PROVINCE OF NEWFOUNDLAND AND LABRADOR
HOUSE OF ASSEMBLY

Second Session
Fiftieth General Assembly

Proceedings of the Standing Committee on Public Accounts

May 20, 2025 - Issue 2

Report of the Auditor General on Personal Care Homes

Published under the authority of the Speaker of the House of Assembly
Honourable Derek Bennett, MHA

PUBLIC ACCOUNTS COMMITTEE

Report of the Auditor General on Personal Care Homes

Chair: Pleaman Forsey, MHA

Vice-Chair: Lucy Stoyles, MHA

Members: Joedy Wall, MHA
Jordan Brown, MHA
Perry Trimper, MHA

Clerk of the Committee: Bobbi Russell

Appearing:

Office of the Auditor General
Denise Hanrahan, Auditor General
Sandra Russell, Deputy Auditor General
Adam Lippa, Audit Principal, Performance Audit
Chrysta Collins, Manager of Communications

Department of Health and Community Services
John McGrath, Deputy Minister
Jeannine Herritt, Assistant Deputy Minister, Regional Services
Deena Waddleton, Director, Seniors Care
Justin Caines, Legislative Consultant

Newfoundland and Labrador Health Services
Dr. Pat Parfrey, Chief Executive Officer
Craig Davis, Vice-President and Chief Operating Officer, Central

House of Assembly Service
Bobbi Russell, Principal Clerk of Committees
Evan Beazley, Committee Analyst

The Committee met at 9 a.m. in the House of Assembly Chamber.

CHAIR (Forsey): Okay, good morning, everyone and welcome.

At this point, I would like to call the meeting to order. Again, welcome to the Public Accounts Committee public hearing respecting the personal care homes audit report of the Auditor General.

The Committee wishes to thank the witnesses from Health and Community Services, Newfoundland and Labrador Health Services who are appearing this morning, as well as the Auditor General, Denise Hanrahan, and officials from her office who are also attending today.

The Standing Committee on Public Accounts is dedicated to improving public administration in partnership with the Auditor General. The Committee examines the administration of government policy, not the merits of it, and strives to achieve consensus in its decisions whenever possible. Members take a non-partisan approach to their work in this Committee.

Before we start with the review of the matters under consideration, we will proceed with introductions of the Committee, followed by the Auditor General's office and the witnesses appearing. We'll take those in order.

I remind Members and officials to wave as you speak for your microphone to be turned on. The tally light on the desk will turn red and that means it's activated and you can go ahead and speak.

I'll start with the Committee. I'll start. I'm Pleaman Forsey, Member for Exploits, Chair of the Public Accounts Committee.

L. STOYLES: Lucy Stoyles, MHA for Mount Pearl North.

J. BROWN: Jordan Brown, MHA for Labrador West.

J. WALL: Joedy Wall, MHA, Cape St. Francis.

P. TRIMPER: Perry Trimper, MHA for the District of Lake Melville.

D. HANRAHAN: Denise Hanrahan, Auditor General.

S. RUSSELL: Sandra Russell, Deputy Auditor General.

C. COLLINS: Chrysta Collins, Communications, Office of the Auditor General.

A. LIPPA: Adam Lippa, Principal Auditor, Office of the Auditor General.

P. PARFREY: Pat Parfrey, CEO, NL Health Services.

J. MCGRATH: John McGrath, Deputy Minister.

J. HERRITT: Jeannine Herritt, Assistant Deputy Minister, Regional Services.

J. CAINES: Justin Caines, Legislative Consultant.

D. WADDLETON: Deena Waddleton, Director of Seniors Health Care, Department of Health.

C. DAVIS: Craig Davis, Vice-President, Chief Operating Officer of Central Zone, NLHS.

CHAIR: Okay, thank you.

I'll now outline how the hearing will proceed, as some reminders for the witnesses, before I call the Clerk to swear or affirm each witness.

Witnesses are reminded that the public meeting and your testimony here today will

be part of public record. Witnesses appearing before the Standing Committee of the House of Assembly are entitled to the same privileges granted to Members respecting parliamentary privilege. Witnesses may speak freely and what you say in the parliamentary proceeding may not be used against you in civil proceedings.

Live audio will be streamed on the House of Assembly website and social media channels, and an archived version will be available following the hearing. *Hansard* will also be available once this is finalized.

When you speak, please raise your hand for your mic to be activated. The tally light on the desk will turn red and that means it's activated and you can identify yourself by saying your first name. We'll proceed as follows: First, I will ask the deputy minister and the CEO of NL Health Services to make opening remarks. Then the Committee will pose questions in turn for 10-minute periods; these rounds will continue until the Committee have exhausted all their questioning.

I'll now ask the Clerk to administer oaths and affirmations of the witnesses.

Swearing of Witnesses

Dr. Pat Parfrey
Mr. John McGrath
Ms. Jeannine Herritt
Mr. Justin Caines
Ms. Deena Waddleton
Mr. Craig Davis

CHAIR: Thank you.

I'll now call upon the Deputy Minister of Health and Community Services to bring opening remarks.

J. MCGRATH: Thank you, Chair, for the opportunity to appear today and also for the work of the Office of the Auditor General for the report and the recommendations. The department values the recommendations and has accepted each of them.

Since the report, we have made significant progress as a department in implementing each of the recommendations. We have developed an action plan that has been shared with the Committee that outlines specific tasks, accountabilities and target dates to satisfy each recommendation.

I am pleased to advise the Committee that we have completed a comprehensive review of the operational standards and will be sharing those with the personal care home industry in the coming days and weeks for feedback.

We then plan to lead and develop training with appropriate stakeholders and staff to guide the implementation and have a targeted go-live date effective for September 2025, which I'm pleased to say we are on track to meet.

These refreshed standards include robust oversight processes and key performance indicators, as well as quality assurance indicators and processes which, again, is a key recommendation from the report. For serious incidents, again, we have developed an operational standard to strengthen the process for reporting, monitoring and follow-up.

In addition, a standard operating procedure has been developed and it is currently implemented. This will ensure that each serious incident is addressed in a timely manner and that information management processes are strengthened and, again, meet the recommendation put forward by the AG. This process is currently in place again and is being followed.

The department is also committed to meeting and satisfying the recommendations around complaint management processes. The new standards have a robust complaint management standard and, again, that has

been developed and will go live in September of 2025.

In the interim, we have reviewed our internal complaint management process and have formalized this process to ensure that complaints are documented in a timely manner. We have also improved information management processes to better enable trend analysis of complaints received by the department to inform policy and quality improvement initiatives.

Once the standards are implemented, we will then be working to make more information available to the public online. While licensure status is currently available online, we are looking to make inspection results and non-compliance publicly available. We have been engaged with the OCIO on this and again, once the standards are live, we can look at making as much information as possible publicly available, as appropriate, and I expect that to be completed again later on the fall.

Just as an aside, we are looking at using the AMANDA system. I think some of you might be familiar with that from DGSNL as well.

Again, thank you and happy to answer questions that the Committee may have.

CHAIR: Okay, thank you.

I'll now call upon the CEO of HL Services to bring opening remarks.

P. PARFREY: I just echo that we are fully aligned with the Department of Health and Community Services and how we go forward in ensuring that these recommendations are acted upon.

As regards to policy, we definitely support aging-in-place, which includes home supports and personal care homes and recognize that there are 4,400 people in personal care homes. Many like it, but the Auditor General has identified problems with personal care homes across many parts that we agree with.

NLH Services has got responsibilities for our case management for monitoring standards and for licensing and problems are identified with each of those pieces. The three major strategies that we want to embark upon, that will help meet those issues that have been identified, include one that John has brought up, which is updating the standards, identifying how to monitor those standards.

