External Municipalities (Jan1 to June 30, 2024)

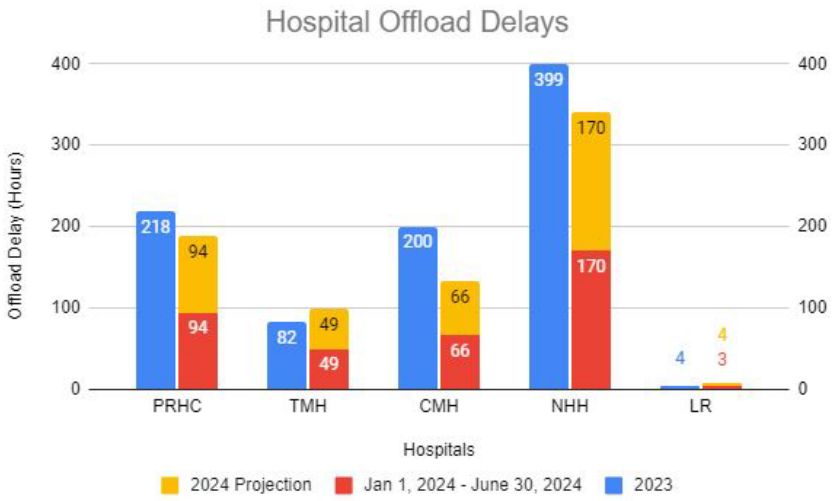


2024 External Municipal Responses to Northumberland County (Jan 1 to June 30, 2024)



APPENDIX 3

Hospital Off-Load Delays (Jan 1 to June 30, 2024)



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Report 2024-086

Report Title: **Northumberland Community Paramedic, 2024 Semi-annual Report**

Committee Name: Community Health

Committee Meeting Date: July 30, 2024

Prepared by: Kim Wilkinson
Coordinator
Northumberland Paramedics

Reviewed by: Susan Brown
Chief
Northumberland Paramedics

Approved by: Jennifer Moore, CAO

Council Meeting Date: August 14, 2024

Strategic Plan Priorities:
☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☒ Foster a Thriving Community
☐ Propel Sustainable Growth
☐Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2024-086 'Northumberland Community Paramedic, 2024 Semi-annual Report' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

The purpose of this report is to provide a semi-annual review of Northumberland Community Paramedic Program services for information purposes. All data and statistics presented include the time period of January 1 to June 30, 2024.

Background

The Northumberland Community Paramedic (CP) Program has been providing non-emergency services to the members of our community since early in 2020. In 2022, it was announced that the Ministry of Long-Term Care would be funding a pilot program to expand CP services across the province. At this time Northumberland County was awarded a temporary funding opportunity of $3 million per year until March 31, 2024. Since then, the Ministry has extended the funding with a current end date of March 31, 2026. The primary goal of the program is to provide the right care to the right person in the right location while allowing individuals to remain at home longer, safely.

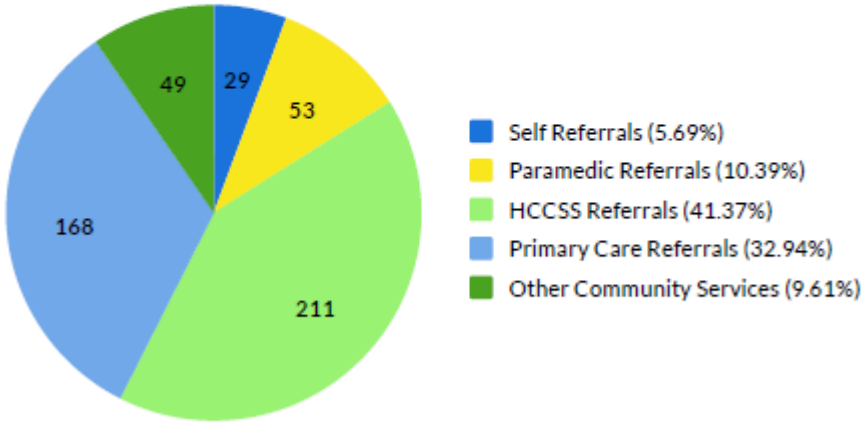
We also receive a small amount of funding through Ontario Health; approximately $345,000 annually. Within each funding stream there are specific requirements for services provided and to which populations. This chart summarizes the current funding structure.

	CP LTC	Ontario Health/HCCSS	OHT-N
Funding	3 M / year until March 31, 2026	259,000 + 50 RPM HISH - $18,000	2024 – 0 2023 – 50 RPM 2021/22 - $64,411
Goals	• LTC waitlist • Assessed for admission to LTC • Eligible for admission to LTC	• HISH • Referred by HCCSS • Decrease 911	• Homelessness • Addictions • Frail/co-morbid • Mental Health

Since the inception of the CP program, we have provided services for approximately 5000 community members across Northumberland County. From January 1 to June 30, 2024, we have had 1283 active clients with 317 new enrollments throughout the county (see map attached). We provide Community Paramedic services to the municipalities of Alnwick/Haldimand, Brighton, Cobourg, Cramahe, Hamilton, Port Hope and Trent Hills. Referrals are received from various community partners including Ontario Health @ Home (formally known as Home and Community Care Support Services), primary care providers, hospitals, other community partners and self / family. To date this year our largest referral source has been Ontario Health @ Home (211) followed by our primary care providers (168). Currently, when referrals are received initial contact with the potential client has been made within 72 hours 98% of the time.

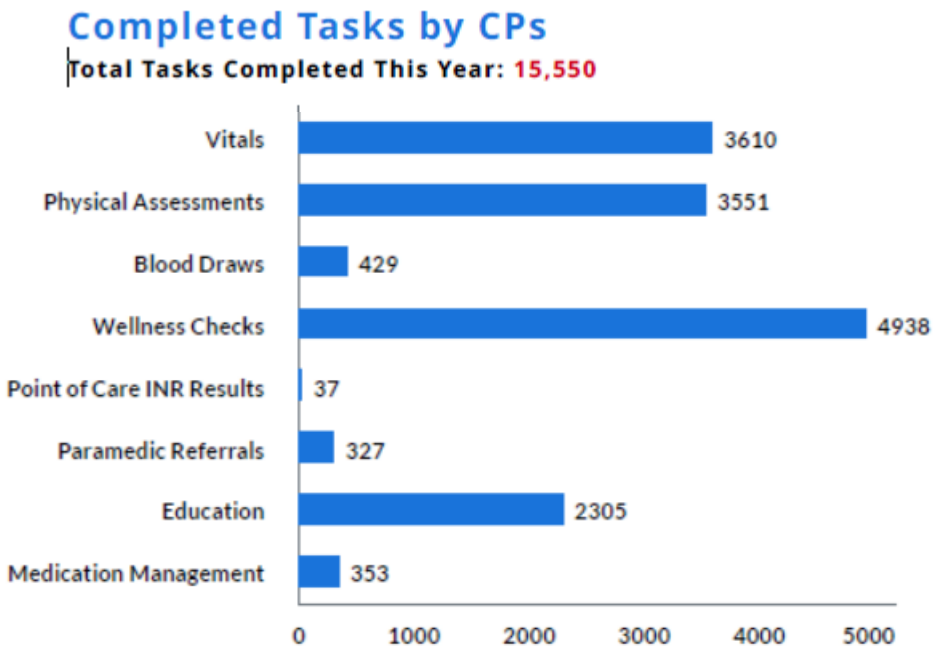
New Referrals

Total Referrals Submitted this Year: 510



Currently, we have twelve (12) full time CP positions with four (4) stationed in Cobourg and two (2) in Campbellford who all work on a 12-hour continental shift rotation. Our full time CPs are all certified paramedics with a minimum of 108 additional hours of specialized training in geriatrics and community paramedicine to start with continued specialized education provided annually. Part time CPs participate in an introductory 12-hour geriatric and community paramedicine course as well as annual continuing medical education for CP. Recently we were able to send 4 CPs to a 2-day advanced wound care training program focusing on skin health and proactive care plus best wound care practice for minor to major wounds. In addition, 15 CPs have recently completed the Montreal Cognitive Assessment (MoCA) course which is a recognized cognitive assessment test across multiple disciplinary fields.

CP services include both home and telephone wellness assessments, medication administration, point of care testing such as urinalysis, and blood tests, phlebotomy for homebound individuals, ECGs, vaccinations, remote patient monitoring, IV antibiotic administration, wound care, health education, and system navigation assistance. To date in 2024, we have completed over 15,500 different tasks for our clients including almost 5,000 wellness assessments (see attached 2024 YTD infograph). We work with our community partners to identify gaps in healthcare within the community to avoid redundancy of services provided.



Reduction of 911 calls for many of our high 911 users has been seen after enrollment in the community paramedic program. In 2023, we were able to help reduce 134 ambulance calls with just 25 of our clients for a cost savings of at least $31,160. This estimated cost savings is based on $240 per ambulance call as per the Ambulance Services Billing document from the Ministry of Health and Ministry of Long-Term Care last modified 2023-10-25.

Since January 1, 2024, the CPs have responded to at least 195 urgent requests for assessment due to various concerns by clients, family and caregivers including urinary tract infections (UTI), chest infections, skin infections, post fall assessments, and wound care to name a few. Many of these urgent visits have led to many emergency department diversions for a significant cost savings to the healthcare system. These estimated cost savings are based on the Canadian Institute for Health Information patient cost estimator from 2021-2022 for patients who are at least 60 years of age. The chart below is an overview of major illnesses/injuries that we have seen and does not include more general wellness complaints.

Illness/injury	No. of calls	Estimated cost of hospital visit	Total estimated savings
UTI	30	6762.50	202,875.00
Chest infection /COPD exacerbation	7	5886.50	42,205.50
Cellulitis	3	8515.50	25,546.50
Dehydration	4	5293.00	21,172.00
Wound care	9	5310.00	47,790.00
Congestive Heart Failure (CHF)	3	8841.00	26,523.00
TOTAL			$366,112.00

The Community Paramedic program also holds monthly wellness clinics at 7 county housing units and weekly clinics at Transition House and the warming hub (seasonal). This year we have held a total of 84 clinics over 138 hours with 139 in attendance to date. During these clinics we have been able to help prevent emergency department visits by connecting individuals with the resources they required. For example, during one clinic we were able to assess and bandage minor burns for 2 individuals. At the warming hub we facilitated a prescription of antibiotic and steroid creams for a skin infection.

Another integral part of our program is our remote patient monitoring (RPM) which allows Community Paramedics to monitor heart rate, blood pressure, oxygen saturation and weight of some of our clients remotely. We have had a total of 108 active RPM clients and performed 63 RPM assessments since the beginning of 2024. During this time, we have actioned 770 RPM alerts through telephone wellness checks and or home visits collaborating with primary care providers to adjust medications as required. The ability to enroll clients in the RPM program can help to facilitate earlier hospital discharge while providing peace of mind to the client, caregiver and primary care providers knowing they will be monitored daily for any changes in vital signs. Daily monitoring of an individual's vital signs allows for early intervention when / if changes are noted with a reduction in ED visits and potential hospitalization. We currently have 91 active RPM clients in our program.

Collaborating with our community partners including HCCSS, local hospitals and family health teams as well as the Ontario Health Team – Northumberland allows us to continue providing services to members of our community to assist them to stay home longer, safely. We can help, not just our clients, but also their caregivers and primary care practitioners. As the county's population ages the need for mobile healthcare support will continue to grow.

Through our quarterly surveys we received valuable feedback that help us improve our services. Surveys from the first half of 2024 show that 87% of respondents feel that the Community

Paramedic program has helped to prevent avoidable emergency room and/or hospital visits. While 85% of respondents feel that being in the CP program has helped decrease their use of 911.

See the attached January – June 2024 survey results.

Testimonials:

"Cannot say enough about program and the paramedics I've met. Please continue. We seniors and the disabled are an **"at risk" group**. It's **reassuring** to know there is **help available**."
-Q1 2024 Survey response

"They were helpful from the very beginning and still are. It is **comforting** to know I can reach out to them as needed. They are always **helpful** and **informative**, **friendly**, as well as **professional**. Just knowing I can call if I need to is comforting."
-Q2 2024 Survey response

“This program has been a **safety net** for me as [the CP] always checks my blood pressure - I was in so much pain with my swollen legs and feet that I could barely walk. If he hadn't visited me **at home** and **contacted my doctor, I would still be suffering**.”
-Q1 2024 Survey response

Consultations

Prehos documentation data

Future Health Remote Patient Monitoring data

Eastern Ontario Association Paramedic Chiefs / Community Paramedic Programs

Northumberland Community Paramedic Quarterly Surveys

Canadian Institute for Health Information Patient Cost Estimator 2021-2022

Ministry of Health & Ministry of Long-Term Care Ambulance Services Billing publication, last revised 2023-10-25

Legislative Authority / Risk Considerations

N/A

Discussion / Options

N/A

Financial Impact

N/A

Member Municipality Impacts

Data presented is a semi-annual report inclusive of Northumberland County.

Conclusion / Outcomes

Staff request that the Community Health Committee receive Report 2024-086 ‘Northumberland Community Paramedic 2024 Semi-annual Report’ for information.

Attachments

1) Report 2024-086 ATTACH 1 ‘CP Client Map 2024’
2) Report 2024-086 ATTACH 2 ‘Northumberland Community Paramedic January – June 2024 Infograph’
3) Report 2024-086 ATTACH 3 ‘January – June 2024 Survey Results’

Community Paramedic Client Map

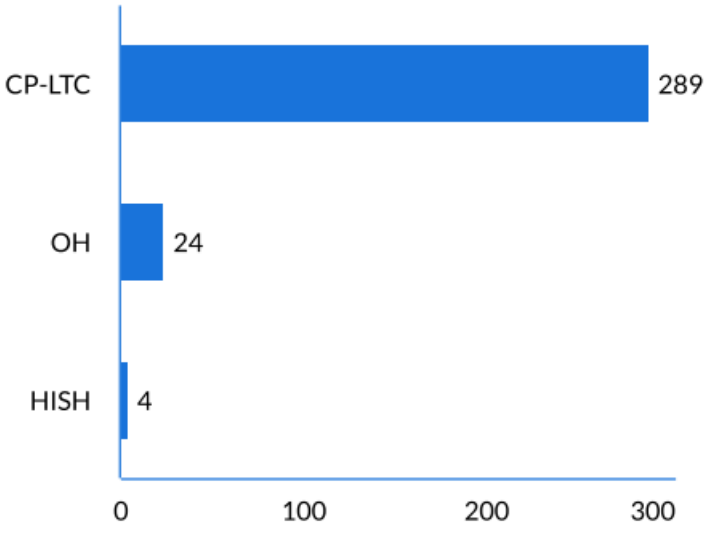
January – June 2024

Community Paramedicine Year-To-Date Report

January-June 2024

1283 Active CP Clients

New Enrollments



317 New Clients Enrolled into the CP program in 2024

Scheduling

64% of CP clients are scheduled within 7 days of receiving referral

36% of CP clients are scheduled over 7 days of receiving referral

*Note: many clients were difficult to contact, requested visit for a later date, and/or needed visit rescheduled.

