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Ontario Auditor General Report on COVID-19 in Ontario's LTC Homes Supports Longstanding Calls for Real Change

Toronto – Ontario's Auditor General released a 107-page report today assessing the province's response to COVID-19 in long-term care homes, listing a litany of problems that contributed to the lack of preparedness and inadequate management of the pandemic in the homes. Major issues highlighted in the report include: overcrowded homes, offloading of hospital patients into already overcrowded homes struggling with outbreaks, longstanding understaffing and critical staffing shortages as the pandemic progressed, restrictions on family and caregiver access, widespread non-compliance with sound infection control practices, the cancellation of comprehensive annual surprise inspections, delays and inadequate directives to address the spread of the virus in the homes, and lack of enforcement among others.

The Ontario Health Coalition, which was one of the stakeholders cited in the report, supports many of the key recommendations and findings of the Auditor General.

Critically, the Auditor notes that although vaccines have reduced the outbreaks of COVID-19, change is still needed to address the longstanding issues and the risks of severe outcomes for residents. She goes on to advise that the changes she is recommending, and more, are needed to ensure that the homes meet fundamental principle of Ontario's Long-Term Care Homes Act, that a long-term-care home is: "to be operated so that it is a place where [residents] may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

The Auditor adds to the already existent bulk of evidence giving context to the horrific rate of infection and death in Ontario's long-term care homes. Of the 15 ltc homes with the highest death rate as of December 2020, 13 were operated by for-profits corporations. These 15 homes, having only approximately 4.4% of all long-term-care home beds, accounted for 28% of all resident deaths. The data includes the first and second wave up until the end of December 2020, and does not include the devastating deaths in January and February from the second wave, which were also overwhelmingly in for-profit long-term care homes.

The Auditor vindicates years of our work, along with that of other advocates who have tried to win policy change to improve levels of care and accountability, reporting that although longstanding issues had been raised for years prior to the pandemic, they were not addressed and still remain unaddressed. The Auditor further supports that establishing and enforcing minimum care (staffing standards) would better ensure that care needs are met.

She reports that delays, unclear communications and lack of enforcement by the Long-Term Care Ministry hampered the effectiveness of measures to contain COVID-19, noting that recommending rather than mandating measures to protect residents, failing to inspect and enforce containment measures, contributed to the disproportionate toll of infection and death.

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