The second one is how we bring about change across over 90 personal care homes that exist in five zones of this province. We have taken a provincial approach to this and already announced that we will have a strategic health network, provincial in nature, chaired by Craig Davis who is the VP for Central zone. This will bring together several people that are responsible for evolving what's going on in the community and in long-term care facilities and personal care homes. We'll take responsibility for the evolution of meeting the recommendations of the Auditor General.

On top of that, we have a Health Transformation Sub-Table, which contains people from Health and Community Services and from this network to ensure that we are aligned – the department and NL Health Services to ensure that we get improvement in these areas that the Auditor General has identified.

I think it's important to state here that there is a conflict for us in terms of the pieces that we are responsible for. We are responsible for the case management. that's not going to change, but in terms of monitoring and licensing, we favour a third party to be able to do this.

Certainly, the recommendations that have been specifically identified around food and staffing, licensing, resident assessments and quality control will be enhanced by our

provincial approach and by the strategic health network and the Health Transformation Sub-Table. We would expect that action can take place in all the zones of the province as a consequence of having this provincial approach.

Thank you.

CHAIR: Thank you.

With that, I guess, we'll start with questioning. I now recognize the Member for Mount Pearl North to start with the questioning.

L. STOYLES: Thank you, Chair.

Again, thank you everybody for coming and being here for the hearing today, especially to the Auditor General and her team for doing such an outstanding job on this report. When we look at the report, as me and I'm sure all of my colleagues, we certainly found when we received the report how, I guess, disturbing it was to families, especially families who have loved ones in home care and in nursing homes, and especially if they have nobody that belongs to them. If somebody has loved ones and they're visiting every week and they're monitoring and checking on them; the biggest concern I have is people who don't have any family members to go to visit them and they're left there with just the staff and that to look after them.

So, I guess, the main thing that stuck out to me was the report on the meds and how the carts are left in the hallways, sometimes not fully locked up and that. I know you've already looked at the report and accepted all the recommendations in the report. That sounds great now for us sitting here this morning and listening to what you're going to do, but when we look at the report in 2015, hardly anything changed, actually. If anything, it got worse than it did in the past.

What will make people feel their loved ones are being looked after? What guarantee are you going to look at more supervision in homes and more criteria for the homes to be monitored more?

I'd just like to hear what your response is on that.

P. PARFREY: Clearly, what's necessary here is to have the standards put into the public arena, those standards accepted both by Health and Community Services and by NLHS and by the personal care home industry themselves. Then the metrics that would be associated with monitoring those standards would be important and the capacity to centralize that information for over 90 personal care homes in five different zones and to be able to ensure that there is action taken on the deficiencies that have been identified as a consequence of that monitoring.

We feel that the number of human resources that were available to do some of this work was probably inadequate, but we think that by taking a provincial approach we'll do a better job at being able to ensure an accountability structure.

Previously, this accountability structure didn't go through to the CEO of NL Health Services; we had four regional health authorities. The change in the structure allows us to be able to say that the NLHS is actually accountable right through the system to the CEO.

So that accountability structure, together with the network and the health transformation table, I do think will ensure better action at the delivery side.

L. STOYLES: So on the inspections end of it, I mean, I know we have a lot of homes and we have over 4,000 seniors in those homes, I'm just wondering, the inspection part of it, how are you going to monitor that? Are you going to look for a third party to look at that as well? Because when you look at, I'm going to say, the restaurants and how they're inspected. Are there going to be

fines? Are you going to look at putting fines in place if somebody is non-compliant? These issues are really serious. Are you going to look at fining some of these homes if they're not compliant? What's the plan moving forward?

P. PARFREY: I just think that in principle, NLHS will prefer to have a third party do the monitoring and the licensing, but I'll pass over to Deena Waddleton to respond to that as well.

J. MCGRATH: (Inaudible.)

L. STOYLES: Just wave. The system is really slow because we have a new system in place and when we've been doing our Estimates and everything, sometimes when you wave it doesn't come on right away. So bear with us if you're light doesn't come on right away.

J. MCGRATH: So I think first and foremost, as I said, we have accepted all the recommendations from the Auditor General. I think a large part of it is to put the new standards out there – not new standards, but the refreshed and strengthened standards.

There's been a lot of work that went into them. As you know, we had an expert panel that gave us advice and recommendations on personal care homes and long-term care. So that now has been integrated into those standards. That review has been completed and, as part of those standards – and I think this kind of speaks to getting at what your question is – is that there are going to be robust, key performance indicators in there.

When it comes to inspections and things like that – and I'll let Deena speak to specific on that – we have put in place other oversight mechanisms. We do now have one provincial health authority and I think some of the comments here in recommendations from the Auditor General report was, kind of, you had four different health authorities, four different sets of policies and that'll now come together as one provincial approach.

As Pat alluded to, we do have a strategic health network now with one vice-president responsible for this sector now across the province. I think there's a lot of alignment, and that's going to really strengthen oversight and also operationalizing these types of things.

With the specifics to your question, I'm going to let Deena speak to the inspections piece.

D. WADDLETON: Thank you.

I think it's important to note that the NLHS does do a lot of monitoring in this sector already. There are definitely opportunities identified to strengthen that process and to have it more consistent provincially, as was noted in the review. There are a lot of indicators that are already reported from the operator to NLHS, but one of the things that we have done in the revised standards is to really look at how we're using that information to inform licensing and to look more holistically on the performance of each personal care home during the relicensing process.

So really looking at key indicators and identifying what those could be in terms of evictions, how many individuals are being sent to acute care and those kinds of things to really inform the strengthening of the licensing process.

A new quality assurance framework has been developed as part of the new operational standards, and we really feel that this will strengthen the process that is already in place. Another action, I think, that will address some of the concerns that have been raised is to have some guidelines for NLHS in their work, when they're doing their reviews, that there is more provincially consistent approach to, basically, determine

when sanctions could be imposed in a more consistent manner.

L. STOYLES: Thank you.

We all have so many questions concerning this report. Some of the things that stick out to me, of course, is staffing issues. I'm wondering if the homes are able to find the quality of staff that's needed. Because in the report there was a lot of talk about some of the staff weren't qualified and didn't have their vulnerable-sector check done and a lot of stuff like that.

I'm just wondering if you can elaborate on that for me.

P. PARFREY: Well, I don't think I can elaborate more than what we've previously said that we're trying to change the system in terms of getting an evaluation of the important things that are related to personal care homes, insofar as we measure those important things that have been identified in that when we see problems, that we act upon them and that there's an accountability structure that's provincial-wide to ensure that we act upon them.

L. STOYLES: So you've indicated that you're looking at a third party. Is this something new or have there always been a third party –

P. PARFREY: No.

L. STOYLES: – that did this work? I'm just asking a question.

P. PARFREY: No, the situation has been that NLHS – well, in the past the legacy regions were responsible for the homes in their region. Since NLHS has come together, those legacy regions are now one provincial health authority, and that's actually a change that allows us to have a provincial approach which is really necessary because there are likely to be different problems in different regions and we need to have one way of being able to assess what's going on and we have to have a way of being able to have an effect when there are divergents from these policies.

Currently – and this will have to continue until such time as there is a third party – NLHS is responsible for not only monitoring, but then mitigating the adverse things that they find. There is a conflict, because they're in there doing their best to manage the patients that's in the personal care home and need to be able to ensure that that patient continues to get the appropriate care and then making a decision around licensing is, to me, a conflict of interest.

So the department and ourselves have been discussing the need for a third party to do the monitoring and the licensing, but the solution to that has not been identified yet.

J. MCGRATH: With regard to your question on staffing – and I know it's one of things in the report that was identified was that the qualifications of staff and vacancies of staff in the personal care home sector. Part of that – and I can let Deena speak to it, give specifics – is that the qualifications of staff have been strengthened in the new revised operational standards.