98% of Clients contacted within 72 hours of receiving referral on first attempt

2% of Clients contacted over 72 hours of receiving referral on first attempt

12% of Clients required multiple contact attempts

Wellness Clinics

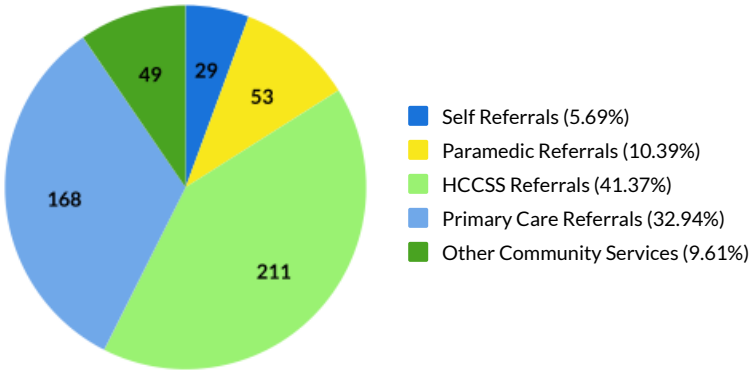
11	84	138	139
Total Sites	Total Clinics	Total Hours	Total Attendance

CP Remote Patient Monitoring

- 108 Total Active Users
- 19 New Enrollments
- 28 Discharged
- 770 RPM Alerts
- 1821 Compliance Tasks
- 63 CPRPM Assessments

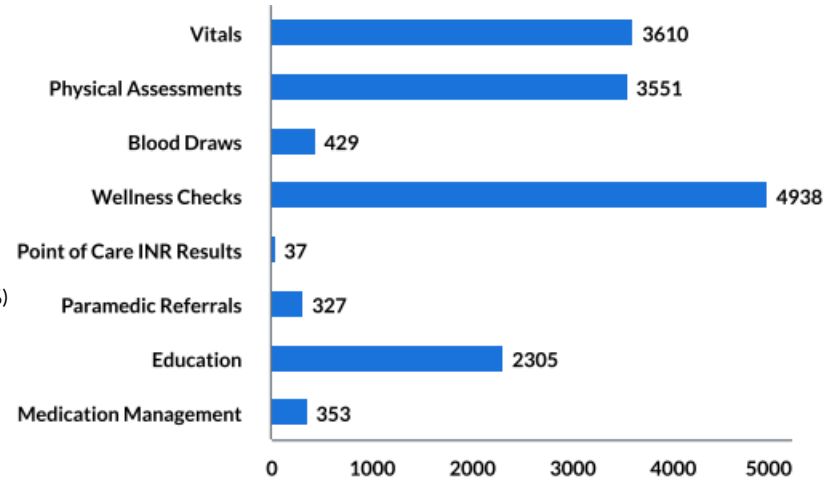
New Referrals

Total Referrals Submitted this Year: 510



Completed Tasks by CPs

Total Tasks Completed This Year: 15,550



CP Feedback

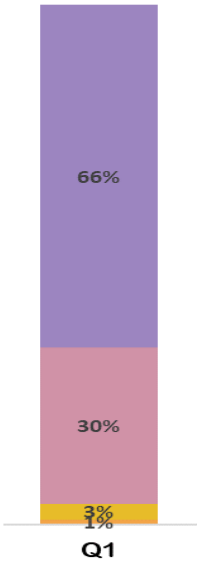
"Cannot say enough about program and the paramedics I've met. Please continue. We seniors and the disabled are an "at risk" group. It's reassuring to know there is help available."
-Q4 2024 Survey response

"They were helpful from the very beginning and still are. It is comforting to know I can reach out to them as needed. They are always helpful and informative, friendly, as well as professional. Just knowing I can call if I need to is comforting."
-Q1 2024 Survey response

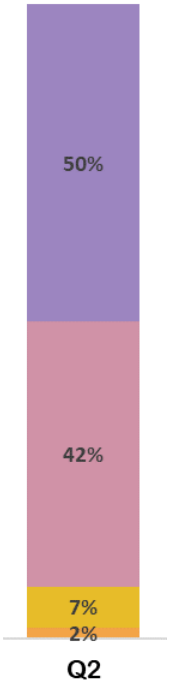
January – June 2024 Survey Results

Legend

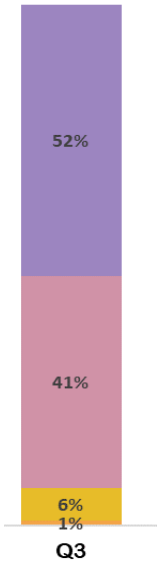
Do Not Agree Somewhat Agree Agree Strongly Agree



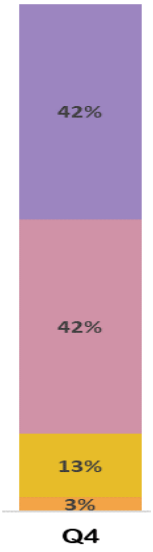
Q1. I found that the Community Paramedicine (CP) Program met my needs at the time of enrollment.



Q2. Since being enrolled in the Remote Monitoring Program I have a greater sense of wellbeing and security (i.e., I feel comfortable, happy, and healthy).

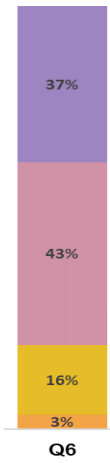


Q3. The home visits from the Community Paramedics answered my concerns and took the time to answer my questions (i.e., the Community Paramedic provided me with helpful information and advice on how to maintain or improve my health and well-being or the health and well-being of the person I care for).

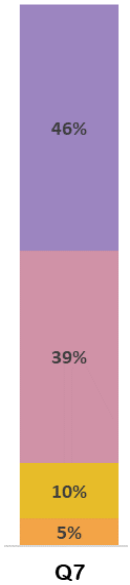


Q4. I feel that the CP program has helped me to access community- based care providers and services that I may not have been able to do prior to being seen by a Community Paramedic.

Q5. The CP program has helped to prevent avoidable emergency room and/or hospital visits.



Q6. I feel my overall Health has stabilized or improved with the assistance of the CP program.



Q7. I feel that being in the CP program has helped decrease my use of 911.

IVY's Progression

SEPT 15 2023 - JULY 15 2024

IVY's Trainer

Karen Laws, Ontario Dog Trainer

Graduations

Community Paramedic Client Visits

- Usually start at 1.5 - 2 years of age
- Accelerated program due to her abilities
- 10 Client visits
  - Client Survey
  - Caregiver Survey
  - Community Paramedic Survey

What did you enjoy most about your visit with Ivy?

"Just seeing her and talking to her" (client feedback)

"Much more talkative than any other visit I have ever seen him. Ivy appeared to brighten up his mood and engagement for the visit." (CP feedback)

What did you enjoy the most about Ivy?

"Ivy is very calming, and gentle. It was a delight having her as she would snuggle up to you and loved being pet. It was such a nice companion visit" She is so well behaved! We are both looking forward to her next visit." (Client feedback)

What did you enjoy the most about Ivy?

"Her kisses; shook paws and "made up to me so quick" (Ivy was happy to see me)"

What do you like about Community Paramedicine?

"Everything; Paramedics are great – amazing program with IVY" (Client feedback)

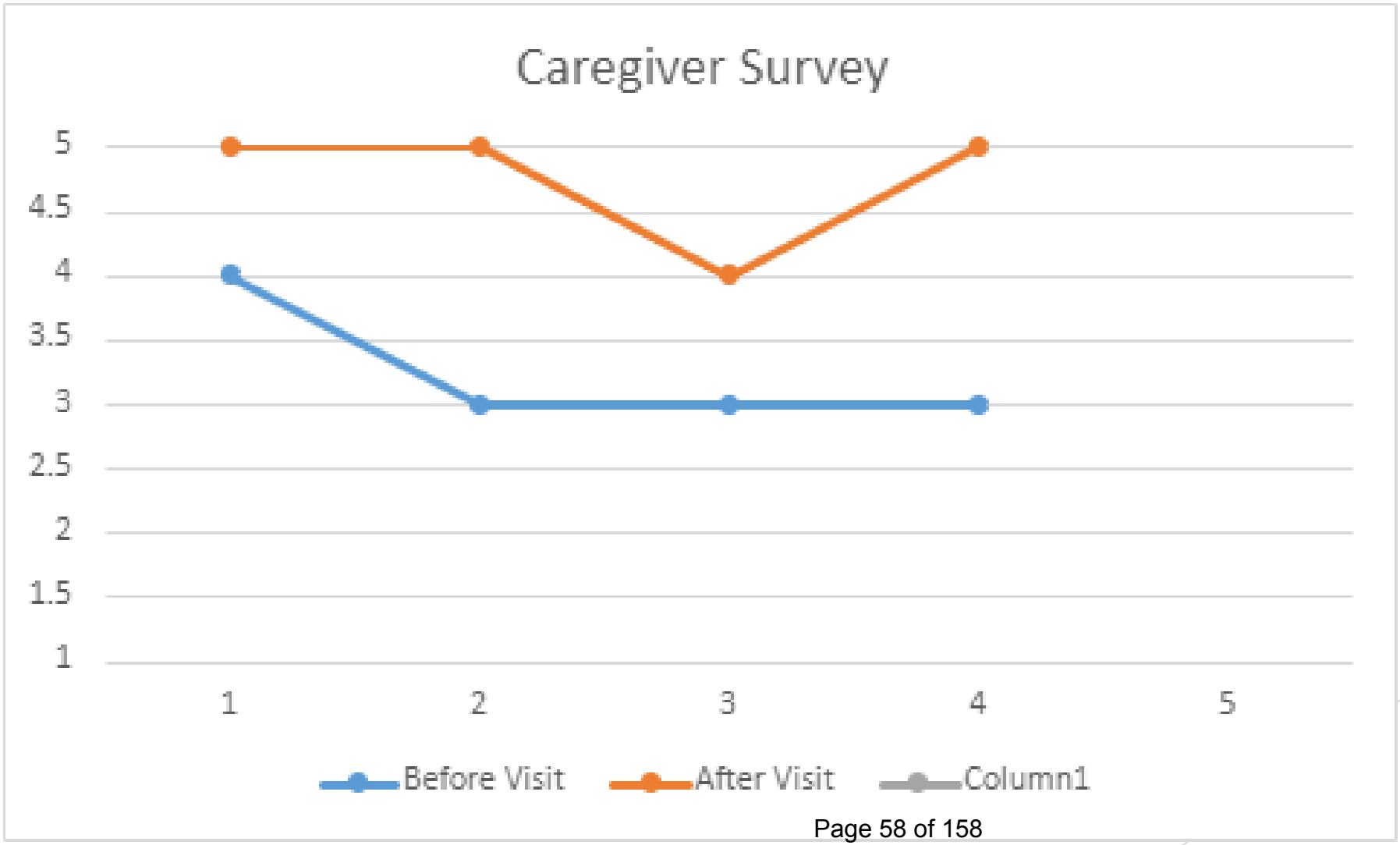
These clients are always very happy kind people, but it was next level today. The client met me outside as I pulled up in anticipation of Ivy. When I was leaving the clients walked out with us, and he rolled around on the ground with her – reminiscing about his old dog. It brought tears to my eyes- THIS IS WHAT IT"S ALL ABOUT ☺ (CP feedback)

What did you enjoy the most about Ivy?

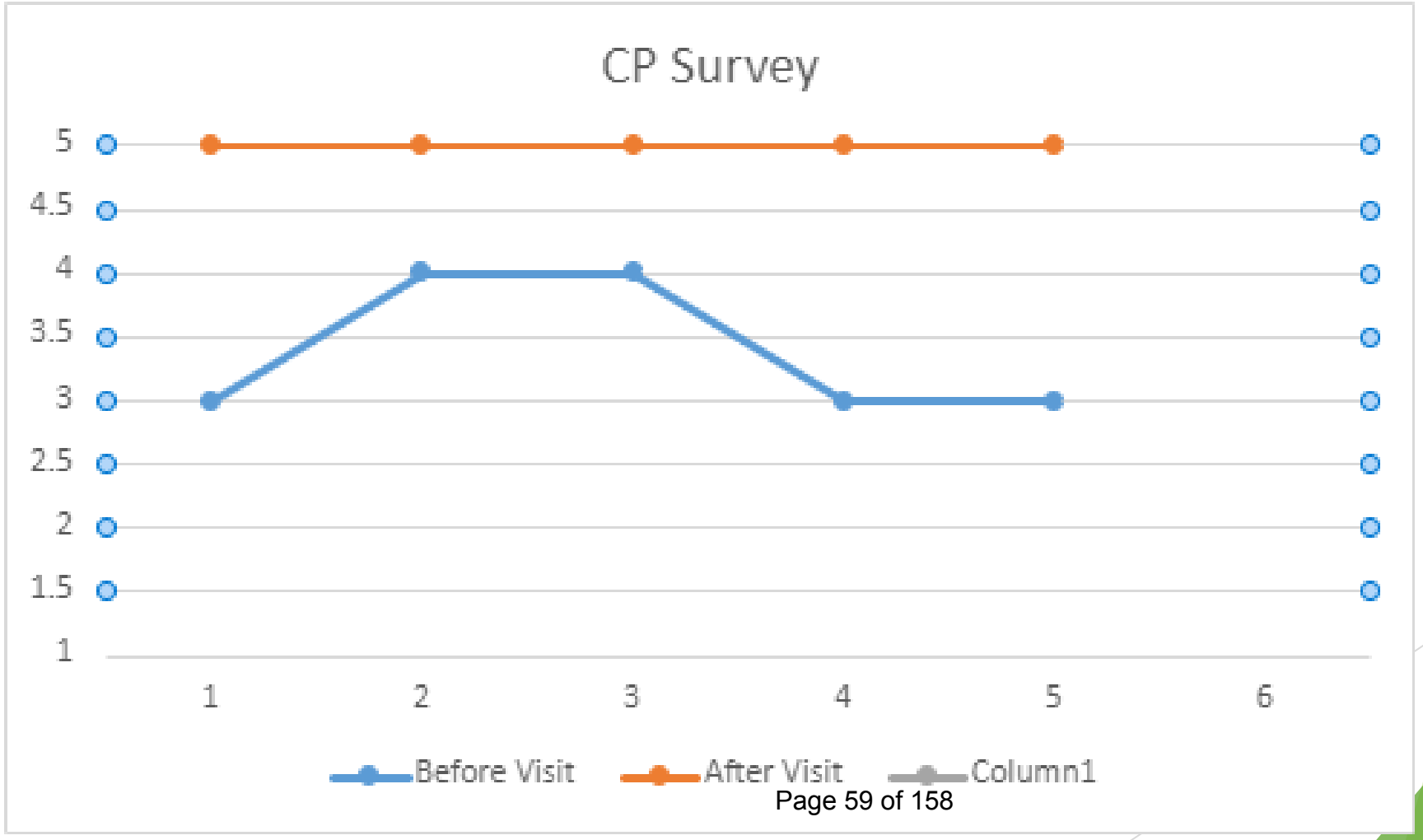
“I enjoyed how friendly she was. She was very sweet and very polite. She even gave me a pedicure. I very much looked forward to her visit and I couldn't wait to show my family the pictures.
I have a sick family member who is battling leukemia and he looked forward to receiving the pictures from the visit. She isn't just helping us in the community, she is also reaching people in Hamilton.” (Client feedback)

Client Satisfaction Survey

Caregiver Satisfaction Survey

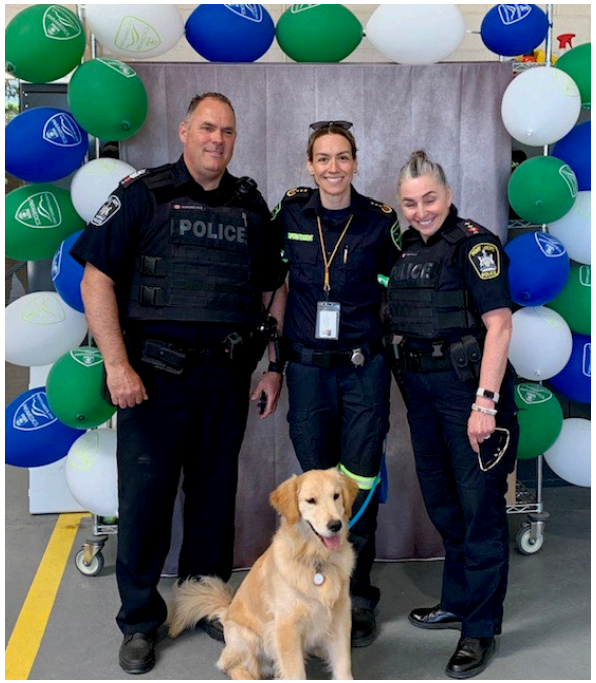


Community Paramedic Survey



County Staff Survey results

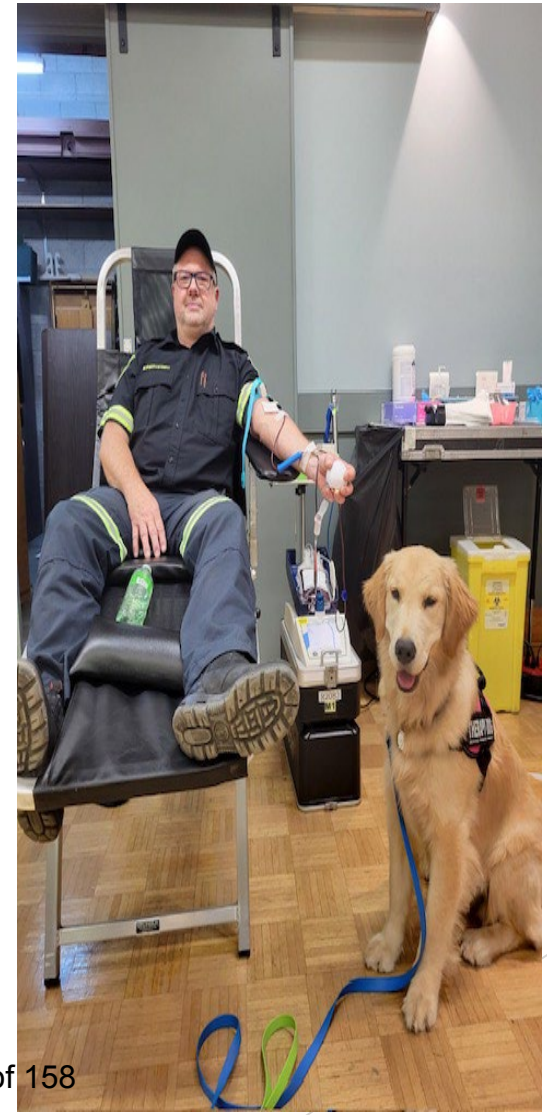
Northumberland Hills Hospital - Visits

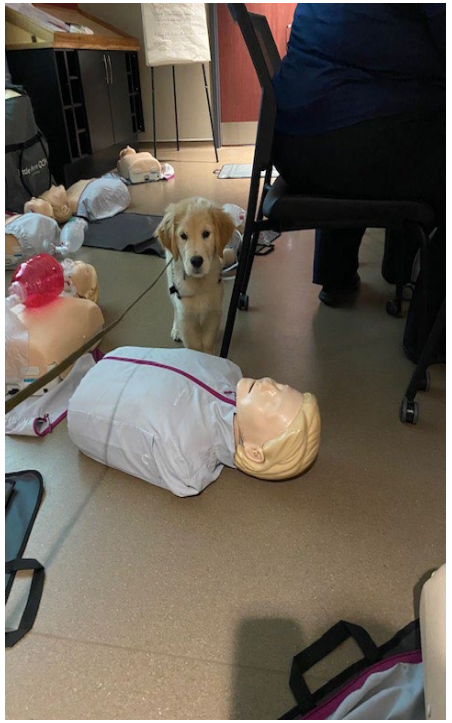


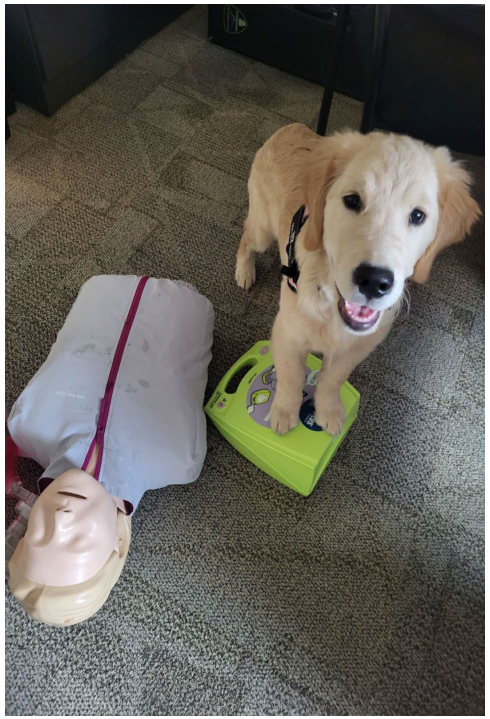
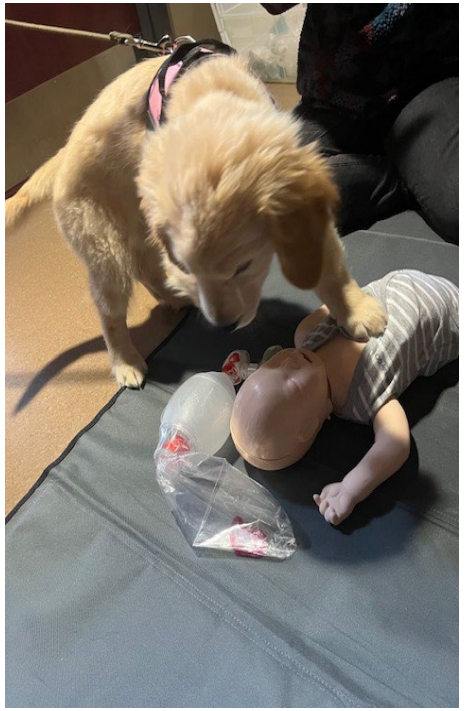
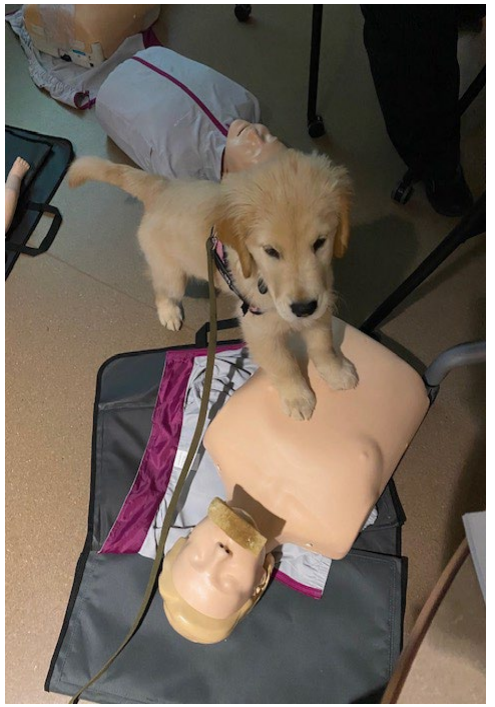
Paramedic Week Celebrations

- Celebrate the Profession with family friends and the community

Blood Drive - Donation



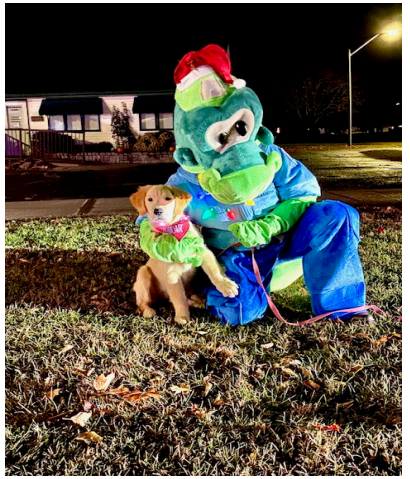


CPR - Training

- Early Recognition – CPR and Defib

County Staff



IVY and the Warden

Spreading happiness, one smile at a time….

Happy Birthday

July 15, 2024

1st

Questions

If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327

Report 2024-087

Report Title: **2024 Ministry of Long-Term Care Inspection Reports Update**

Committee Name: Community Health

Committee Meeting Date: July 30, 2024

Prepared by: Alanna Clark
Administrator
Golden Plough Lodge

Reviewed by: Glenn Dees
Director, Health and Human Services
Golden Plough Lodge

Approved by: Jennifer Moore, CAO

Council Meeting Date: August 14, 2024

Strategic Plan Priorities: ☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☒ Foster a Thriving Community
☒ Propel Sustainable Growth
☐Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2024-087 '2024 Ministry of Long-Term Care Inspection Reports Update' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

This report for information will provide an overview of the three Golden Plough Lodge's (GPL) Ministry of Long-Term Care Inspection Reports, received to date for 2024.

Background

The GPL is a municipally owned and operated long term care home. The Province mandates every upper tier municipality to have at least one long-term care home in operation. First

established in the 1850's as a County House of Refuge, the GPL has a long-established history of caring for others.

Today, the GPL serves others whose needs cannot be met in the community and require both personal care and nursing expertise. The GPL is first and foremost home to 151 residents, cared for and supported by 230 dedicated staff members providing Nursing Care, Dietary Services, Life Enrichment Programming, Environmental Services and Administration Support.

As an operating division of the Corporation of the County of Northumberland, the following core values are embedded in all facets of the GPL operations:

- Accountability
- Care & Support
- Collaboration/Communication
- Honesty & Integrity
- Innovation & Excellence
- Mutual Trust and Respect

The GPL operates on an annual budget of $23,945,474 (2024). Of that $13,312,827 is funded from Provincial subsidies, $6,982,034 County levy, $3,529,313 resident accommodation revenue and $121,300 other revenues. The bulk of the Provincial subsidies is in the form of a per diem based on occupied beds under various funding envelopes. The largest funding envelope is for nursing and personal care, and this is adjusted by a Case Mix Index factor dependent on the reported acuity levels of the resident population.
The Ministry of Long-Term Care (MLTC) Inspections Branch has visited the GPL three times to date in 2024.

The MLTC conducted a proactive compliance inspection from February 12-16, 2024. The GPL received the follow up Inspection report on February 26, 2024. This is an annual inspection which reviewed the following protocols:

-Resident care and support services
-Skin and Wound Prevention and Management
-Residents' and Family Councils
-Medication Management
-Food. Nutrition and Hydration
-Safe and Secure Home
-Infection Prevention and Control
-Quality Improvement
-Pain Management
-Falls Prevention and Management

The Ministry conducted an inspection of critical incidents and Infection Prevention and Control from May 22-29, 2024, and June 3-7, 2024. The follow up Inspection Report was received on June 26, 2024. Five critical incidents were reviewed which related to the following protocols that were inspected:

- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect

- Staffing, Training and Care Standards

The Ministry also conducted an inspection from June 3-7, 2024, related to one critical incident. The follow up inspection report was received on July 5, 2024.The protocols inspected related to this critical incident were:

- Housekeeping, Laundry and Maintenance Services
- Medication Management
- Infection Prevention and Control
- Safe and Secure Home
- Falls Prevention and Management
- Restraints/Personal Assistance Services Devices (PASD) Management

From June 3-7, 2024, there were two inspectors onsite conducting two separate inspections. An Inspection Manager was also onsite from June 3-7, 2024. Her role as communicated was to observe.

During all three exit interviews, the inspectors were complimentary of the home, stating that GPL staff were friendly and welcoming. They also stated information requested was provided in a timely manner which was appreciated.

For clarification, long-term care homes must report critical incidents to the Ministry as defined in legislation. Long-term care homes identify each critical incident using incident categories. If an incident appears to fall into more than one category, the most appropriate incident category is selected. A critical incident is completed for a variety of reasons including but not limited to a missing or unaccounted for controlled substance, contamination of drinking water supply, suspected neglect or abuse of a resident.

A Written Notification may be issued when a non-compliance is identified as low impact or risk to a resident. A Compliance Order will be issued when a non-compliance is identified as significant impact or risk to a single resident's health, safety or quality of life, or moderate impact or risk to multiple residents. If an inspector finds non-compliance with the Fixing Long-term Care Act (FLTCA) during an inspection, they are required by the Act to take the following factors into account:

- Severity
- Scope
- Compliance History.

<u>Severity:</u>

An inspector determines severity based on:

1. The impact to the resident(s) as a result of the finding of non-compliance.

2. The risk to the resident(s) at the time of the non-compliance.

3. The risk to the resident(s) at the time of the inspection (when relevant).

Scope:

An inspector determines scope based on how many residents were affected by the non-compliance. For example, is the finding of non-compliance an isolated incident or a broader issue in the home.

Compliance History:

A licensee is considered to have a history of non-compliance related to a finding if they have a previous finding of non-compliance on the same specific legislative reference (or equivalent in the Long-Term Care Homes Act, 2007) in the past 36 months.

To further explain compliance history, the GPL would have to have no findings for 36 months in an inspection protocol like, Infection Prevention and Control Program (IPAC), to be clear of repeat orders and AMP's. A staff member could be found to be out of compliance by for example, missing one handwashing opportunity, forgetting a step in donning/doffing procedure, misreading a precautions sign and so on. These are important measures that GPL take seriously and when performed, minimize the spread of infectious diseases and provide a safe home for residents. Striving for continuous quality improvement is key and training, repetition and on the spot audits reinforcing best practice behaviour and correcting mistakes are ways to improve IPAC practices within a long-term care home.

Consultations

The GPL senior management team routinely reviews all Inspection Reports upon receipt to initiate corrective actions if required. The GPL continues to work collaboratively and proactively with the HKPR District Public Health Unit to ensure IPAC protocols and mandates are followed

Consultations were completed with:

- leaders in other homes across the Eastern region of Ontario

- Northumberland County CAO and Director of Health and Human Services

- Ministry of Long-Term Care Inspection Manager

Legislative Authority / Risk Considerations

Ministry of Long-Term Care (MLTC)

Fixing Long-Term Care Act, 2021

Ontario Regulation 246/22

Discussion / Options

Ministry Findings

There were no Ministry Findings of non-compliance from the annual proactive compliance inspection. The GPL received 15 written notifications and 9 compliance orders from the May and June inspections. Of the 9 orders, two resulted in administrative monetary penalties (AMP's) totaling $36,000.

Recognizing multiple findings from two of the inspections, this is indicative of what is being realized overall for all homes as inspections become more stringent in a heavily legislated sector with minimal latitude.

An action plan has been prepared and to date the following actions have been implemented to return to compliance with the Ministry of Long-Term Care regulations under the FLTCA, 2021. The focus is on coming into compliance with the 9 Ministry orders and then secondly, the written notifications.

Further to actioning items noted in these inspections, staff will review opportunities for sourcing external expertise to conduct preparatory reviews for future inspections. This will assist in highlighting areas for improvement. Recognizing extent of requirements under the FLTCA and level of scrutiny seen in latest inspections this will help but would not alleviate likelihood of future findings.

Orders

A/C and Air temperature

1) **Non-compliance with: O. Reg. 246/22, s. 23.1 (1)** Air conditioning requirements s. 23.1 (1) Every licensee of a long-term care home shall ensure that air conditioning is installed, operational and in good working order for the purpose of cooling the temperature in the following areas of the long-term care home during at least the period from May 15 to September 15 in each year: 1. Every resident bedroom. 2. Every designated cooling area, in the case of a home without central air conditioning. O. Reg. 66/23, s. 4.