We've also been having conversations with the personal care home industry about, kind of, what additional education, what additional training those staff require, how do we strengthen that moving forward. Because I think that was something that you had mentioned that did come out of the report.

So that is top of mind for us; we have had conversations with the industry to say what can we do to help strengthen training, what can we do to also help with recruitment, even though they're not really our employees, but how can we assist.

CHAIR: Thank you.

The hon. the Member for Labrador West.

J. BROWN: Thank you, Chair.

Under Recommendation 7: "Newfoundland and Labrador Health Services should ensure personal care home staffing levels are appropriate, that staff have satisfied hiring requirements before starting their employment, and that staff have the necessary training to comply with all aspects of the operational standards."

So this recommendation, I'm asking, when it comes to hiring standards and stuff, there was some stuff identified in the report about appropriateness of staffing, training, and recommendations and requirements. With these standards, how does NLHS start to address the training levels, making sure that there are appropriate people trained to do appropriate things? I know there were incidents where first aid wasn't available to train the people and there were different job requirements that they weren't properly trained.

What is the go-forward now with NLHS on this?

C. DAVIS: Thank you for the question.

As a go-forward, and as the CEO has alluded to, we now do have a strategic health network and a provincial approach for personal care homes and long-term care. So one of the things that we are starting to do within NLHS, working collaboratively with the department, is really look at doing a gap analysis of the training and the staff education for the individuals in the personal care homes, seeing where there are opportunities, I guess, to improve that orientation and training for those individuals and then being able to roll out a provincial, standardized approach to training for all the individuals that work in the personal care homes.

J. BROWN: Thank you.

Given that there were some significant gaps in the AG report, will the province be helping get these individuals trained to a standard that is acceptable, or are we going to leave it to the personal care homes to hopefully pick up that slack? Given some of the ruralness of some of these homes, are we expecting some of them to send staff outside of their regions to train? Are we going to train them in-house?

What's the vision here on making sure that people in care have standard care no matter where the home is located?

J. MCGRATH: I think for the staff that are Newfoundland and Labrador Health Services employees, we would provide assistance, and we would provide additional funding. For example, one of the things that came out of the report was that there was a backlog of the ability for reassessments, so we did provide funding for 17 new positions that are being hired to kind of address that issue.

When it comes to personal care home employees, those are governed through the standards. Like I said, those have been revised, and we also provide subsidy to them as well. There was a significant investment there, I think it was a couple of years ago, to increase that subsidy, and part of that would be a wage component as well.

For the specifics of what's in the standard when it comes to employees, I'm going to hand it over to Deena as well.

D. WADDLETON: Thank you.

Just in respect to your question around education, there are some educational requirements in the existing standards, and I think there's opportunity to make sure and strengthen, through the monitoring process, that those are met.

We also have been working to develop an education strategy for personal care home workers, as well as home support workers. The scope of work of employment is similar,

so we're using the same approach. There has been a curriculum that has been developed and has been provided to training institutions for their review. We have feedback from that. It's been incorporated, and we anticipate that those programs would be available in the fall of 2025.

We have also been working with the department of immigration, population growth and skills and with Keyin College for work on a micro-credential course. So that is a 40-hour course. When it's developed, it is virtual. So we are trying to be cognizant of the needs of people who work in rural communities, and Keyin College has been very flexible in the approach. Programs are being offered during evening.

We are treating this as a bit of a demonstration project. There are almost 1,400 people who have registered for this program, and we are going to look and see the outcome of what their experience has been to help inform our next steps on educational requirements for the sector.

J. BROWN: Perfect, thank you.

Given that there are homes that have people working in them that do not meet standard and do not meet current criteria, how does NLHS intend to address the non-compliance issue with that? There are some people who don't even have first aid. There are some people who don't have these things that are in some of these homes and stuff working right now. What is the plan now to address that?

You have a course, you have all this, all that, but right now there are people who are working in these homes currently that don't have all the necessary training. What's the plan to address this non-compliance?

J. MCGRATH: Thanks.

As I said, the first thing is identifying all those staff who do not have the requirements, as you mentioned, and then working with the staff, the operators and with our staff, if it's training that our staff can provide, or then also working with the operators to identify opportunities for their staff to get the necessary training such as first aid, as you mentioned.

For us, from a provincial lens, it's really identifying now provincially where we do have all those gaps in education and training and to work then with the operators and the staff to up-train them to ensure that they do meet the standards as outlined.

J. BROWN: Perfect, thank you.

Given that there are others training, like food handling, things like that currently, where is the department going to go, I guess, going forward to make sure that these kitchens and stuff that do provide that sort of thing are going to be also brought up to meet the standards? Once again, I put a rural lens on it, a lot of these homes that in rural areas of this province, what are we going to do to make sure to bring those standards up and also make sure that the people who are working inside those facilities are also properly trained and meet provincial standards, even like Atlantic Canadian standards when it comes to food preparations for seniors?

D. WADDLETON: Thank you for the question.

I think in terms of training in the sector, with respect to what's included in the new standards, we have identified specific training that is required on orientation and the new standards also do include the frequency of when retraining is required.

For example, with medication administration – I think there was a question on that earlier – we do require that this would be done every three months. With the revised standard, there's also a training module that has been developed and will be shared with operators.

We also are requiring personal care home operators to have their staff attend any in-person or any training that's offered by NLHS. Specifically for food safety, that is under the purview of digital government and Service NL – the new name, Government Modernization and Service Delivery.

So that is under the preview, but we are working very closely with that department. Under the memorandum of understanding we have regular meetings with the department, NLHS staff and DGSNL to talk about some of the operational challenges that both are facing in their role with inspecting and monitoring personal care homes.

But DGSNL would be responsible for the food safety, specifically.

J. BROWN: Perfect.

My one final question here is on top of food safety is also the food nutrition side of things. So where does the department, with the standards moving forward, about making sure the nutritional value – these are health care facilities – make sure that they are also meeting that standard as well – there's food safety, but there's also health safety and health standards for nutrition value.

What's the work being done there with the standard?

D. WADDLETON: The operational standard does require operators to abide by Canada's Food Guide, in terms of food quality. There certainly have been some concerns and it is a common area of concern for people around food quality.

Certainly, we recognize in settings of potentially up to 100 residents that there would be various – trying to please everybody is difficult, but there's also balance to achieve in terms of individuals wanting to eat the food that they want at this point in their life and having choice.

Part of the long-term care and personal care home review, in addition to the Auditor General review, as John mentioned, there are a number of recommendations arising from that review also with respect to quality of life for residents in long-term care and personal care homes. Food and food culture, food safety, quality of food and choice and dignity for residents are really embedded in that recommendation.

So we'll be doing some work specifically on a quality of life framework. This will be included within there. But right now personal care home operators are already required to abide by Canada's Food Guide.

J. BROWN: Thank you.

CHAIR: Thank you.

The hon. the Member for Cape St. Francis.

J. WALL: Thank you, Chair, and thank you all for being here today.

The Auditor General released her findings into specific categories: Program Delivery, Licensing, Resident Care Assessment, Operational Standards, Program Oversight and Compliance.

Could you please go through each of those areas and outline who is responsible, either the department or NLHS?

P. PARFREY: Ultimately, I think they translate across both NLHS and Health and Community Services; we have to be aligned. The Auditor General has identified food, staffing, licensing, resident assessments and quality control as specifically the responsibility of NLHS, but we also believe that we have a need to be involved in what responsibilities that were attributed to Health and Community Services as well because they go across both the structures.