*The Licensee has failed to comply with FLTCA, 2021 **Notice of Administrative Monetary Penalty AMP #001 Related to Compliance Order CO #001**

2) **Non-compliance with: O. Reg. 246/22, s. 23.2 (4)** Uninstalling portable or window air conditioning s. 23.2 (4) A licensee who uninstalls or does not install a portable air conditioning unit or a window air conditioning unit in accordance with a resident's request shall promptly include in the plan of care for each resident in the room, (a) any specific risk factors that may lead to heat related illness as a result of the lack of an air conditioning unit; and (b) the specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness.

3) **Non-compliance with: O. Reg. 246/22, s. 23.2 (8)** Uninstalling portable or window air conditioning s. 23.2 (8) In all cases where portable air conditioning units or window air conditioning units are uninstalled or not installed pursuant to this section, the units must remain accessible and available for use, (a) at the request of any one or more of the residents who reside in the bedroom; or (b) when required to cool and maintain the temperature of the bedroom for the health, safety and comfort of the residents in that bedroom.

4) **Non-compliance with: O. Reg. 246/22, s. 24 (4)** Air temperature s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on, (a) every day during the period of May 15 to September

15; and (b) every other day during which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day.

Actions: A/C, Air temperature- Order to comply by July 12, 15, 2024 and August 9, 2024

Air conditioner units have been installed in every resident room. Audits of all residents to see if they decline air conditioning install with documentation in care plan completed. Nursing plan of care includes risk factors that may lead to heat related illness and specific interventions as a result of not having air conditioning completed. There is an air conditioning unit readily available for install for every resident who opts out of air conditioning based on audit. Moving forward for every resident room without A/C a temperature will be taken and documented once daily between 12-5pm. This process has been communicated to all responsible for taking these temps. Currently undergoing audit of recorded temperatures daily for 2 weeks and then weekly for 4 weeks.

Resident rooms were not all fully equipped with A/C units at the time of inspection, however regular temperature checks to ensure rooms were within the acceptable range of 22 degrees Celsius to 26 degrees Celsius were completed. All residents also continue to have access to cooling rooms such as the auditorium as needed based on weather conditions. Hallways are equipped with air chillers providing a cool space as well. The delay in installing A/C units in every resident room is related to the delays in construction of the new GPL building. It was previously understood that the GPL would move into the new build well before the Ministry ordered all homes to become fully air conditioned. Resident care and comfort were and continue to be a priority within the GPL for all residents.

Training

1) **Non-compliance with: FLTCA, 2021, s. 82 (2)** Training s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 28 to make mandatory reports. 5. The protections afforded by section 30. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

Actions: Training- Order to comply by July 30, 2024

Currently providing training in all areas required under FLTCA, 2021, s. 82 (2) to all Security staff/ any other Agencies working in home. There will be a written record of all training along with a record of demonstrated knowledge of the training for the Ministry to review. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the Agency staff who received this training.

Currently developing a process to ensure that all Agency staff and all newly hired staff, receive the required training under FLTCA, 2021, s. 82 (2) as well as any other required training specific to their role, prior to working in the home.

Currently conducting an audit of all Agency staff who work at the GPL, as well as all staff hired in the home from January 1, 2023, to present, to ensure that all required training has been completed and there is a documented record of this training.

Infection Prevention and Control Program

1) **Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)** Infection prevention and control program s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2.)

Ministry Inspector observations and interviews with 9 direct care staff.

*The Licensee has failed to comply with FLTCA, 2021 **Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #006**

Compliance History:
Prior non-compliance with O. Reg 246/22, s.102 (2) (b), resulting in:
-WN issued on July 07, 2022, in #2022-1553-0001
-CO issued on July 07, 2022, in #2022-1553-0001

This is the second AMP that has been issued to the licensee for failing to comply with this requirement. The infection prevention and control program would have to be without findings for 36 consecutive months in order to be clear from repeat AMP's.

2) **Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.** Infection prevention and control programs. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: 11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

Ministry inspector observed one direct care staff.

Actions: Infection Prevention and Control Program- Order to comply by July 30, 2024 and August 5, 2024

Currently developing and implementing a process to ensure that donning and doffing is completed by staff as per IPAC Best Practice standards for every resident who requires additional precautions. Also, PPE disposal bins have been made available in the appropriate locations, inside the resident's bedroom, as per the Best Practice vs. outside of rooms. Currently providing training on the four moments of hand hygiene to staff mentioned in the order. Conducting three random audits over a period of three weeks for each staff member.

A process has been developed and implemented to ensure that 70-90% Alcohol Based Hand Rub (ABHR) is readily available at all times, in common areas and at the point of care, including medication carts, treatment carts, snack carts and multi-use equipment such as blood pressure

machines. Currently conducting audits twice a week for 4 weeks of every home area to ensure the hand sanitizer is readily available.

Recreational Cannabis

1) **Non-compliance with: O. Reg. 246/22, s. 142 (1)** Recreational cannabis
s. 142 (1) Every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

Actions: Recreational Cannabis- Order to comply by July 29, 2024

Currently creating and implementing a Recreational Cannabis Policy and process for residents which adheres to the legislated requirements. Once created, all direct care staff will be trained on the Recreational Cannabis policy and procedure.

Hiring Staff, Accepting Volunteers

1) **Non-compliance with: O. Reg. 246/22, s. 252 (3)** Hiring staff, accepting volunteers
s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

Actions: Hiring staff, accepting volunteers- Order to comply by July 30, 2024

Currently working to create a process to ensure that all staff hired to work at the GPL, including Agency staff, provide a police record check with a vulnerable sector screening, prior to working in the home. Currently undertaking a review of the HR files for all staff hired since January 2023 to present, including Agency staff, to ensure that a valid police record check was completed and is retained on file. If valid police checks are identified as missing, that staff or Agency staff member will immediately apply for a police record check with a vulnerable sector screening and may not work until the valid document is provided. Primarily, this was related to individuals working in the home through contracted services.

Notifications

Duty to Protect

1) **Non-compliance with: FLTCA, 2021, s. 24 (1)** Duty to protect s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Actions: Duty to Protect- Written notification

Planning education on resident care and skin integrity for staff involved in Ministry observations.

Responsive Behaviours

1) **Non-compliance with: O. Reg. 246/22, s. 58 (3) (c)** Responsive behaviours s. 58 (3) The licensee shall ensure that, (c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
2) **Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)** Responsive behaviours s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Actions: Responsive Behaviours- Written notification

In the process of updating the responsive behaviours evaluation and ensuring a process is in place to update program evaluations as per Ministry requirements.

Infection Prevention and Control Program

1) **Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.** Infection prevention and control program s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: 3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

Actions: IPAC- Written notification

The Ministry inspector observed one volunteer student bring a resident to the dining room without washing their hands. All staff, including volunteers to be included in IPAC and staff orientation training.

Visitor Policy

1) **Non-compliance with: O. Reg. 246/22, s. 267 (1) (c)** Visitor policy s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum, (c) complies with all applicable laws including any applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act.

Actions: Visitor Policy-Written notification

Continuing to monitor updated visitor logs and explore digital options for visitor/volunteer sign in/out.

Home to be Safe and Secure Environment

1) **Non-compliance with: FLTCA, 2021, s. 5** Home to be safe, secure environment s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents

Actions: Home to be safe and secure environment- Written Notification

Ensured tub room doors are closed and locked at all times.

Plan of Care

1) **Non-compliance with: FLTCA, 2021, s. 6 (1)** (c) Plan of care s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.
2) **Non-compliance with: FLTCA, 2021, s. 6 (9) 1**. Plan of care s. 6 (9) The licensee shall ensure that the following are documented: 1. The provision of the care set out in the plan of care.
3) **Non-compliance with: FLTCA, 2021, s. 6 (9) 2.** Plan of care s. 6 (9) The licensee shall ensure that the following are documented: 2. The outcomes of the care set out in the plan of care.
4) **Non-compliance with: FLTCA, 2021, s. 6 (10)** (b) Plan of care s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

Actions: Plan of Care- Written Notification

Develop plans to ensure plan of care sets out clear directions to staff related to resident's falls prevention interventions and the use of a tilt wheelchair, and seatbelt restraint. Also exploring interventions to ensure timely and accurate documentation in care plans through the use of technology i.e. setting mandatory fields and update time in the care management system. Care plans are unique and should reflect the care needs of each resident. This message will be reinforced with all care staff through education.

Requirements relating to restraining by a physical device

1) **Non-compliance with: O. Reg. 246/22, s. 119 (2) 3**. Requirements relating to restraining by a physical device s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act: 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
2) **Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.** Requirements relating to restraining by a physical device s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act: 4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.
3) **Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.** Requirements relating to restraining by a physical device s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 4. Consent.

Actions: Requirements relating to restraining by a physical device- Written notification

Opportunity to review, update as needed and disseminate Restraints Policy to ensure accurate practice and documentation of practice as it relates to restraints use.

Minimizing Restraints

1) **Non-compliance with: O. Reg. 246/22, s. 122** (a) Evaluation s. 122. Every licensee of a long-term care home shall ensure, (a) that an analysis of the restraining of residents by use of a physical device under section 35 of the Act or pursuant to the common law duty referred to in section 39 of the Act is undertaken on a monthly basis.

Actions: Minimizing restraints- Written notification

Opportunity to review, update as needed and disseminate Restraints Policy to ensure accurate practice and documentation of practice as it relates to restraints use.

Administration of Drugs

1) **Non-compliance with: O. Reg. 246/22, s. 140** (2) Administration of drugs s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2)

Actions: Administration of Drugs-Written notification

Opportunity to review care staff's understanding of how to safely and accurately administer drugs to all residents on the floor. Going forward medication administration will be complete and documented for each resident before moving on to the next resident medication pass.

Upon consultation with other municipally owned long-term care homes in the Easter Region, many are experiencing lengthy, in-depth investigations similar to the experience in May/June at the GPL. Over the course of the inspection period, inspectors conducted several interviews (with many repeat interviews), observed and requested multiple records for their review. At one home, an inspector called back to conduct interviews on an inspection that was already closed. While not formally announcing a shift in inspection methodology, it appears inspectors are taking deep dives into their inspections, staying for longer periods and providing multiple findings of non-compliance. There are multiple areas for improvement as noted in the aforementioned Ministry reports, and GPL staff, lead by senior leadership, will focus on the areas listed to ensure we are prepared for follow up inspections. Senior leadership, namely the Administrator of the GPL will continue to develop and grow professional relationships with the Ministry of Long-Term Care staff. All staff will continue to offer a welcoming, positive and safe environment for everyone.

Financial Impact

Notice of Administrative Monetary Penalty AMP #001 Related to Compliance Order CO #001 Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $25,000.00, to be paid within 30 days from the date of the invoice.

Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #006 Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11,000.00, to be paid within 30 days from the date of the invoice.

Member Municipality Impacts

N/A

Conclusion / Outcomes

GPL senior management request that the Community Health Committee and County Council receive this report for information.

Attachments

1) Report 2024-08 ATTACH 1 ‘Inspection Report under the Fixing Long-Term Care Act, 2021 (June 26, 2024)

2) Report 2024-08 ATTACH 2 ‘Inspection Report under the Fixing Long-Term Care Act, 2021 (July 5, 2024)

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 26, 2024	
Inspection Number: 2024-1553-0003	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Northumberland	
Long Term Care Home and City: Golden Plough Lodge, Cobourg	
Lead Inspector Tiffany Forde (741746)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22-29, 31, 2024 and June 3-7, 2024

The following intake(s) were inspected:
- Critical Incident related Outbreak declared on 09DEC23.
- Critical Incident related Outbreak declared on 30DEC23.
- Critical Incident related Outbreak declared on 30DEC24.
- Critical Incident related Staff to resident neglect.
- Critical Incident related verbal abuse staff to resident.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that resident #002 was protected from neglect by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect 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."

Rationale and Summary:

A Critical Incident System (CIS) report was submitted to the Director alleging the care needs and requests of resident #002 were not addressed . The family of resident submitted a complaint to the LTCH home to report their concerns. The family of resident requested for staff to assist the resident with care needs, and it was not completed until the following shift started. The family reported that staff

were seated at the nursing station when the requested was made. Staff stated the resident usually is put to bed after lunch and if family requested care, it would have been done.

The Assistant Director of Care (ADOC) acknowledged staff should have assisted the resident when the family requested, instead of having the resident wait for 40 minutes. They also acknowledged staff were responsible for residents care until the end of their shifts.

In failing to protect the resident from neglect, the resident's emotional wellbeing was impacted, the resident was left uncomfortable and was at increased risk of skin breakdown.

Sources: Interviews with PSW#116, ADOC#118, Critical incident Report . [741746]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (c)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Licensee failed to keep an accurate record of the home's evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes

were implemented

Summary Review

During the inspection for a critical incident involving staff to resident verbal abuse the LTC home was asked to provide two years of annual program evaluation of the Responsive behavior program. At the time of request, inspector was provided with annual evaluation printed version dated "2018", crossed out with black marker and replaced with "2022". Inspector received the 2023 evaluation the next day from ADOC.

During an interview with the ADOC, it was confirmed that the documents received were official records from the home.

The Inspector conducted a record review of the two documents, both evaluations did not include any dates of when revisions were made. The 2023 and 2024 Responsive Behavior evaluation were dated on the exact same day of March 31. Note March 31, 2024 was a Sunday. The documented outcomes from both 2023 and 2024 reports were the same, related to percentage of residents with worsen behavior. The Inspector requested minutes for the meeting, the ADOC confirmed during an interview that no minutes were kept for the meeting.

The ADOC indicated the goal was to complete the report by March 31 annually, which note the date of completion. They acknowledged the home does not complete the evaluation with others present but uses notes and past communication to complete the annual evaluation reports.

The DOC confirmed that, program evaluation was to be completed by March 31 each year, and the home used a template for evaluation and identified if goals are met. The DOC acknowledged the whole team should meet to conduct the review of

the program.

There was no impact and low risk to residents, when the home failed to ensure, that at least annually, the Responsive Behaviours program was evaluated and updated.

Sources: Program evaluation 2023, 2024, Interviews with DOC, ADOC #118. [741746]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure actions are taken to respond to the needs of resident #001, including assessments, reassessments and interventions and that the resident's response to interventions are documented.

Rationale and Summary
The director received a CIR involving staff to resident verbal abuse. A review of resident written plan of care identified that the resident had a history of responsive behaviors.

The Resident demonstrated a responsive behavior when they went outside the home with one to one (1:1) K9ine agency staff to go and smoke. It was reported that

at that time resident consumed multiple capsules unwitnessed by staff. When the resident returned to the home, they suffered medical distress and was sent to local hospital.

A review of resident's progress indicated many responsive behavior notes with little to no interventions to improve or assess the resident's behavior. Registered Nurse (RN) documented in the progress notes "Resident is rude, rude, rude. Interventions doesn't help to bring changes in the behavior."

The LTC home did not follow their Responsive Behaviour policy.

According to the home's Responsive Behaviours Policy , when there is a significant change in residents medical and psychological status and quarterly, an assessment is to be completed. Interviews with Behaviour Support Ontario (BSO) and ADOC acknowledge a DOS should have been started when resident was exhibiting responsive behaviours.

Failing to ensure that the home's policy was complied with posed a risk of potential behavioural triggers going unidentified and staff not being kept aware of the behavioural triggers.

Sources: Resident progress notes and assessments, Responsive behavior Policy, Interviews with ADOC & BSO.

[741746]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.

Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The licensee has failed provide volunteer student with the necessary training as it relates to infection prevention and control for all staff, caregivers, volunteers, visitors and residents.