I think that our discussions with Health and Community Services have demonstrated

that; we need to have that alignment and our structures that we want to put into effect going forward demonstrate that we have to be aligned as well. Both the policy side and the delivery side need to be aligned. I think that we can undoubtedly say that is the case.

J. WALL: Thank you.

So with respect to either the NLHS or the department, does each have a specific person or persons who has responsibility for the implementation of the recommendations?

P. PARFREY: We've already identified Craig Davis, who is a VP on the executive committee of the provincial health authority as being the primary person responsible for the issues that arise at NLHS. There's already been a decision to allocate a senior director and allocate a director to his portfolio. When we use the term strategic health network, this is a provincial structure that brings together the skill sets of the various zones in such a way that we're able to create a provincial policy, and that we're actually able to implement that provincial policy across the five zones.

So the structure has already been established, there's been discussion about the staffing and the staffing is in the progress of being put into place. Then the connections that are necessary across the zones are there. There are already directors responsible for our personal care homes in each zone, but the key piece is that we have a provincial approach that has equity in the way that these recommendations are rolled out.

J. WALL: Thank you for that.

Since this report has come out, there has been a new Department of Seniors created. So I'm looking for anything with respect to involvement that the department has regarding personal care homes and long-term care.

Does that involve either NLHS or Department of Health and Community Services?

J. MCGRATH: I can certainly speak to the role of the Department of Health and Community Services, and I'll let Justin speak to specifics on the role the minister and the role of Newfoundland and Labrador Health Services has as well.

At the Department of Health and Community Services, we will be responsible for oversight of the program and we're also responsible for updating the standards and the policy as well. As we did say in the recommendations, that those standards – there has been a comprehensive review done of those standards. That is scheduled to roll out in September.

As for the role of the Department of Seniors, that's really a kind of a government decision with the long-term care and personal care home, the operating piece of it, is with the health authority and the policy and the oversight is generally with the department.

With that, I'll let Justin just give an overview of –

J. CAINES: Under the *Provincial Health Authority Act*, the Minister of Health and Community Services is responsible for setting standards and providing general oversight to the provincial health authority. Under provincial health authority regulations, NLHS is responsible for the administration and delivery of health and community services, which includes continuum in long-term care and those pieces. So they'd be responsible there.

We also have the personal care home regulations which are under the *Health and Community Services Act* that sets out the responsibilities for licensing, relicensing with NLHS as well as with DGSNL for certain components of that. The Minister of Health and Community Services is responsible for setting standards, guidelines and policies.

I think, to John's point, the oversight from a policy-standard guideline perspective rests with the minister. The operational pieces either with NLHS or DGSNL is outlined in the various regulations.

J. WALL: Thank you.

Just as a follow-up to that, as you are aware the Seniors' Advocate released her report this week where she called for the Department of Seniors to have greater oversight in this role. I'm just wondering, in your respective roles, do you agree or disagree?

J. MCGRATH: I think the minister commented last week when that report came out that she is reviewing that report and I'm sure she'll be speaking to government policy on that.

J. WALL: Thank you.

I want to get into the evictions from personal care homes Unfortunately, I'm dealing with a situation now with a constituent in my district who was brought to the ER for whatever needed to be done and the family was told by the staff at the hospital that he wouldn't be returning to the personal care home and was not given any notice of eviction, any heads up whatsoever. The gentleman left on a stretcher, with ambulatory services, with the clothes on his back and his cellphone in his pocket.

I find it very, very frustrating and very disturbing that that can happen to a loved one. My question is, what work has taken place or will take place to prevent evictions of seniors by simply dropping them off to our emergency rooms?

J. MCGRATH: That has been addressed in the new standard, and I will let Deena speak to the specifics on that.

D. WADDLETON: With respect to evictions, I guess there are really two pieces there. One is evictions when an individual, a resident, is causing some challenges for operations of the home. We did develop a new operational standard which had been implemented in 2019 to address the process that should happen when evictions occur and, basically, to outline the conditions under which an operator may be able to do an eviction and the process and the work that they need to do with NLHS in order to ensure an appropriate transition plan.

With respect to evictions, again, there's sort of two pieces. One can be when the care needs of an individual, of a resident, have increased and the operator sometimes feels they can't manage that. There are cases where individuals are transferred to acute care. We only consider that an eviction when the operator refuses to take the person back. If the health team at the acute-care site does identify that the needs are too great and it's no longer safe for an individual to return, we don't consider that an eviction. I just wanted to make that point clear.

There are cases where the team does feel that a person could safely return to a personal care home; however, the operator might refuse to do that, to take the person back. To help address that, we have been working, through our Home First philosophy and approach, to make extra resources available for personal care homes to help support them when they are providing care to individuals with higher care needs.

So, certainly, we do support an aging-in-place approach. Individuals, as their care needs increase, are exceeding the regular capacity of a personal care home to provide care for them, and we have, again through Home First, provided guidelines to NL Health Services in order to put in place additional things to support the resident. This could be additional hours of care that are added; it could be different equipment that an individual might need; it could be access to a private room for individuals who have behavioural concerns that are not

managed. So there are some things like that that are happening.

We also have increased the subsidy rate. In recognition of the care needs when an individual's care needs increase, there are additional hours of care that are already included in the higher subsidy rate, but the funding is higher for enhanced care residents and for residents with level three care needs.

So all of those initiatives, we're trying to support the sector better and to make sure that the needs of individuals are being met when they increase.

J. WALL: Thank you, Deena.

Chair, my time is expired, so I'll look forward to my next allotment.

CHAIR: Thank you.

The Member for Lake Melville.

P. TRIMPER: Thank you, Chair.

It's always an honour to have an opportunity to participate in an inquiry such as this and see what we can do to improve the situation in our province.

Let me start first – I'm trying to figure out which way to go. I'm going to start first with, I'm wondering what kind of feedback the department and/or NLHS might have received as a result of the Auditor General's report. I spoke to the Auditor General earlier. We were tracking our own kind of feedback. Obviously, a lot of serious conclusions, recommendations. I wonder if you could comment on the nature that you might have heard from the public and/or others.

P. PARFREY: Clearly, there's a congruence between the report that the Seniors' Advocate provided on the quality of care and quality of life in long-term care facilities and the Auditor General's report around standards that are present in those places.

I think that, in this province, we do have a major challenge in that we have the society getting older; a quarter of the society is 65 years and older, and it's going to get worse. We have urbanization occurring, which means that younger people are leaving rural communities and the capacity to look after people is diminishing and we have a community sector that's in the process of change which has only started.

By that I mean Family Care Teams with a focus on people who are fragile and trying to prevent them from going into institutional care; a focus on aging in place, or aging at home or aging in place, whichever is preferred by the individual. We have one of the biggest spends on home supports and personal care homes in the country; nonetheless, it's not able to meet the need that we've got, and it's all going to get worse.

We have a major challenge in trying to make those community things work to prevent people from going into long-term care facilities and they're not yet mature. Hopefully, over the next number of years, those efforts in care of the elderly: geriatric programs, outreach of geriatric programs into the community and into the Family Care Teams, the development of care, the elderly family physicians and the development of community paramedicine to be able to provide resources that would prevent people from going into acute care hospitals and requiring care in the emergency rooms that are already overworked and going into beds that we don't have, actually, when all is said and done.

So unless we get an approach that allows us to be able to have improved community care to prevent these types of pieces, it will all get worse.

There's a lot of work ongoing in the community that hasn't yet reached fruition,

which I hope will reach fruition. There is going to be a requirement to be able to put more resources, I think, into the community side, to be able to prevent these admissions into acute care.

I'm making those comments to say that we have a major challenge in this province and we're at the pointy end of it. Other provinces don't have that challenge, as of yet, with the number of people that are over the age of 65.