Rationale Summary

Three separate Critical Incident Report (CIR) were submitted to the Director for an Acute respiratory infection (ARI)- COVID-19 outbreak each declared in December 2023, over eight units in the home.

During a meal observation on a home unit, a student was observed wheeling residents into the dining room for lunch without completing hand hygiene. When the student was asked about training, they stated they had not competed training for IPAC. Inspector requested the student training records and was notified by the Manager of Resident and Family Services it was their oversight and training were not completed.

The IPAC lead confirmed student should have completed the required training prior to starting to work in home.

Failure to ensure students receive IPAC education prior to working in the home puts residents at risk for infection.

Sources: Observations, Interviews with IPAC lead & Manager of Resident and Family Services, volunteer student.

[741746]

WRITTEN NOTIFICATION: Visitor policy

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (1) (c)
Visitor policy
s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum,
(c) complies with all applicable laws including any applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act; and

The licensee has failed to ensure that the home's visitor policy included visitor contact information as part of the requirements for visitors.

Summary Review

Three separate Critical Incident Report (CIR) were submitted to the Director for an Acute respiratory infection (ARI)- COVID-19 outbreak each declared in December 2023, over eight units in the home.

Upon entering the Long-Term Care (LTC) home for inspection the inspector was required to sign into the home's visitor log placed in a binder. The log, however, did not ask for visitor's contact information. A review of the home's Visitor Policy did not indicated that visitors must sign in with their contact information when visiting the LTC home.

The LTC home is utilizing a paper sign-in via the Visitor Log. The IPAC Lead confirmed that the current Visitor Log did not require the visitors to provide their contact information .

There was a potential risk and impact to the residents as the home might not be able to contact the visitors should they need to be contacted in future.

Sources: Observations, home's Visitor Policy, and an interview with the IPAC Lead.

[741746]

COMPLIANCE ORDER CO #001 Air conditioning requirements

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (1)
Air conditioning requirements
s. 23.1 (1) Every licensee of a long-term care home shall ensure that air conditioning is installed, operational and in good working order for the purpose of cooling the temperature in the following areas of the long-term care home during at least the period from May 15 to September 15 in each year:
1. Every resident bedroom.
2. Every designated cooling area, in the case of a home without central air conditioning. O. Reg. 66/23, s. 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
All resident bedrooms and all designated cooling areas that are not equipped with central air conditioning, will have portable air conditioning units installed, operational and in good working order for the purposes of cooling the temperature.

Grounds
The licensee failed to ensure that air conditioning is installed, operational and in good working order for the purpose of cooling the temperature in every resident bedroom and every designated cooling area, in the case of a home without central air conditioning, during at least the period from May 15 to September 15 in each year.

Rationale and Summary:
An on-site inspection was conducted from May 22 to June 07, 2024. During a tour of the home, it was noted by the inspector that the long-term care home had areas of the home that felt warm and did not appear to have central air conditioning in all resident rooms.

Two home areas were observed to not be supported by central air conditioning and they appeared to be using air chillers in the hallway. Some resident rooms were supported with portable air conditioning units while, 38 resident rooms were noted to be without portable air conditioning units installed in their rooms.

Another tour of the home was completed with the ESM, the inspector was shown two types of air vents which was believed to be part of air conditioning system. Later determined to be cold air return vents.

On June 4, 2024, the temperature listed by Environment and Climate Change Canada was 27.1 degrees Celsius and the Humidex was 33 degrees Celsius in

Cobourg, Ontario.

Failure to provide air conditioning that is installed, operational and in good working order for the purpose of cooling temperatures in every resident bedroom and every designated cooling area, for a home that did not have central air conditioning, placed the residents at risk for a heat related illness.

Sources: Observation of residents' rooms, Environmental Services Manager, Missing Portable units list.
[741746]

This order must be complied with by July 12, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $25000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Training

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1.The management team, led by the Administrator, will provide training in all areas required under FLTCA, 2021, s. 82 (2) to all K9ine Security staff/ any other Agencies working in home.

2.A written record of all training along with a record of demonstrated knowledge of the training is to be kept. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the Agency staff who received this training. These records are to be made available to the inspector immediately upon request.

3.The Administrator will develop a process to ensure that all Agency staff and all newly hired staff, receive the required training under FLTCA, 2021, s. 82 (2) as well as any other required training specific to their role, prior to working in the home. In the case of emergencies or exceptional and unforeseen circumstances, in which case the training must be provided within one week of when the person begins performing their responsibilities.

4.The Administrator or a management designate will conduct an audit of all Agency staff who work in the home, as well as all staff hired in the home from January 1, 2023, to present, to ensure that all required training has been completed and the

home has a documented record of this training. Any deficiencies identified will be recorded and those staff are to be immediately trained in accordance with the legislated requirements. A documented record is to be kept of this audit including the corrective action and made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an

employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The home retained a third party contractor dated on contract "Effective" October 02, 2023, K9ine, for security guard services that provided 1:1 supervision of residents. During a critical incident inspection which involved K9ine staff it was discovered that, staff currently working in home have not completed the required IPAC training and LTC homes policy training.

A further review of the third-party contractor staffing list that provided 1:1 resident supervision identified 77 staff had worked without receiving the required orientation training. A review of the contract between the County of Northumberland and K9ine Security did not discuss and training responsibilities nor security clearances.

The Administrator stated during an interview the agency staff did not have any surge learning logins or passwords to complete required training as per ministry standard.

Failure to ensure all staff competed required orientation, placed residents at risk of harm.

Sources: Record Reviews, K9ine Contract, Observations, interviews .
[741746]

This order must be complied with by July 30, 2024

COMPLIANCE ORDER CO #003 Uninstalling portable or window

air conditioning

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.2 (4)
Uninstalling portable or window air conditioning
s. 23.2 (4) A licensee who uninstalls or does not install a portable air conditioning unit or a window air conditioning unit in accordance with a resident's request shall promptly include in the plan of care for each resident in the room,
(a) any specific risk factors that may lead to heat related illness as a result of the lack of an air conditioning unit; and
(b) the specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The Administrator, ESM or a management designate will conduct an audit of all residents or their SDM to determine if the resident or the SDM decline the installation of a portable air conditioner, where central air conditioning is not available. This refusal will be documented in the residents written care plan and is to be revisited with the resident or SDM at each quarterly evaluation.
2.The Director of Care, or a nursing management designate will ensure that for every resident who does not have air conditioning installed in their bedroom, that a plan of care identifies any risk factors that may lead to any heat related illness and specific interventions to be taken, as a result of the lack of air conditioning.

Grounds
The licensee failed to ensure when portable air conditioning units are not installed, to update residents' care plan with risk factors and interventions.

Rationale and Summary

An on-site inspection was conducted between May 22 to June 07, 2024. During a tour of the home, it was noted by the inspector that the long-term care home felt warm in some areas and did not appear to have central air conditioning in all resident rooms. The long-term care home was noted to be serviced by chillers located in resident area hallways and some rooms supported with portable units. During the record review process, it was identified that 38 residents living on two units did not have portable air conditioning units in their rooms.

During an observation of temperature recording, it was noted on a home unit a family member of a resident complained of feeling hot. They asked about purchasing their own air conditioning unit for their resident and asked the inspector if the Ministry will be purchasing air conditioners. Residents complained to the Inspector of feeling hot in their room.

During an interview with the ESM they indicated residents located on both units who opted out of portable air conditioning units in their rooms although no records were provided to the inspector during inspection to support this.

Record review was conducted with residents' plans of care, there were no specific risk factors that may lead to heat related illness listed and interventions identified in the written plan of care. The home's policy 'Heat Risk Assessment 'indicated a "heat risk assessment is an assessment used to determine their potential for heat stress. One resident score was high and other residents score was moderate. A review of these residents' care plan did not indicate any evidence-based interventions to be implemented in high heat or humidity. There was no documentation to indicate that the residents had chosen to not have an air conditioner in their room.

After reviewing the records, there was no written record located identifying the date the air conditioner was removed from rooms or that the resident declined the installation of the portable air conditioner.

By failing to update heat related illness prevention in care plans put residents at increased risk.

Sources: Observations, record Review and interviews with ESM and residents. [741746]

This order must be complied with by July 15, 2024

COMPLIANCE ORDER CO #004 Uninstalling portable or window air conditioning

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.2 (8)
Uninstalling portable or window air conditioning
s. 23.2 (8) In all cases where portable air conditioning units or window air conditioning units are uninstalled or not installed pursuant to this section, the units must remain accessible and available for use,
(a) at the request of any one or more of the residents who reside in the bedroom; or
(b) when required to cool and maintain the temperature of the bedroom for the health, safety and comfort of the residents in that bedroom.

The inspector is ordering the licensee to comply with a Compliance Order []:
1. The ESM is to ensure that portable Air conditioning units or window air conditioning units are installed into all resident rooms without a central air

conditioner.
2.The ESM is to ensure that for every resident bedroom that does not have a portable air conditioning unit or a window air conditioning unit installed, at the request of the resident, that there is a unit available to be immediately installed if the resident should change their mind, or if it is required to cool and maintain the temperature of the bedroom for health, safety and comfort.

Grounds
The licensee failed to ensure portable air conditioning units that are not installed remained accessible and available for use.

Rationale and Summary
An on-site inspection was conducted from May 22 to June 7, 2024. During a tour of the home, it was observed by the inspector that the long-term care home did not appear to have central air conditioning in all resident bedrooms. The long-term care home was noted to be serviced by air chillers located in resident area hallways and some bedrooms were supported with portable units but not all. After conducting interviews , tours of the home along with record reviews it was determined with a list provided by ESM , which identified that 38 residents living on two home units did not have portable air conditioning units in their rooms.

During an observation of the LTC homes storage area and interviews with Maintenance Staff and ESM confirmed the home only has one or three portable air conditioners in working condition as extra. There were not enough for every resident room that did not have a portable air conditioner or window air conditioner unit installed.

The Administrator indicated during an interview that they should have enough portable air conditioner for all of the resident bedrooms not supported by central air

conditioning.

Sources: Observations, Interview with Administrator, Maintenance staff , ESM and Administrator.
[741746]

This order must be complied with by July 15, 2024

COMPLIANCE ORDER CO #005 Air temperature

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (4)
Air temperature
s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,
(a) every day during the period of May 15 to September 15; and
(b) every other day during which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The ESM will develop and implement a process to ensure that a temperature is taken daily between 12 pm and 5 pm in each resident bedroom where air conditioning is not installed. This must be completed in accordance with O, Reg. 246.22, s. 24 (4) (a) and (b) requirements.

2.This process will be communicated to all staff identified as being responsible to complete the temperatures. A record of how this is communicated is to be retained and provided to the inspector immediately upon request.
3.The ESM or a designate will conduct a daily audit for 2 weeks and then weekly audit for 4 weeks to ensure that all required temperatures are taken, recorded and corrective action is documented when the temperature is outside of the acceptable range. A documented record of the audits will be maintained and provided to the inspector immediately upon request.

Grounds
The Licensee failed to ensure that for any resident room, which was not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. and evening or night.

Rationale and Summary
An on-site inspection was conducted from May 22 to June7, 2024. During a tour of the home, it was noted by the inspector that the long-term care home did not appear to have central air conditioning in all resident bedrooms. The long-term care home was noted to be serviced by air chillers located in resident area hallways and some resident bedrooms were supported with portable air conditioning units.

A document was provided which identified that 38 residents living on two home units did not have portable air conditioning units in their bedrooms.

The home's policy, Facility Temperatures, noted "In addition to the requirements above, every resident bedroom that is not served by air conditioning, must have a temperature measured and documented in writing each day in morning before noon, afternoon between 12 p.m. and 5 p.m. and evening." The air temperature logs for the month of May/ June 2024 were reviewed. It was noted LTCH missed several

readings for air temperatures in May 2024.

The ESM acknowledged that the temperatures for some home units were missing on identified dates, and they would expect staff to complete and document temperatures accurately.

There was an increase in risk to residents related to heat related illnesses when room temperatures were not monitored.

Sources: Interviews with Administrator, ESM, Air temperature logs, Facility Temperatures policy effective June 2021.
[741746]
This order must be complied with by August 9, 2024

COMPLIANCE ORDER CO #006 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The IPAC Lead will develop and implement a process to ensure that PPE supplies are available, and that donning and doffing is completed by staff as per IPAC Best

Practice standards for every resident who requires additional precautions.
2.The IPAC Lead will ensure that PPE disposal bins are made available in the appropriate locations, inside the resident's bedroom, as per the Best Practice.
3. The IPAC Lead will retrain registered staff on the four moments of hand hygiene. IPAC lead will conduct three random audits over a period of three weeks for each staff member. Keep a written copy of audits with dates, staff names, times and corrective action taken if deficiencies identified. This record will be made available to the inspector immediately upon request

Grounds
1.) The licensee has failed to ensure that PSW's don and doff personal protective equipment (PPE) in the appropriate sequence when providing direct care to residents who were identified as requiring additional precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director for three separate Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home

During the Initial tour of the home observations on two home areas, it was observed that all of the "red PPE disposal" bins for doffing were located in the hallways instead of inside the resident bedrooms. A resident was observed sitting in their

wheelchair which was positioned sideways in front of "red PPE disposal" bin in the hallway.

PSW indicated they doff in the hallway and resident should not have been placed in that location. The IPAC lead confirmed "red PPE disposal " bins should be located in the resident's room and staff should not be doffing PPE in the hallways. They also confirmed that the resident should not have been placed in front of PPE disposal bin.

During an observation, Inspector observed PSW exiting a contact precaution bedroom then doffing at the doorway in the incorrect sequence, removing the gown first then gloves and touch their mask at the front instead of by ear loops. An interview with Infection Prevention and Control Lead (IPAC) confirmed the home's expectation for the correct sequence of donning and doffing of (PPE) were not followed by PSW #113.

Failure of staff to Donn and doff PPE in the appropriate sequence and by not placing PPE disposal bins in appropriate location put residents at increased risk for transmission of infection.

Sources: Observation & Interview with IPAC lead #125, PSW# 103.
[741746]

2.) The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with. Specifically, the licensee did not provide support for residents to perform hand hygiene prior to receiving meals and snacks according to additional requirement under the IPAC standard section 10.4(h).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for three separate Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home.

During the course of the inspection, several staff were observed not performing hand hygiene with residents prior to meal or snack service.
•On a home unit a PSW transported resident into the dining room for lunch without completing hand hygiene.
•On a home unit a staff transported resident into the dining room for lunch without completing hand hygiene.

IPAC lead acknowledged all staff should be following the four moments of hand hygiene and they have received training.

By failing to ensure all staff follow the four moments of hand hygiene placed the residents at increased risk for transmission of infectious diseases.

Sources: Observations, Interview with IPAC Lead, PSW.
[741746]

3.) The licensee has failed to ensure that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, At minimum Routine Practices shall include section 9.1 (b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident

environment contact).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for three separate Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home.

Inspector conducted observations throughout the inspection, an RPN was observed administrating medications to residents on a home unit and no hand hygiene was completed prior to interacting with the resident.

·On a home unit, an RPN was observed administering medication to a resident. No hand hygiene was conducted prior to entering residents' room. Inspector asked RPN what the four moment of hand hygiene were. The RPN stated " I am bad for that".

·On a home unit an RPN was observed, no hand hygiene was conducted before handling medications, no hand hygiene was conducted after leaving the resident room. The RPN then touched the computer, removed more medication without any hand hygiene preformed. The Inspector asked, " Can you tell me the four moments of hand hygiene?", no response was provided.

·On a home unit, an RPN was observed to complete hand hygiene prior to the start of the medication pass. They were then observed touching the computer mouse and keyboard. No hand hygiene was performed. The RPN then applied gloves to administer nasal spray. removed the gloves and no hand hygiene was performed.

·On a home unit, an RPN was observed taking a blood pressure on a resident and the inspector noted that the RPN did not perform hand hygiene or clean the blood pressure cuff afterwards. It was also observed that the blood

pressure cuff machine did not have any hand sanitizer or cleaning wipes located on it. The RPN reported that the resident was on contact precautions.

The IPAC lead acknowledged all staff have received education regarding IPAC standards, all staff should be following routine practice standards including performing hand hygiene following the four moments best practice guidelines.

Failing to complete hand hygiene as per routine practices increases the risk for the spread of infectious disease.

Sources: Observations, Interviews with IPAC lead

[741746]

4.) The licensee has failed provide PPE supplies for staff and visitors as per IPAC standards for residents on Contact precautions on Blacklock cottage.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2022, section 9.1(a) states at minimum additional precautions shall include evidence-based practices related to potential contact transmission and required precautions.

Summary Review

Three separate Critical Incident Report (CIR) were submitted to the Director for Acute respiratory infection (ARI)- COVID-19 outbreaks declared in December 2023, over eight units in the home.

During an IPAC tour on the secured unit, the inspector observed there was no donning and doffing for PPE supplies located outside of resident's rooms that were identified as requiring additional precautions. The RPN stated that they don and doff at the nursing station, they did not keep PPE supplies at the resident's room because the residents will touch the supplies. During an

interview with the IPAC Lead, they indicated being aware staff were donning and doffing inside the nursing station. The IPAC Lead agreed supplies for donning and doffing should not be kept in the nursing station, they should be placed outside the room that required additional precautions, so the supplies were readily available.

Additional observations were conducted of a shared room, on a home unit, where one resident required contact precautions. The precaution sign posted outside the door, did not clearly indicate which resident required contact precautions. During an interview with the IPAC lead and coordinator it was indicated that the home treated the room as isolation and staff were to don PPE for both residents.

During a snack observation on a home unit a PSW walked out of a resident room carrying soiled bed linen in their hands while pushing the snack cart. Then they lifted the lid of the soiled linen cart, to dispose of the soiled linens, no hand hygiene was performed when leaving resident room, or when they touched the snack cart. The inspector asked the PSW if they were aware of the four moment of hand hygiene they responded, "I didn't touch the resident."

By failing to ensure all staff properly use of PPE, including storage, removal, and disposal put the resident risk for infectious diseases.

Sources: Observations, Interviews with IPAC Lead and Coordinator & RPN.

[741746]

This order must be complied with by July 30, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002

Related to Compliance Order CO #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #007 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

Infection prevention and control program

s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:

11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1.The IPAC Lead and ESM will develop and implement a process to ensure that 70-90% Alcohol Based Hand Rub (ABHR) is readily available at all times, in common areas and at the point of care, including medication carts, treatment carts, snack carts and multi-use equipment such as blood pressure machines. .

2.The IPAC Lead or nursing management designate will conduct audits twice a week for 4 weeks of every home area to ensure the hand sanitizer is readily available. A documented record is to be kept of the audits and will include who completed the audit, date, time, location, all areas audited, any deficiencies identified, and any corrective action taken. These records are to be made immediately available to the inspector upon request.

Grounds

The licensee has failed to ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: 11. ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care.

Rationale and Summary

Observations during a medication pass were conducted in the home. It was noted there was no hand sanitizer located on the medication carts. Inspector observed the RPN not performing hand hygiene.

During an interview with the IPAC lead, they indicated that all hand sanitizer was removed from medication carts because of the expiry dates. They indicated that a new process was implemented where staff are to request hand sanitizer from maintenance staff when they require it.

Failure to have ABHR readily available at point of care decreased the staff compliance with hand hygiene requirements and increased the residents' risk of infection.

Sources: Observations, Interviews with IPAC lead, IPAC Standard for long-term care homes (LTCHs), dated April 2022.

[741746]

This order must be complied with by August 5, 2024

COMPLIANCE ORDER CO #008 Recreational cannabis

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 142 (1)

Recreational cannabis

s. 142 (1) Every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The Administrator and Director of Care will create and implement a Recreational Cannabis Policy and process for residents which adheres to the legislated requirements.

2. All direct care staff will be trained on the Recreational Cannabis policy and procedure. A written record will be kept including how the training was delivered, who delivered it, who attended, dates and times. The training record will be made available to the inspector immediately upon request.

Grounds

The licensee failed to develop a policy, with respect to residents, the administration, possession, storage, and disposal of recreational cannabis is in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an allegation of staff to resident verbal abuse, which led to resident hospitalization related to reduced level of consciousness as a result of a suspected consumption of THC capsules (16).

The Resident's written plan of care identified that the resident had a history of responsive behaviors and known recreational cannabis use.

The Inspector requested a copy of the home's Recreational Cannabis policy, none was provided.

During an interview with the Administrator, they acknowledged the home did not have a policy in place for Recreational Cannabis with respect to residents for the administration, possession, storage, and disposal of recreational cannabis.

When the licensee failed to create and implement a policy for Recreational Cannabis with respect to residents, it placed residents at risk for unintended access and restricted a resident right to safely possess recreational cannabis.

Sources: Resident's plan of care, Interview with Administrator

[741746]

This order must be complied with by July 29, 2024

COMPLIANCE ORDER CO #009 Hiring staff, accepting volunteers

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 252 (3)

Hiring staff, accepting volunteers

s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The Administrator will create a process to ensure that all staff hired to work in the home, including Agency staff, provide a police record check with a

vulnerable sector screening, prior to working in the home. A copy of this police records check will be retained in the home.

2. The Administrator or a management designate will review the HR files for all staff hired since January 2023 to present, including Agency staff, to ensure that a valid police record check was completed and is retained in the home on file. If valid police checks are identified as missing, that staff or Agency staff member must immediately apply for a police record check with a vulnerable sector screening, and may not work in the home until the valid document is provided.

3. The home will retain on site a valid police record check with a vulnerable sector screening, for all staff including agency staff, and all volunteers, and make these records available to the inspector immediately upon request.

Grounds

The licensee failed to ensure that where a police record check is required before a licensee hires a staff member as set out in subsection 81 (2) of the Act that the police record check must be a vulnerable sector check.

Rationale and Summary

As defined in FLTCA, 2021, s. 80 (2), “agency staff” means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3) a staff member who is agency staff, is considered to be hired when they first work at the home.

The home retained a third-party contractor dated on the contract "Effective" October 02, 2023, K9ine, for security guard services that provided 1:1 supervision of residents. A review of the 1:1 K9ine staffing list provided by the

Administrator with no date documented, identified 77 staff who had worked in the home through the K9ine security staffing agency.

Inspector requested a copy of the police record check with a vulnerable sector screening, for the K9ine Security agency staff who were present in the home during the inspection. No documents were provided by the end of inspection.

Failure to ensure all staff provided the required police records check with a vulnerable sector screening, prior to working in the home, places residents at risk of harm.

Sources: Record Review for police checks, K9ine staff list, Interview with Administrator.

[741746]

This order must be complied with by July 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 5, 2024	
Inspection Number: 2024-1553-0002	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Northumberland	
Long Term Care Home and City: Golden Plough Lodge, Cobourg	
Lead Inspector Julie Mercer (000737)	**Inspector Digital Signature**
Additional Inspector(s) Sarah Gillis (623)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-7, 2024.

The following intake(s) were inspected:
A Critical Incident related to a resident fall that resulted in injury and a significant change in health status.

The following **Inspection Protocols** were used during this inspection:

Housekeeping, Laundry, and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: HOME TO BE SAFE, SECURE ENVIRONMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure a safe and secure environment was provided to all residents.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director related to a resident fall.

Observation during the inspection, Inspector observed that a home area tub room door was left open, and unsupervised with multiple cleaning chemicals easily accessible to residents.

Inspector observed that a home area's tub room was unsupervised and contained one bottle of Oxivir Plus and two bottles of Diversey Bathroom Cleaner and Scale Remover.

A Registered Practical Nurse (RPN) confirmed that all tub room doors were to be closed and locked, at all times, for resident safety.

Failure to ensure that a home area's tub room door was kept closed and locked, with chemicals left accessible and unsupervised, has placed residents at risk for potential injury and/or accidental poisoning.

Sources: Inspector observation, and an interview with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that a resident's written plan of care set out clear directions to staff related to a resident's fall's prevention interventions, Personal Assistance Services Device (PASD) and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

Review of a resident's plan of care did not indicate clear direction to staff for a resident's use of falls prevention interventions, PASD and/or restraint.

A PSW confirmed that they were aware of a resident's past falls interventions and were unaware of a resident's current fall's interventions, which included monitoring of a resident's when using a PASD and/or restraint.

Observation during inspection, Inspector observed that a resident's falls prevention interventions, indicated in the plan of care, were inconsistent with a resident's beside fall's logos and Point of Care (POC) tasks for PSW documentation.

Observation during inspection, Inspector observed that a resident did not have one of their falls interventions in place as indicated in the plan of care.

A Physiotherapist (PT) confirmed that a resident using a PASD and/or restraint, were to be repositioned every hour as indicated in the plan of care.

Review of a resident's plan of care indicated fall's prevention interventions were in place and not being followed by staff.

Failure to ensure that a resident's written plan of care set out clear directions to staff on the use of falls prevention interventions, PASD and/or restraint has placed a resident at increased risk for future falls and potential injury.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of a resident's care, set out in the plan was documented for the use of a PASD and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A resident's progress notes, at a specific date/time, indicated that a resident was transferred into a PASD and/or restraint.

A resident was assessed by a PT who implemented the use of a PASD and/or restraint for safety. A PSW and PT, both confirmed that a resident was unable to remove themselves when using a PASD and/or restraint.

Review of a resident's plan of care did not indicate a Focus for the use of a PASD and/or restraint.

A Director of Care (DOC) confirmed that a resident's plan of care did not indicate the use of a PASD and/or restraint and should have.

Failure to ensure that the provision of a resident's care, set out in the plan of care, was documented related to the use of a PASD and/or restraint has placed a resident's safety at risk.

Sources: A CIR, the home's Physical Restraints Policy, a resident's electronic health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of a resident's care, set out in the plan of care, related to fall's prevention interventions were documented.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A resident's plan of care did not indicate all fall's prevention interventions that were currently in place for a resident.

Review of a resident's Point of Care (POC) tasks, did not indicate all current falls prevention interventions that were currently in place for a resident, as directed by the home's "Falls Prevention Devices" Policy.

Review of a resident's POC tasks for falls prevention interventions indicated that PSW documentation was required on every shift.

Review of a resident's POC tasks for fall's prevention interventions, indicated that the required PSW documentation on every shift was missing on numerous dates/times during a specific time frame.

Failure to ensure that the outcomes of a resident's care, set out in the plan of care, were documented related to falls prevention interventions has placed a resident at increased risk for falls and potential injury.

Sources: A CIR, the home's Fall's Prevention Devices Policy, a resident's electronic health records, and Inspector observations. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that when a resident was reassessed, the plan of care was reviewed and revised when the residents care needs changed, in relation to fall's prevention interventions and the use of a PASD and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A PSW and an RPN, both confirmed a change in a resident's falls prevention interventions.

Review of a resident's plan of care did not indicate all fall's prevention interventions that were currently in place for a resident.

Review of a resident's plan of care did not indicate the use of and monitoring of a resident when using a PASD and/or restraint.

Review of a resident's assessment documentation, conducted on a specific date, did not indicate all fall's prevention interventions that were currently in place. For a resident. Additionally, a resident's assessment documentation did not indicate a change in a resident's health status, and indicated that the plan of care was reviewed, current, and did not require updating.

Review of a resident's assessment documentation, conducted on a specific date, indicated that the plan of care was updated with the use of a PASD and/or restraint.

A DOC confirmed that a resident's plan of care was not updated when the resident's care needs changed and should have.

A PT confirmed that a resident was to be repositioned every hour when using a PASD and/or restraint, as indicated in the plan of care. A PT confirmed that a resident's plan of care was not updated when a resident's care needs changed.

A PSW confirmed that they were unaware of directions for monitoring of a resident when using a PASD and/or restraint.

A PSW confirmed that a resident's fall's prevention intervention device was discontinued when a resident's care needs changed.

Review of a resident's plan of care indicated that a discontinued fall's prevention intervention device was indicated in the plan of care.

Failure to ensure, when a resident's care needs changed, that the plan of care was reviewed and revised, has placed a resident's safety and well-being at risk.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 3.

Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

The licensee has failed to ensure that when a resident was restrained by a PASD and/or restraint, the resident was monitored at least every hour by a member of the Registered Nursing Staff or by another member of staff as authorized by a member of the Registered Nursing Staff for that purpose.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

Review of a resident's plan of care indicated fall's prevention interventions that included the use of a PASD and/or restraint.

An ADOC and DOC, both confirmed that PSWs were responsible to monitor a resident's use of a PASD and/or restraint every hour for safety and document the monitoring in a POC task.

Review of a resident's POC care task indicated that a resident required monitoring every hour.

Review of a resident's POC tasks indicated, on a specific date/time, that the resident's restraint was applied. For the same date, review of a resident's POC tasks confirmed that numerous hourly safety checks were not conducted, and a resident's

progress notes did not indicate a rationale for not conducting hourly safety checks, during a specific time frame.

Review of a resident's POC task, did not indicate who or when a PASD and/or restraint was applied for a resident on numerous dates/times, during a specific time frame. On the same date, a review of a resident's progress notes, did not indicate a rationale for not documenting who or when a PASD and/or restrain was applied on numerous dates/times, during a specific time frame.

Failure to ensure that when a resident was restrained by a PASD and/or restraint, a resident was monitored at least every hour, has placed a resident's well-being and safety at risk.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, and interviews with staff. [000737]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)

The licensee has failed to ensure that when a resident was restrained by a PASD and/or restraint, the resident was released from the physical device and

repositioned at least once every two hours.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

Review of a resident's plan of care indicated the use of a PASD and/or restraint as falls prevention interventions.

Review of a resident's plan of care did not indicate a repositioning strategy for the use of a PASD and/or restraint.

A DOC and PT, both confirmed that a resident's plan of care did not indicate a Focus for the use of a PASD and/or restraint and did not provide a repositioning strategy for a resident.

A PT confirmed that a resident was to be repositioned every hour when using a PASD and/or restraint.

A PSW and PT, both confirmed that a resident was unable to remove themselves when using a PASD and/or restraint.

A PSW confirmed that they were unaware of a resident's required repositioning when using a PASD and/or restraint.

Review of a resident's POC task documentation for a specific time frame, indicated the following:

Fourteen instances when a resident required repositioning when using a PASD and/or restraint and was not indicated in PSW's documentation.

Twenty-three instances when PSW documentation indicated a resident response that warranted a resident's repositioning when using a PASD and/or restraint and was not indicated in PSW's documentation.

Five instances when a resident's response was not indicated in PSW's documentation.

Failure to ensure that a resident was released from a PASD and/or restraint and repositioned at least once every two hours has placed a resident's safety and well-being at risk.

Sources: A CIR, the home's Physical Restraints and Restraint Monitoring Policies, a resident's electronic health records, and interviews with staff. [000737]

WRITTEN NOTIFICATION: REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent.

The licensee has failed to ensure documented consent was obtained related to a resident's use of a PASD and/or restraint.

Rationale and Summary

A CIR was received by the Director related to a resident fall that resulted in injury and a significant change in health status.

A PT confirmed that a resident was assessed post-fall, and implemented the use of a PASD and/or restraint for safety.