P. TRIMPER: So in terms of the feedback you're getting – and I must say I consider myself one of the biggest fans of your work and that of Sister Elizabeth, the Health Accord, what's happening. I'm glad that I've had the opportunity to serve during this – I don't want to use the word turbulent time but I think it's the change that is needed and the future will be better if we can allow it to happen.

I just wonder how is the public feedback you might be receiving as a result of this effort, this particular effort? We certainly saw some in the press. The Seniors' Advocate, as you indicated, has come out quite strongly in a very similar way. Just wondering what that feedback – do you feel that the public is getting it? Are they understanding?

I'll just add to that point. We recognize amongst ourselves in the PAC the confusion that's out there between the role of Level 1, Level 2 care versus 3 and 4; the province, what we're doing here with the privately operated homes and so on. Let me just say, it's challenging for someone in elected office, and in your role, senior heads of these departments, to be able to communicate exactly what is going.

Do you feel the public is getting there? What kind of support do you feel you're getting?

P. PARFREY: Well, I don't have any objective data to tell you whether or not the public support it, but I think that's what Ms. Doyle said about the concern of the public for what's going on in personal care homes and probably in long-term care facilities is undoubtedly true. We use the term construct validity, which is: Are the ideas expressed by these types of discussions that we're having, is that what you'd expect?

I think that we would expect strong support for what the Seniors' Advocate said around quality of care and quality of life and what the Auditor General is saying around ensuring that there are appropriate standards for personal care. I think that would be inherently the outlook of the population, but I don't have any objective survey data to see whether or not they support us.

P. TRIMPER: I'm going to give you part of the answer to my next question because I deal with it often. It's not widespread but I certainly welcome the collapse of these regional health authorities into the entity we have. As a representative in Labrador, and I look to my colleague from Labrador West, four of us frankly, we feel a lot of that Labrador Strong, what are we doing type of attitude. However, I see the errors of what was done years ago, and I welcome where we're going.

That said, I'm still perplexed as to how some of the recommendations from 2015 remain outstanding. How did we miss that? How did those not get followed through? Some of them are tied to the RHAs, but, nevertheless, in terms of that transition, I wonder if you could speak to what progress was being made, the whole status. To me, that jumped out right off the bat when I heard from the AG.

P. PARFREY: I'm only in the job for 3½ months, I can't speak to 2015, but John might be able to.

J. MCGRATH: I can certainly provide some context that might be helpful.

I think back in 2015, there was a recommendation, certainly from the

department's perspective, was to get the standards revised. The recommendation was to do a comprehensive review of the standards. I know that – I wasn't around then – work started back in 2015. There were a number of things along the way that kind of, I would say, derailed that work. One was the pandemic, which we talked about before.

So, all of a sudden, the focus from the department turned from revising the standards to more into the operations of long-term care and personal care homes with the seniors division. That was largely successful; we did have a successful response to the pandemic.

Coming out of that, the minister of the day then commissioned an expert panel on personal care homes in long-term care. So we do have that report now. I think that took about a year and a half. There were experts who did their work and we wanted to make sure that that feedback and those recommendations were put into place for the revised standards as well.

I would say, though, I think one of the things that has happened is that, when it came to the standards, we didn't just kind of wait until now. There have been standards released as well. I can certainly have Deena speak to those. But I think there were six or seven standards released in the interim. There were other pieces of procedures and other documentation as well as we went along that period.

But again, that's just to provide some context, MHA Trimper.

P. TRIMPER: If I may – and I'm just watching my time – I want to make a point and have you respond to it, but having had the honour to serve as minister for several departments and walking in each time, I know one of the first questions I had asked of staff around me at that table was, what current obligations do we have? What's outstanding?

I guess I'm trying to get to, frankly, the role of the Auditor General and the work that's been done past. Are departments taking them seriously? Is this a priority? As you say, some of the things have gone on, yeah, we can point to them all – and I don't want to be sarcastic, but I just want to say it's not like we're painting a picture. We're objectively trying to implement a structure policy oversight into the supervisory role that we have in personal care homes.

J. MCGRATH: I think by and large, yes, I certainly do and I know the department does take those recommendations seriously. Certainly, when it comes to this report and every report, we have put together a fairly detailed action plan that I think has been circulated to the Committee. As part of that, there were specific accountabilities assigned to each one. There are specific target dates for each as well.

I think that action plan should demonstrate our commitment to that and certainly the department is fully committed to meeting each one of those targets in a timely manner. I can't speak to really 2015 per se, but I can certainly say that there is a commitment moving forward with this report in particular, and some of the actions that we've taken, such as putting in place a strategic health network with Newfoundland and Labrador Health Services assigned this, as you alluded to, taking a provincial approach and having one vice-president responsible for this now instead of four or five different zones.

These are kind of tangible things that we've done. We've got a lot of different guidance, I would say, at our fingertips now with that long-term care and personal care home review as well. There are a number of recommendations in there. I think, over the next coming – specifically with the AG, there's an action plan in place for sure to address those recommendations. By and large, from a policy perspective, we do have that expert report on personal care homes

and long-term care and there are a number of recommendations in there as well that we've accepted those to move forward on as well.

P. PARFREY: I think that it goes without saying – and I shouldn't need to say it, but this is an important area. We definitely believe what the Auditor General has said to us. The data supports what she said. We've taken action already to ensure that we have accountability, and that the accountability stops at the CEO's office.

There is a change in that environment already, and I think that we are serious about trying to ensure that these recommendations are acted upon. I would also say that goes for any other things that the Auditor General has in her sights, that we will be serious around trying to implement the recommendations made.

CHAIR: Thank you.

Getting back to the operational standards – and I appreciate the role of the CEO for only a short while. In the action plan, the Auditor General did state for the revision of the operational standards and it says here that the standards are drafted. But those standards in the Auditor General's report have been drafted since 2022. This is 2025; why have those standards not been fully implemented?

J. MCGRATH: I think there are a couple of things. Since that time, an expert panel commissioned a report on personal care homes and long-term care, so we wanted to make sure that information, those recommendations, were encompassed in those standards as well.

There were also standards that have been issued in the interim while that comprehensive review was ongoing.

CHAIR: Okay, thank you.

Since 2019, how many residents in personal care homes have died where negligence or mistakes may have been a contributing factor?

J. MCGRATH: We don't have that information on us here at this time and, depending on the numbers, there might be personal health information impacts as well with regard to disclosure. So I can certainly take that away.

CHAIR: Okay.

In those cases, same thing, when a child dies in care of government, a review of circumstances is automatically triggered. Does something similar happen when a senior dies in a personal care home?

J. MCGRATH: Yes, that is considered a serious incident. There is a protocol that is in place, and I'll let Deena speak to the specifics of that.

D. WADDLETON: When there is a serious incident in a personal care home, the personal care home is required to report to NLHS on the serious incident and the details surrounding that. NLHS is also required to report to the department, and we've provided guidelines for the information that is to be included in the serious incident report.

We have recently strengthened that process and have issued a form that NLHS is to complete with all the details surrounding a serious incident. When there is the potential for criminal activity related to a serious incident, there is reporting to appropriate entities with respect to that, and then they would make a determination of whether or not there would be an investigation.

When there is a serious incident, NLHS does a review of the circumstances surrounding that incident, makes the determination of whether or not the home was in compliance with the operational standards with respect to that incident or

other incidents and that information is also reported to the department.

There is often learnings or information that becomes available following that review and there could be corrective action plans that are point in place for operators so that they would avoid incidents from happening again.

It is about quality improvement and identifying opportunities to make sure residents remain safe. In many instances, there are issues that happen in personal care homes that are not due to negligence of operators. NLHS does that review and makes the determination of the follow-up that's required. Sometimes it's education to staff that would help support quality improvement.