A DOC confirmed that prior to the application of a resident's PASD and/or restraint, signed consent was to be obtained on the home's paper PASD/restraint consent form. A DOC confirmed that signed PASD/restraint consent forms were stored in a resident's physical chart located at the nursing station.

Review of a resident's progress notes, for a specific time frame, indicated that a resident's Substitute Decision Maker (SDM) needed to sign a PASD/restraint consent form for the use of a PASD and/or restraint.

During the inspection, Inspector failed to locate a signed consent form by a resident's SDM for the use of a PASD and/or restraint.

Failure to ensure documented consent was obtained for a resident's use of a PASD and/or restraint has placed a resident's safety at risk.

Sources: A CIR, the home's Physical Restraints and Monthly Analysis of Restraints Policies, a resident's electronic and paper health records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: MINIMIZING OF RESTRAINING

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 122 (a)

Evaluation

s. 122. Every licensee of a long-term care home shall ensure,

(a) that an analysis of the restraining of residents by use of a physical device under section 35 of the Act or pursuant to the common law duty referred to in section 39 of the Act is undertaken on a monthly basis.

The licensee has failed to ensure that an analysis of a resident's use of a PASD and/or restraint was undertaken on a monthly basis.

Rationale and Summary

A CIR was received by the Director related to a resident fall, that resulted in injury and a significant change in their health status.

Review of a resident's plan of care indicated the use of a PASD and/or restraint as a falls prevention intervention.

Review of a resident's plan of care did not indicate a repositioning strategy for the use of a PASD and/or restraint.

A PSW and PT, both confirmed that a resident was unable to remove themselves from the device when using a PASD and/or restraint.

An ADOC and PT, both confirmed that the home's Multidisciplinary Falls Committee (MFC) did not assess or discuss a resident's use of a PASD and/or restraint.

Review of the home's MFC meeting minutes, for a specific time frame, indicated a need to conduct random monthly audits of residents' use of PASD and/or restraint, and an updated list of residents that require them.

An ADOC confirmed that the home was not conducting monthly restraint analysis as directed in the home's "Monthly Analysis of Physical Restraints" Policy.

Failure to ensure that an analysis of a resident's use of a PASD and/or restraint was undertaken on a monthly basis has placed a resident's well-being at risk and did not ensure that the least form of restraint was used.

Sources: A CIR, the home's Monthly Analysis of Restraints Policy, Monthly Analysis of Restraint Use Form, a resident's electronic health records, and interviews with staff. [000737]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident's nutritional medication was administered to a resident in accordance with the direction for use specified by the prescriber.

Rationale and Summary
A CIR was received by the Director related to a resident fall.

Review of a resident's Electronic Medication Administration Record (EMAR) confirmed the prescriber's direction for a resident's daily administration of a specified medication.

On a specific date/time, Inspector observed a medication cup containing liquid on a resident's bed side table.

Shortly afterwards, an RPN confirmed that they were responsible to administer a resident's medication and that they left the medication cup containing liquid on a resident's bed side table. An RPN confirmed that they had signed a resident's electronic medication administration record that the full dosage was administered, and they were aware that a resident did not consume the full dosage as per prescribers' direction.

Review of a resident's EMAR on same date, confirmed that an RPN signed that a resident received a full dosage of their specific medication.

Additionally, on a specific date/time, Registered Staff documentation did not indicate that that a resident received their specific medication.

Failure to ensure that a resident's medication was administered to a resident in accordance with the direction for use specified by the prescriber has placed a resident at risk.

Sources: A CIR, a resident's electronic health records, Inspector observations and an interview with staff. [000737]

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

BOARD OF HEALTH MEETING

March 21, 2024

MINUTES

The meeting was convened by Mr. Marshall at 9:36 am at the Health Unit's Lindsay office.

Those in attendance were Messrs. Marshall, Logel, Ryall, Crate, and Perry, Mrs. Richardson (left at 10:27 am), Dr. Hankivsky, Dr. Bocking, Mr. Vrooman, Ms. Beaulac, and Mrs. Dickson (Recorder).

1. LAND ACKNOWLEDGEMENT

The Haliburton, Kawartha, Pine Ridge District Health Unit is situated on the traditional territories of the Michi Saagiig and Chippewa Nations. This includes the territories of Treaty 20 and Williams Treaties. We respectfully acknowledge that these Nations are the stewards and caretakers of these lands and waters for all time and that they continue to maintain this responsibility to ensure their health and integrity for generations to come.

The Haliburton, Kawartha, Pine Ridge District Health Unit recognizes the many harms done to Indigenous peoples and our collective responsibility to right those wrongs. As an organization that is rooted in a colonial system, we are committed to change, to building meaningful relationships with Indigenous communities and in improving our understanding of local Indigenous peoples as we celebrate their cultures and traditions, serve their communities, and responsibly honour all our relations.

2. ADOPTION OF AGENDA

Moved by Mr. Perry

Seconded by Mr. Ryall

THAT the agenda be adopted as presented.

2024-032
carried

3. DECLARATION OF CONFLICT OF INTEREST

None

4. ADOPTION OF MINUTES

Moved by Mrs. Richardson

Seconded by Mr. Logel

THAT the minutes from the February 15, 2024 open session be approved.

2024-033
carried

5. BUSINESS ARISING

5.1 Motion to approve in-camera minutes from January 18, 2024, and February 5, 2024.

Moved by Mr. Logel

Seconded by Mr. Crate

THAT the in-camera minutes from January 18, 2024 and February 5, 2024 be approved.

2024-034

carried

5.2 Motion re: intention to pursue a merger with Peterborough Public Health

Moved by Mr. Perry

Seconded by Mr. Ryall

THAT the Board ratify the following resolution:

WHEREAS, the Board of Health understands that full and adequate funding for voluntary public health unit mergers will be supported by the Ministry of Health;

WHEREAS, the Board of Health believes that a merger of the HKPRDHU and Peterborough Public Health (PPH) Boards of Health will result in a more effective level of service to all area residents; and

WHEREAS, the Board of Health seeks to maintain or enhance the existing partnerships with First Nations in communities served by the Health Units;

Therefore, be it resolved that the Board of Health for HKPRDHU:

- Intends to pursue a merger with the Board of Health for PPH; and
- Agrees to work together to develop a business case and funding proposal regarding the merger, subject to sufficient funding being provided by the Ministry of Health as specifically outlined in the business case; and
- Create a joint Board of Health Merger Steering Committee, with equal membership from both HKPRDHU and PPH, to support the development of a Business Case and guide collaborative work towards a merger.

2024-035
carried

6. MEDICAL OFFICER OF HEALTH UPDATES

Measles

In December 2023, The World Health Organization reported an alarming 30-fold rise in measles cases in Europe. Since January 1, 2024, 28 measles cases have been reported in Quebec, and 9 cases have been reported in Ontario (2 have no clear exposures (no travel history)). Public Health's response to measles includes prevention (promotion of vaccination), early detection (awareness among health care providers and travellers) and disrupting ongoing transmission through identifying contacts exposed to confirmed cases.

Solar Eclipse

The role of Public Health with regard to the upcoming solar eclipse is to raise awareness regarding safety considerations (solar retinopathy, and the implications of mass gatherings). The Health Unit has been working with municipalities to make sure that mass gathering response plans are in place.

Drug Poisoning Crisis

The Health Unit continues to support the Haliburton Kawartha Lakes Northumberland Drug Strategy through data analysis of a survey among people who use drugs and coordinating and hosting monthly meetings.

The Health Unit also maintains the Opioid Dashboard Report, which provides up-to-date information regarding opioid overdoses and deaths in Haliburton County, the City of Kawartha Lakes, and Northumberland County.

Dr. Bocking also updated the Board of Health on a pilot project to support the distribution of test strips for fentanyl and xylaxine and two community partner sessions focused on preparation for acute drug poisoning events.

Moved by Mr. Ryall

Seconded by Mrs. Richardson

THAT the Board receive Dr. Bocking's updates for information.

2024-36
carried

7. REPORTS

There are no reports for this meeting due to time restraints.

8. NEW BUSINESS

8.1 Merger Exploration Update

8.1.1 Terms of Reference – Joint Board of Health Merger Steering Committee

Mr. Marshall and Dr. Bocking provided a brief update on the merger and presented the Terms of Reference for the Joint Board of Health Merger Steering Committee.

Moved by Mr. Logel

Seconded by Mr. Ryall

THAT the Board receive the update on the merger for information and THAT the Terms of Reference for the Joint Board of Health Merger Steering Committee be approved.

Mr. Perry opposed the motion.

2024-037
carried

8.2 Request for Support for Bill C-322 *National Framework for a School Food Program Act*

Dr. Bocking proposed that the Board of Health endorse a letter of support for Bill C-322 *National Framework for a School Food Program Act*. A national policy would set a standard both for securing food for schools and ensuring it is delivered consistently, sustainably, and within a context of transformative action to improve students' health and achievement outcomes and build cultural and economic success.

Moved by Mrs. Richardson

Seconded by Mr. Crate

THAT the proposed draft correspondence to MPs Philip Lawrence and Jamie Schmale in support of Private Member's Bill C-322 *National Framework for a School Food Program Act* be approved and issued.

2024-038

carried

8.3 Corporate Services Updates including Unaudited Operating Statements

Moved by Mr. Crate

Seconded by Mr. Logel

THAT the Corporate Services updates be received for information including the unaudited operating statements for the two-month period ending February 29, 2024 in the amount of $3,587,670.

2024-039

carried

9. BUSINESS FROM BOARD MEMBERS

None

10. CORRESPONDENCE

Moved by Mr. Perry

Seconded by Mrs. Richardson

THAT the following correspondence be received for information:

- Ontario Public Health Association RE: Alcohol Expansion into Convenience, Grocery, and Big Box Stores

2024-040

carried

11. IN-CAMERA

Moved by Mr. Perry

Seconded by Mr. Ryall

THAT the Board of Health move in-camera to discuss legal, property, and personnel matters.

2024-041
carried

Moved by Mr. Crate

Seconded by Mr. Perry

THAT the in-camera session be dissolved, and the membership return to the Board of Health open session.

2024-042
carried

Moved by Dr. Hankivsky

Seconded by Mr. Ryall

THAT the in-camera minutes from the February 15, 2024 closed session be approved.

2024-043
carried

Moved by Mr. Logel

Seconded by Mr. Crate

THAT the Board of Health approve the bargaining mandate and associated recommendations.

2024-044
carried

Moved by Mr. Logel

Seconded by Mr. Crate

THAT the Board of Health receive the update provided under legal, personnel, and property item 11.4 for information.

2024-045
carried

12. DATE OF NEXT MEETING

The next meeting of the Board of Health will be held on April 18, 2024 at the Health Unit's Port Hope office from 9:30 am – 11:30 am.

13. ADJOURNMENT

Moved by Mr. Perry

Seconded by Mr. Crate

THAT the meeting be adjourned. The meeting adjourned at 11:25 am.
2024-046
carried

Board of Health Chair	Recorder
April 18, 2024	

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

BOARD OF HEALTH MEETING

April 18, 2024

MINUTES

The meeting was convened by Mr. Marshall at 9:30 am at the Health Unit's Port Hope office.

Those in attendance were Messrs. Marshall, Logel, Ryall, Crate, and Perry (joined virtually at 9:45 am – left at 11:00 am), Mrs. Richardson, Dr. Hankivsky, Dr. Bocking, Mr. Vrooman, and Mrs. Dickson (Recorder).

1. LAND ACKNOWLEDGEMENT

The Haliburton, Kawartha, Pine Ridge District Health Unit is situated on the traditional territories of the Michi Saagiig and Chippewa Nations. This includes the territories of Treaty 20 and Williams Treaties. We respectfully acknowledge that these Nations are the stewards and caretakers of these lands and waters for all time and that they continue to maintain this responsibility to ensure their health and integrity for generations to come.

The Haliburton, Kawartha, Pine Ridge District Health Unit recognizes the many harms done to Indigenous peoples and our collective responsibility to right those wrongs. As an organization that is rooted in a colonial system, we are committed to change, to building meaningful relationships with Indigenous communities and in improving our understanding of local Indigenous peoples as we celebrate their cultures and traditions, serve their communities, and responsibly honour all our relations.

2. ADOPTION OF AGENDA

Moved by Mr. Logel

Seconded by Dr. Hankivsky

THAT the agenda be adopted as presented.

2024-047
carried

3. DECLARATION OF CONFLICT OF INTEREST

None

4. ADOPTION OF MINUTES

Moved by Mr. Crate

Seconded by Mrs. Richardson

THAT the minutes from the March 21, 2024 open session be approved.

2024-048
carried

5. BUSINESS ARISING

None

6. MEDICAL OFFICER OF HEALTH UPDATES

Dr. Bocking provided the Board of Health with updates on enforcement of the *Immunization of School Pupils* Act, vaccine preventable diseases (measles, pertussis), and the COVID Vaccine Spring Campaign.

First notice of missing immunization records was sent to families of elementary students (with the exception of Grade 3) on March 4th. As of April 15th, 2,162 records are still missing. Suspension notices will be sent out on April 29th and actual suspensions will begin on May 14th for students whose records are still not up to date.

Dr. Bocking shared that April is Oral Health Month and highlighted the essential role oral health plays in overall health and also made the Board aware of other campaigns the Health Unit is running on social media with regard to emergency preparedness for spring floods and preventing tick bites and Lyme disease.

Moved by Dr. Hankivsky

Seconded by Mr. Logel

THAT the Board receive Dr. Bocking's updates for information.

2024-49
carried

7. REPORTS

7.1 Matthew Vrooman, Director of Corporate Services, will be providing the Board of Health a presentation on Cyber Security

Mr. Vrooman provided the Board of Health with a comprehensive presentation on cyber security.

Moved by Dr. Hankivsky

Seconded by Mr. Crate

THAT the Board receive Mr. Vrooman's presentation on cyber security for information.

2024-50
carried

8. NEW BUSINESS

8.1 Chief Medical Officer of Health Annual Report (Dr. Bocking)

On March 28, 2024, The Annual Report of the Chief Medical Officer of Health (2023), Balancing Act: An All-of-Society Approach to Substance Use and Harms (the report) was released. This report calls for a comprehensive, coordinated, all of society approach to address the urgent public health issue of the rising rates of substance use and related harms in Ontario. It calls for an investment in upstream approaches (i.e. building stronger families, improving mental health, and building stronger communities) that will prevent substance use issues before they occur, while still supporting downstream approaches that help mitigate the harms of substance use (i.e. education, regulatory measures, and harm reduction interventions). It also acknowledges that substance use, and related harms is an issue that cannot be solved by public health alone, and that it needs all of society to effectively address it.

The Board of Health endorsed that a letter of support for the report be sent to be sent to the Premier, Minister of Health for the province of Ontario, and MPPs Laurie Scott and David Piccini.

Moved by Mr. Ryall

Seconded by Dr. Hankivsky

THAT the Board of Health receive the information outlined in CMOH's 2023 Annual Report and FURTHER THAT a letter of support for the Report be sent to the Premier, Minister of Health for the province of Ontario and local MPPs.

2024-051
carried

8.2 Corporate Services Updates including Unaudited Operating Statements (Matthew Vrooman)

Moved by Dr. Hankivsky

Seconded by Mr. Crate

THAT the updates from Corporate Services be received for information including the unaudited operating statements for the three-month period ending March 31, 2024 in the amount of $5,827,622.

2024-052

carried

9. BUSINESS FROM BOARD MEMBERS

None

10. CORRESPONDENCE

Moved by Mr. Logel

Seconded by Mrs. Richardson

THAT the following correspondence be received for information:

- alPHa's response to the Chief Medical Officer of Health's 2023 Annual Report

2024-053

carried

11. IN-CAMERA

Moved by Dr. Hankivsky

Seconded by Mr. Ryall

THAT the Board of Health move in-camera to discuss legal, property, and personnel matters.

2024-054
carried

Moved by Mr. Crate

Seconded by Mrs. Richardson

THAT the in-camera session be dissolved, and the membership return to the Board of Health open session.

2024-055
carried

Moved by Mr. Crate

Seconded by Mr. Ryall

THAT the in-camera minutes from the March 21, 2024 closed session be approved.

2024-056
carried

Moved by Mr. Logel

Seconded by Mr. Crate

THAT the information provided under legal item 11.2 be received for information.

2024-057
carried

Moved by Dr. Hankivsky

Seconded by Mr. Logel

THAT the Board of Health receive the update regarding bargaining under legal item 11.3 for information.

2024-058
carried

Moved by Mr. Crate

Seconded by Mr. Ryall

THAT the Board of Health receive the update under legal item 11.4 for information.

2024-059
carried

Moved by Dr. Hankivsky

Seconded by Mrs. Richardson

THAT the Board of Health receive the update under legal, property, and personnel item 11.5 for information.

2024-060
carried

12. DATE OF NEXT MEETING

The next meeting of the Board of Health will be held on May 16, 2024 at the Health Unit's Lindsay office from 9:30 am – 11:30 am.

13. ADJOURNMENT

Moved by Mr. Logel

Seconded by Dr. Hankivsky

THAT the meeting be adjourned. The meeting adjourned at 11:40 am.

2024-060
carried

Board of Health Chair	Recorder
May 16, 2024	

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

BOARD OF HEALTH MEETING

May 16, 2024

MINUTES

The meeting was convened by Mr. Marshall at 9:30 am at the Health Unit's Lindsay office.

Those in attendance were Messrs. Marshall, Logel, Ryall, and Crate, Mrs. Richardson, Dr. Hankivsky, Dr. Bocking, Mr. Vrooman (virtual), and Mrs. Dickson (Recorder).

Mr. Perry was absent with regrets.

1. LAND ACKNOWLEDGEMENT

The Haliburton, Kawartha, Pine Ridge District Health Unit is situated on the traditional territories of the Michi Saagiig and Chippewa Nations. This includes the territories of Treaty 20 and Williams Treaties. We respectfully acknowledge that these Nations are the stewards and caretakers of these lands and waters for all time and that they continue to maintain this responsibility to ensure their health and integrity for generations to come.

The Haliburton, Kawartha, Pine Ridge District Health Unit recognizes the many harms done to Indigenous peoples and our collective responsibility to right those wrongs. As an organization that is rooted in a colonial system, we are committed to change, to building meaningful relationships with Indigenous communities and in improving our understanding of local Indigenous peoples as we celebrate their cultures and traditions, serve their communities, and responsibly honour all our relations.

2. ADOPTION OF AGENDA

Moved by Dr. Hankivsky

Seconded by Mrs. Richardson

THAT the agenda be adopted as presented.

2024-061
carried

3. DECLARATION OF CONFLICT OF INTEREST

None

4. ADOPTION OF MINUTES

Moved by Mr. Logel

Seconded by Mr. Ryall

THAT the minutes from the April 18, 2024 open session be approved.

2024-062
carried

5. BUSINESS ARISING

None

6. MEDICAL OFFICER OF HEALTH UPDATES

Dr. Bocking provided the Board of Health with updates on the launch of the Nutritious Food Basket report, enforcement of the *Immunization of School Pupils Act* (ISPA), and summer preparations.

"Addressing Food Insecurity and Poverty in the Haliburton, Kawartha, Pine Ridge District" 2023 report.

Food insecurity is defined as not having enough money to buy food and increases people's risk of mental health diagnoses (e.g. depression, social anxiety), infections and chronic diseases (e.g. diabetes, heart disease). Families living on low income (e.g. on social assistance, minimum wage) have little money left over, if any, to pay for other basic expenses. Food charities, such as food banks, offer only temporary solutions to food insecurity; income-based strategies that are long-term and that focus on poverty reduction are needed (e.g. adequate incomes to ensure a minimum standard of living, improving employment standards, increasing social assistance rates, and providing a basic income guarantee).

Two-year rates of food insecurity in the HKPR District area have not changed significantly. Rental costs and cost of the nutritious food basket have gone up, but people's incomes have not kept pace with general rising prices of goods and services.

Update on enforcement of *Immunization of School Pupils Act* (ISPA)

On March 4th, 3,596 notices were sent to parents/guardians of elementary students (except Grade 3) advising them of missing immunization records. After a joint effort by parents/ guardians, school staff, and Health Unit employees, there were only 663 records outstanding as of May 14th. These 663 students have received suspension notices until their immunization records are up-to-date.

Summer preparations

The Health Protection Division has been preparing for inspections of seasonal premises, vector-borne disease surveillance (e.g. ticks, mosquitos), and emergency preparedness (e.g. extreme heat events, air quality events, power outages, etc.).

Moved by Dr. Hankivsky

Seconded by Mr. Crate

THAT the Board receive Dr. Bocking's updates for information.

2024-63
carried

7. REPORTS

7.1 Richard Ovcharovich, Manager, Health Protection, and Abby Tabaco, Emergency Management Health Hazard Coordinator, provided the Board of Health with a presentation on the Health Unit's role as it relates to the 2024 International Plowing Match.

The International Plowing Match is the largest event of its kind in North America, attracting on average 70,000+ people for a five-day celebration of agriculture and rural living. The event will be held in Lindsay from October 1st to 5th, 2024.

Mass gathering events require collaboration and coordination within the Health Unit and with external stakeholders as there is a potential for injuries and illness, and concentrated crowds place a strain on public health infrastructure and increase demands for services such as infectious disease monitoring, food and water surveillance, and campsite safety. Other areas where the Health Unit has a role in mass gatherings include animal bite response, enforcement of the *Smoke Free Ontario Act*, and ensuring that provisions for the sanitary disposal of solid and liquid waste are in place.

Moved by Mr. Logel

Seconded Mr. Crate

THAT the Board receive the presentation on the 2024 International Plowing Match.

2024-64
carried

8. NEW BUSINESS

8.1 Corporate Services Updates

Moved by Mrs. Richardson

Seconded by Mr. Logel

THAT the unaudited operating statements for the four-month period ending April 30, 2024 in the amount of $7,527,359 be received for information.

2024-065
carried

8.2 Q1-2024 Board of Health Quarterly Report Summary

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (OPHS) outline the minimum requirements that boards of health must meet for mandatory health programs and services. Dr. Bocking provided a summary of key program achievements for the first quarter of 2024 (January 1st to March 31st) to inform the Board about activities of the organization, and so they can monitor progress of activities and ensure that the program requirements under the (OPHS) are met.

Moved by Dr. Hankivsky

Seconded by Mr. Crate

THAT Q1-2024 Board of Health Quarterly Report Summary be received for information.

2024-066

carried

8.3 2023 Annual Report

Dr. Bocking provided an overview of the Haliburton, Kawartha, Pine Ridge District Health Unit's 2023 Annual Report.

Moved by Dr. Hankivsky

Seconded by Mr. Ryall

THAT the 2023 Annual Report be received for information.

2024-067

carried

9. BUSINESS FROM BOARD MEMBERS

Dr. Hankivsky raised Port Hope residents' concerns about the fumes coming from a local factory and asked what the Health Unit's process is to respond to and investigate complaints. Dr.

Bocking advised that complaints would be assessed as health hazard concerns, but that the Ministry of Environment, Conservation, and Parks monitors air quality. Dr. Bocking will have the Health Protection team prepare a more fulsome explanation.

10. CORRESPONDENCE

Moved by Dr. Hankivsky

Seconded by Mr. Crate

THAT the following correspondence be received for information:

- Canadian Public Health Association – A Public Health Approach to Sex Work
- Association of Local Public Health Agencies – Ontario's Not-for-Profit Compliance Activities

2024-068

carried

11. IN-CAMERA

Moved by Mr. Crate

Seconded by Mrs. Richardson

THAT the Board of Health move in-camera to discuss legal, property, and personnel matters.

2024-069
carried

Moved by Mr. Logel

Seconded by Mr. Crate

THAT the in-camera session be dissolved, and the membership return to the Board of Health open session.

2024-070
carried

Moved by Dr. Hankivsky

Seconded by Mr. Crate

THAT the in-camera minutes from the April 18, 2024 closed session be approved.

2024-071
carried

Moved by Dr. Hankivsky

Seconded by Mrs. Richardson

THAT the information provided under legal, property and personnel item 11.2 be received for information.

2024-072
carried

12. DATE OF NEXT MEETING

The next meeting of the Board of Health will be held on June 20, 2024 at the Health Unit's Port Hope office from 9:30 am – 11:30 am.

13. ADJOURNMENT

Moved by Mr. Logel

Seconded by Mr. Ryall

THAT the meeting be adjourned. The meeting adjourned at 11:11 am.

2024-073
carried

Board of Health Chair	Recorder
June 20, 2024	

Date: May 16, 2024 | Time: 9:30 a.m. – 11:30 p.m. | Location: 108 Angeline St. S., Lindsay

6. Medical Officer of Health Update
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

Dr. Bocking provided the Board of Health with updates on the launch of the Nutritious Food Basket report, enforcement of the *Immunization of School Pupils Act* (ISPA), and summer preparations.

"Addressing Food Insecurity and Poverty in the Haliburton, Kawartha, Pine Ridge District" 2023 report.

Food insecurity is defined as not having enough money to buy food and increases people's risk of mental health diagnoses (e.g. depression, social anxiety), infections and chronic diseases (e.g. diabetes, heart disease). Families living on low income (e.g. on social assistance, minimum wage) have little money left over, if any, to pay for other basic expenses. Food charities, such as food banks, offer only temporary solutions to food insecurity; income-based strategies that are long-term and that focus on poverty reduction are needed (e.g. adequate incomes to ensure a minimum standard of living, improving employment standards, increasing social assistance rates, and providing a basic income guarantee).

Two-year rates of food insecurity in the HKPR District area have not changed significantly. Rental costs and cost of the nutritious food basket have gone up, but people's incomes have not kept pace with general rising prices of goods and services.

The full report will be publicly launched soon. Please check the Health Unit's website.

Update on enforcement of *Immunization of School Pupils Act* (ISPA)

On March 4th, 3,596 notices were sent to parents/guardians of elementary students (except Grade 3) advising them of missing immunization records. After a joint effort by parents/ guardians, school staff, and Health Unit employees, there were only 663 records outstanding as of May 14th. These 663 students have received suspension notices until their immunization records are up-to-date.

Summer preparations

The Health Protection Division has been preparing for inspections of seasonal premises, vector-borne disease surveillance (e.g. ticks, mosquitos), and emergency preparedness (e.g. extreme heat events, air quality events, power outages, etc.).

The complete update can be found here in the recorded meeting session.

7. Report

Presenters: Richard Ovcharovich, Manager, Health Protection, and Abby Tabaco, Emergency Management Health Hazard Coordinator, provided the Board of Health with a presentation on the Health Unit's role as it relates to the 2024 International Plowing Match.

The International Plowing Match is the largest event of its kind in North America, attracting on average 70,000+ people for a five-day celebration of agriculture and rural living. The event will be held in Lindsay from October 1st to 5th, 2024.

Mass gathering events require collaboration and coordination within the Health Unit and with external stakeholders as there is a potential for injuries and illness, and concentrated crowds place a strain on public health infrastructure and increase demands for services such as infectious disease monitoring, food and water surveillance, and campsite safety. Other areas where the Health Unit has a role in mass gatherings include animal bite response, enforcement of the *Smoke Free Ontario Act*, and ensuring that provisions for the sanitary disposal of solid and liquid waste are in place.

The full presentation can be read here or watched here.

8. New Business

Q1-2024 Board of Health Quarterly Report Summary

Presenter: Dr. Bocking, Medical Officer of Health and Chief Executive Officer

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (OPHS) outline the minimum requirements that boards of health must meet for mandatory health programs and services. Dr. Bocking provided a summary of key program achievements for the first quarter of 2024 (January 1st to March 31st) to inform the Board about activities of the organization, and so they can monitor progress of activities and ensure that the program requirements under the (OPHS) are met.

The full summary can be read here.

2023 Annual Report

Presenter: Dr. Bocking, Medical Officer of Health and Chief Executive Officer

Dr. Bocking provided an overview of the Haliburton, Kawartha, Pine Ridge District Health Unit's 2023 Annual Report.

The complete 2023 Annual Report can be read here.

For the complete meeting details, please see the agenda package or view our video recording online.

Date of Next Meeting

June 20, 2024, 9:30 am – 11:30 am, Port Hope Office, 200 Rose Glen Road, Port Hope.

Date: June 20, 2024 | Time: 9:30 a.m. – 11:30 p.m. | Location: 200 Rose Glen Road, Port Hope

5. Business Arising
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

At the May 16, 2024 Board of Health meeting, there was a request for more information on how the Health Unit manages complaints of health hazards from the public.

The Health Unit is mandated to respond to inquiries from the public related to health hazard concerns. However, many concerns relate to requirements and regulations that fall under other agencies' jurisdictions. Health Unit staff review each complaint received and follow-up according to the type of health hazard identified and the nature of the concern.

The full report can be found here on the Health Unit's website.

6. Medical Officer of Health Update
Presenter: Dr. Natalie Bocking, Medical Officer of Health and Chief Executive Officer

Respiratory Infections Dashboard

A Respiratory Infections Dashboard was developed for the Health Unit's website during the COVID-19 pandemic to show what was happening locally. The dashboard includes data such as COVID-19 wastewater surveillance, hospitalization, and emergency visits. Over time the dashboard expanded to include data on influenza and general information about respiratory visits to the emergency department.

Updating the dashboard has paused for the summer as the respiratory season has passed, and when it returns for the next respiratory season, it will be different due to changes in the data the Health Unit will be receiving (full explanation of the reason for the changes can be heard in the recorded session).

Review of the Ontario Public Health Standards

Dr. Bocking provided the Board with an update on the Province's review of the Ontario Public Health Standards. The objectives of the review are "to refine, refocus and re-level roles and responsibilities, collaborating with partners to optimize functions, for implementation beginning January 1, 2025."

The new draft standards were released to health units for consultation on May 22, 2023 (response due June 20, 2023).

In reviewing the draft, work required of health units remains unchanged if not slightly increased; a decrease in workload is not anticipated. The only requirement that has been removed from the Standards is vision screening in schools.

The complete update can be found here in the recorded meeting session.

7. Report

Presenters: Joanne Brewster and Dearbhla Lynch, Health Promotors, presented the Mental Health Promotion Framework to the Board of Health.

The Mental Health Promotion Framework provides a structured approach to understanding mental health from a public health perspective, addressing the gaps, and advocating for strategies and actions. It supports the commitment of the Health Unit to promote and protect the mental health and well-being of people and communities.

The full presentation can be read here or watched here.

8. New Business

Draft Consolidated Year-End Financial Statements

Presenter: Richard Steiginga, Baker Tilly KDN LLP

Richard Steiginga, the Health Unit's auditor, presented the Draft Consolidated Year-End Financial Statements for 2023 to the Board of Health.

The full statements can be read here.

Updates to Policies

Presenter: Dr. Bocking, Medical Officer of Health and Chief Executive Officer

The Board of Health approved revisions to the Emergency Management and Emergency Management Notification System policies.

For the complete meeting details, please see the agenda package or view our video recording online.

Date of Next Meeting

June 20, 2024, 9:30 am – 11:30 am, Port Hope Office, 200 Rose Glen Road, Port Hope.