CHAIR: Okay, thank you.

The AG raised specific examples where someone died as a result of a mistake. How many investigations into specific circumstances have been completed?

D. WADDLETON: All of the serious incidents that happened are investigated. With respect to the ones where individuals died, they were all investigated as well by NLHS and/or police were involved, where necessary and where appropriate.

I don't think we can really speak specifically around the conditions associated with each one but just that they were reviewed appropriately.

CHAIR: Thank you.

I know it was referenced with regard to evictions and ERs earlier, but in what circumstances does someone not return to a home after being transported to an ER?

D. WADDLETON: So if an individual, their health may decline and they have an emergency department visit and maybe they're admitted. Individuals who no longer would meet the eligibility criteria for a personal care home. Residents who require regular two-person assist, so basically have very high physical care needs would probably not be able to go back to the personal care home, even with extra support, because there are requirements from digital government and services NL around the ability to evacuate. It's a fire, life safety concern, for example, with a resident like that.

In some cases, the residents with advancing dementia, the behavioural concerns may be too great. They could be an increased risk of elopement, so basically leaving the home. These are not secure spaces and there's not always the ability to monitor the safety of residents with increasing dementia and risk of leaving the facility unsupervised.

Those are some examples of where returning to the personal care home might not be possible.

CHAIR: So when that happens, what signifies to that point? If someone got rushed to an ER today and they weren't going to accepted back, wasn't there an assessment or a reassessment done on that patient? It just doesn't happen now today. This must have been ongoing.

Wasn't there an assessment done prior to that for that patient or person to be elevated into long-term care or some other program, rather than just going to an ER and being we're not taking you? What happens here?

D. WADDLETON: I think provincially we do have a number of individuals who are waiting in personal care homes for placement into long-term care. There is a bit of wait-list to enter into long-term care. As I said earlier, NLHS is supporting the personal care home sector to try to support people in the personal care home setting, but sometimes that's not possible. Sometimes it is a result of a fall or some other acute episode that happens with a

resident that would precipitate an ED visit and an admission.

Circumstances can vary for different individuals and we do have, in the operational standards, the requirement to follow up more closely on individuals in personal care homes with higher care needs.

CHAIR: Okay, thank you.

Has there been any sanction or reprimand for employees within the department following the release of the AG's performance audit?

J. MCGRATH: In the Department of Health and Community Services?

CHAIR: Yes, within the department.

J. MCGRATH: No.

CHAIR: Okay.

Have those responsible for oversight, which the audit noted significant concerns about, been retained in their position?

P. PARFREY: I can't answer that.

CHAIR: Okay, thank you.

If a personal care home does not meet standards, their licences may be suspended. If this occurs, what happens to the residents?

D. WADDLETON: When there is non-compliance that is identified, it's always an approach to try to correct the actions. So a corrective action plan is in place. Where a home is not working towards meeting compliance, there can be progressive sanctions that are put in place, for example a hold on admissions.

If it comes to the point where the licence is revoked, then NLHS will work with the residents to transition plan to other settings, to other personal care homes, to maybe home with family with home care, various pieces.

So there is a transition planning process that is in place to support that where necessary.

CHAIR: Okay, thank you.

The hon. the Member for Mount Pearl North.

L. STOYLES: Thank you.

I know it's going to be a long morning answering questions, so bear with us a bit longer.

The Members and some of my colleagues had talked about people waiting for beds in long-term care. Is the biggest issue that the department is finding is that there's not enough beds in long-term care so the residents are staying in personal care homes longer than they should be, and how many patients are in personal care waiting to go into long-term care?

I just look in my district, in Mount Pearl North. I have three nursing homes, three personal care homes in my district, and I'm in all of them on a regular basis, visiting seniors and helping them out. I have some that want to move, want to go back home, the odd one have spent their lifetime in their home and don't want to stay in a personal care home. After they've been there for several months, they felt that they got better and want to go back home.

I'm just wondering if the biggest problem is we don't have enough long-term care beds. Can you respond to that?

P. PARFREY: We're in the midst of a change in approach – I'm talking also as a province – insofar as the public and many others believe that we should have an aging-in-place policy for seniors. That aging at home with home supports is a preferred

solution to long-term care. Similarly, the use of personal care home facilities in places where the people are would be a better solution than entering them into long-term care facilities that are distant from their home.

At the present moment, the long-term care facilities are 98 per cent occupied, so getting in is hard and there's a long wait-list. It contributes to alternate level of care within acute care hospitals and the consequent difficulty we have of being able to provide acute care in various ways across the province occurs in St. John's and Gander and Grand Falls and Corner Brook and Clarenville and Happy Valley-Goose Bay.

The predictions of the need for long-term care beds are that there is a need for more long-term care beds in the province over the next number of years. At the same time, there is the belief that if we provide more appropriate community-based care and more appropriate support, a better approach to aging in place, that we won't need as many long-term beds in the future.

At the present moment, I think that's not the truth. I mean, we need long-term care beds. I think the stay in long-term care facilities has decreased over time as we've matched appropriateness with entry into the long-term care facilities. I think that's actually pretty good. In terms of prediction, in terms of matching appropriateness to transfer to a long-term care facility with various standards, we rank pretty high in the country in terms of doing that appropriately.

The average length of stay is 20 months in the long-term care facility. You can work out from the length of stay and the number of people coming in how many beds we actually need.

It is a difficult policy arena at the present moment to build long-term care facilities that you'd have for 40 or 50 years in an arena where the demographic of increasing seniors is going to happen for another 10 or 15 years, then it will flatten out and decrease, and where we've got an objective of trying to create better facilities and better programs in the community to prevent admission to long-term care facilities.

That's probably a complicated answer to a simple question.

L. STOYLES: No doubt, it's sometimes never simple, some of these questions and answers are never simple.

What I'm hearing is Alzheimer's, especially, we seem to be getting an awful lot more people diagnosed with Alzheimer's and there are not enough locked units. They're in personal care homes staying longer than they should be because to send them in another long-term care without a locked unit, they're staying in the personal care homes, and they shouldn't be in a lot of cases. I'm just wondering if that's a major issue with the department.

P. PARFREY: There is a pilot study going on in two personal care homes around management of dementia patients, and maybe Deena might like to mention them.

D. WADDLETON: Yes, so we are doing some work with the personal care home sector around looking at how we can support people to age well at home, like Dr. Parfrey mentioned. That is what we understand that the public wants and it's what we're trying to further develop in the province.

There is a project for a personal care home in Paradise where we have a 20-bed unit developed there that is a secure space. Those are individuals that all have moderate to advancing dementia that are being cared for in that setting.

What we have found is that while we are doing quite well, as Dr. Parfrey indicated, in terms of the type of client that is going into long-term care, we did identify that there are some people that are probably being placed

earlier than necessary with dementia because we do not have enough community spaces that are secure. So this pilot project, we've just had a year that it's in operation, and we've just completed the evaluation with very good feedback, excellent feedback in fact, from the families of the residents who've been involved in that setting.

We've been able to actually have some discharges from long-term care into that setting. So those are all individuals that would be in long-term care. We have 27 people who went through that project over the last year. All of those would be in long-term care had that project not been in place.

We are ready now to put forward some recommendations for the potential for what the next steps might be with that project. That is being reviewed now by government.

L. STOYLES: So the public wouldn't be aware of this pilot project, I'm just wondering, you know, because the people out there need to know what the government is doing and if these facilities are put in place under pilot projects and are working, is the government looking at having more of those facilities open in the future?

J. MCGRATH: Yes, I think that, given the success that we've seen with that pilot program, in particular, I do expect that we will work with the industry to expand that, and that will be communicated.

L. STOYLES: Okay.

In the AG's report, under the Key Findings under operations, it said in 2007 there wasn't a lot of stuff completed and regulations weren't monitored, but then in 2022, new standards were put in place. My colleague asked the question, but the question I have is similar: Are these the same standards?

You talked about, you have new standards and that, is the new standards you developed the same standards that were in place and not put in place in 2022 or are there new standards that was just developed since the AG's report came out? Am I explaining that right?

J. MCGRATH: I think so.

I think that the standards in 2022, there were a number of things since then. For example, I think there were long-term care national standards that came out since that time as well and there has probably been national work done around those. That feedback has been incorporated into these revised standards. We've also commissioned that report from personal care homes in long-term care from that advisory panel. So that feedback has been put into these standards as well. So I think it's building on those standards. In the interim, we did issue standards, when warranted in the interim.

I think to answer your question, if I'm getting this right, the 2022 one's, additional work went into them, strengthened them to make sure that they're the most appropriate standards and we do expect to have those rolled out, go live, I guess, in September 2025.

L. STOYLES: So there'll be an updated, but it's similar standards that was put in place in 2022?

J. MCGRATH: Strengthen, built upon, yes.

L. STOYLES: Okay.

I have a number of other questions, but my time is coming to an end now.

Back a couple of years ago, the government put a whole lot of money into home care and personal care homes. They put the fees up and a lot of the home cares got back money and got a pile of money and the standards went up for the staff to get paid a higher grade of money.

Is that enough or do you feel that you're not getting the quality of people because the pay is not at equity with other provinces? Just asking the question.

J. MCGRATH: We are currently working with the personal care home associations. It is an issue that they've brought forward, in particular. That space also employs home support workers who have, I believe, a new collective agreement with NAPE. That's something the associations brought forward to us and there has been funding appropriated in this budget, so we're working with the association.

That is a concern – not a concern, I guess, but an issue that they've brought forward and we are engaged with them.

CHAIR: Thank you.

We'll continue now with the MHA for Lab West, but after he's finished, probably we'll take a short break then to stretch our legs for five minutes or so.

The hon. the Member for Labrador West.

J. BROWN: Thank you, Chair.

Recommendation 3, "The Department of Health and Community Services should enhance publicly available information regarding personal care homes, including posting inspection results, non-compliance information, licensure status and retain a history of the information for each home for a minimum of two years."

I know the deputy minister spoke a bit about moving towards what they can and can't post and they're looking at that, but going forward, can you elaborate on the work that's being done to make this information available to the general public?

D. WADDLETON: Thank you for the question.

Currently we do report on the licensure status, so basically if a home has a full licence, a conditional licence, or if it's been revoked. The plan to go forward would be that all inspection reports would be available online, in a manner similar to the way that digital government and service NL reports on food inspection. It would have the standard and the outcome, so whether or not the operator was in compliance with the standard. We would like to have full implementation of the new standards before developing the documentation and the process to upload.

We are very focused on getting the standards implemented over the next – spending the next couple of months to have the standards implemented. There is a lot of training that would have to happen with NLHS staff, personal care home operators and their staff. So we are really focused on trying to do that piece of work.

The public reporting, there is a new quality assurance framework that is outlined in the new standards and being in a position to develop the documentation that would go up online, in alignment with the new standards, is our preferred approach to move forward with public reporting.

We will look at whether or not there is a software tool that would enable the monitoring bodies to better collect the information on the visit, that would then allow it to be uploaded, otherwise there could be processes put in place resulting in duplication of documentation.

So that's our preferred approach to move forward with public reporting. We certainly see the value and want the public to know the outcome of the reporting.

J. BROWN: Perfect, thank you.

Going back to licensing, we talked about the conditional licensing and I guess as part of the public reporting as well is how many

operators operate on conditional licensing for extended periods of time.

So going forward with the new standard and everything like that, what are you looking towards to work with operators and that about the conditional licensing and going back and forth so often, and many of them operating for numerous months and possibly a year on these conditional licensing – what work is being done to bring them all in line with the standard to not have these incidents so often?

D. WADDLETON: I can start, but perhaps it's also something for NLHS to respond to.

One of the things with the new quality assurance framework that is outlined in the standards, there will also be guidelines for the health authority to help them in their decision-making. We will do this work in collaboration with NLHS staff who are responsible for monitoring.

Those guidelines will help them in decision-making. So when a home is non-compliant, what are the sanctions or what is the action that needs to be taken? How long should a corrective action plan be in place before progressive sanctions are implemented? It's not something that can be very black and white, because there are differences with homes, differences with the level and the severity or risk associated with non-compliance.

Sometimes non-compliance, although certainly we want all homes to be compliant with the standards, but it's recognized it's a progressive and quality improvement exercise. There are times where there are things that are very serious that are happening, and there are times that it's not very serious but it still needs to be corrected.

So making sure that there is good decision-making around when to move forward with sanctions, and to also make sure that it is done consistently across the province.

Because I think that was the findings as well.

J. BROWN: Perfect.

Going back to the conditional licence, there was obviously some operating standard previous to the new one that you're going to implement. Was there a lack of staffing and oversight of those standards that led to a lot of the stuff that was picked up in the AG report about the varied frequency and the length of conditional licensing in many homes, some of the other stuff that was picked up in there – was there a lack of monitoring and staffing to keep an eye on a lot of the stuff that probably led to some of this stuff happening for a period of time?

P. PARFREY: John earlier said that there were 16 people who were reallocated to try and help with the staffing. It was definitely a lack of staffing to be able to achieve the things that one is interested in. Even now, there is probably not an efficient reuse of resources as we can think of, particularly as you can see resident assessments are behind in the percentage that are actually undertaken.

It's our feeling that if we have a more accountable approach that's based on a provincial level, with using these standards to drive us, that we'll actually be able to achieve better. That's to be seen I think, and then determine whether or not we actually need even more resources.

Clearly, human resources are a problem in this province anyway in terms of how we staff the personal care homes and how we are able to staff NLHS in an environment that has vacancies for lots of different positions.

J. BROWN: Perfect. Thank you, Dr. Parfrey.

Obviously, you're reallocating resources when these new standards are implemented and then you keep talking about a third

party approach to monitoring that. When you speak of third party, are you talking about third party within the organization, or third party as in an independent contractor being hired to oversee this? Can you elaborate on what you mean by third party?

P. PARFREY: I think the option that's been explored is that there would be an independent structure as part of society, not as part of the NLHS, that would take responsibility for doing the monitoring and making decisions around licensing based on the monitoring that's independent of the connection that NLHS has with case management that's occurring in each of these homes with various numbers of patients.

It's our interest to be able to maintain a patient properly within a personal care home and having the personal care home open is in our interests. I think it's better to have a third party objectively measure the monitoring and follow the guidelines that are provided by the department. I think that we will explore that arena with the department over time.

J. BROWN: Perfect.

Obviously, there are some recommendations that are for both organizations, the department and NLHS. There are some recommendations for yourselves and there are some recommendations for the department. I guess, given that there are multiple organizations involved with this area, what kind of structure are you guys operating on or are planning on operating on to make sure that all the recommendations are implemented?

I know you talked about working groups and stuff like that, but what strength or structure that you're going to make sure that these recommendations are achieved? Because right now, I guess through what was given to us as the Public Accounts Committee, it's all partial implementation or not implemented yet. A lot of these recommendations also stem back from 2015.

So what new resource or new structure are you planning on using to measure these recommendations to make sure they do get implemented?

P. PARFREY: I think we've actually made pretty good progress in terms of working out ways of being able to deal with the Auditor General's recommendations, and we've already put into effect a provincial approach to trying to do better, and with the belief that that accountability structure will help us do better.
The question about how we go forward with a third party, independent structure for monitoring and licensing needs further discussion, and it's really a government policy decision. I don't think that government is ready to make that decision yet because there hasn't been enough work done on it.

However, I do think that the approach we've taken to the strategic health network and the health transformation sub-table is a very good start point. Clearly, NLHS is responsible for implementing the recommendations made by the Auditor General in that interim period, which could be a few years, for instance.

J. BROWN: Thank you.

CHAIR: Okay, thank you.

I think now we'll take a little break and stretch our legs probably for five minutes, and we'll return with the questioning.

Recess

CHAIR: Okay, thank you.

It looks like we're all refreshed, so we'll continue with the questioning from the Member for Cape St. Francis.

J. WALL: Thank you, Chair.

I do have one follow-up question from my last speaking time. My colleague from Exploits did touch on evictions, but I'd just like to ask, are the number of occurrences of evictions tracked on an annual basis for the province?

D. WADDLETON: We did begin reporting of evictions about three years ago or so when the eviction standard was implemented. We have since strengthened the eviction reporting. So we recognized that what we were getting was a provincial summary of evictions, and we were not getting – because we didn't ask for it, to be clear – the details of each eviction.

The new process we've put in place has deidentified information, but it has more about the context of evictions, the reason why, the outcome, and we're going to use this information – NLHS will use it to discuss with individual operators. Like to look for trends of individual operators that may be evicting residents more and we will use it to help inform policy and programming decisions.

J. WALL: Thank you for that.

I want to go back to a couple of comments my colleagues asked with questions with respect to bringing in a third party. As I was listening, I thought that would become the responsibility of the Department of Health. If a third party is brought in, as you mentioned, who will monitor that third party going forward, reporting and what have you? Who will monitor the third party?

P. PARFREY: I presume it will be the responsibility of Health and Community Services to ensure that that third party works properly.

J. WALL: With respect to the third party budget-wise for operations, has that been something that has been discussed currently with the Finance Minister and with Cabinet, or is that something that we're just looking at going forward, as you just said, you presume?

P. PARFREY: This is at the conception stage within discussions with the department.

J. WALL: Okay.

P. PARFREY: There's no plan.

J. WALL: Thank you for that.

I want to go back to another incident with respect to a constituent. The loved one was a in personal care home and was in failing health and passed away, I don't know the exact date, let's say the 28th of the month. On the first of the following month, the full deduction for the month's rent, or what have you, was automatically deducted from her account, but she had passed away three days earlier.

When the family went to ask the question, they were told that the individual didn't give proper notice that she was leaving the home, which in my mind was so cold and callous. Is there a proper protocol to handle that situation? Because when the call came to my office and I reached out, the home ended up refunding half the amount but not the full amount.

Is there a protocol – because this obviously wasn't the first time it happened, it won't be the last and the poor individual who passed away had no idea that they could give 15 days or 25, whatever the proper notice is for the home, to say that they wouldn't be needing the room anymore.

What would be a response that you could share with us, with Public Accounts, that I can share with this particular family who, after losing their mother, in all seriousness none of us want to have to face a situation of that nature – how would you, either NLHS or the department, respond to that?

D. WADDLETON: There are processes around when payments are made. I can't really speak to this specific incident because I'm not aware of it. But certainly if your constituent wants to share their information with us for follow-up, we'll definitely take that away to NLHS and work towards a solution.

We do have strengthened standards with respect to financial accountability in the new operational standards. I really can't say if that specific scenario is outlined in the new standard, but I will take it away and review, and if it is not clarified, we will add something to clarify.

Normally, there is a notice period required; however, obviously if an individual passes away, they're unable to make notice. So we will make sure that that is specifically addressed in the new standards, if it is not already there. I just don't recall if that's clear enough in the existing standard that we have, the new standard.

J. WALL: Thank you for that. I certainly appreciate that, and I'll certainly pass that along.

My follow-up question to that would be: Do each or individual personal care homes have different policies with respect to dealing with that situation, or is that something that would now come from NLHS to all personal care homes in your operational standards?

D. WADDLETON: Through our work in the last number of years and through inquiries to the department, we have become aware of some different practices with respect to the way that operators advise residents of the amounts that they have to pay. This is outlined in the new operational standards in terms of amenities that they may wish to avail of.

There is a process, so it still allows an operator and a resident the right to choose to buy something. If they want cable, if they want cellphone coverage or whatever within the home, there's still the ability and right for the resident to pick those amenities. But the new standards do have a process outlined that operators will be required to adhere to.

There is also some additional information around – not exactly in alignment with the Residential Tenancies Act, but there are some points there that are also included in the new standards in terms of notice period for increases and the amounts of increases that could be incurred or applied. So we will look for any additional – we became aware of an additional issue last week that we are now working into the standard.

I think I would also say that, while we have aimed to have the new standards in place in September, where instances like this happen that we need to address, we will address through addendums, which has been our past process. But we will do that if there are things that are uncovered that perhaps we don't have in the standard, we will address it in that kind of a manner, through a memo, through an addendum which would then be revised in our operational standards and posted online.

J. WALL: Thank you, Deena, I certainly appreciate that response.

I appreciate the strengthening, as you mentioned, of the operational standards. It only bodes well, not only for the department and NLHS, but, of course, the residents of our province.

I just want to touch on – 10 minutes goes so fast. The audit period was April 1, 2022, to September 30, 2024, and as you said with respect to the operational standards being strengthened, what specific ones were updated between the audited period and the release period? Can you share with us what was specifically done that was, as you said, strengthened?

D. WADDLETON: Since the audit period, I don't think we had a new – there was one

that was just maybe outside the audit period around hiring requirements for immigrants, new immigrants to Canada; there was some clarification that NLHS required. I don't believe there has been an additional – the audit scope was until September 2024 so that's six months ago. I don't think any addendums since that time.

J. WALL: Okay, thank you.

The performance audit was delivered on April 1. Are there any deliverables that can be seen within six months of that date, with respect to six months, April 1, what can be shared from that?

D. WADDLETON: Sorry from April 1 to now or –?

J. WALL: From April 1, the performance audit was delivered.

D. WADDLETON: Yes.

J. WALL: So what deliverables would be seen within six months of that, from that time frame?

D. WADDLETON: Oh, what will be seen within six months?

J. WALL: Yes.

D. WADDLETON: Okay.

J. WALL: Sorry if I wasn't clear.

D. WADDLETON: No, that's okay.

We anticipate that we will have the operational standards reviewed by the sector. Training module is under development for NLHS staff and personal care home operators. We anticipate having the training commence and be finished by September. The new standards, we anticipate will be in place within September. We have a new standard operating procedure already developed and in place within the department for both complaints management as well as incident report management and follow up.

The complaints management piece, we do manage complaints as I'm sure many of you are aware and we do send information to NLHS, follow up on all of those. What was really our gap is the consolidation documentation of that follow up.

There are a number of people within the department involved in complaints. We now have a protocol that outlines who is doing what, how complaints come in, how they're being named. That allows us to be able to pull for reporting purposes and for trending analysis, and the documentation system, we use TRIM within our department. So we're using that to store all of the inquiries that come in. This is true for the complaints as well as the incidents.

The gap that was identified was the follow up of serious incidents. These were followed up; however, sometimes it was a verbal follow up between NLHS and the department. What we now have developed is, again, a standard operating procedure for that, that requires the documentation of who reviewed it, what was the outcome, what information, is there any policy change that's required as a result of that and what was the outcome with respect to the individual and NLHS from a monitoring perspective.

J. WALL: Thank you, Deena.

You just answered three other questions that I had for my next one.

Thank you.

P. PARFREY: I just wanted to add a little bit, Mr. Wall, to that answer, insofar as just some contextual stuff that I'm sure you're aware of. But for the public that might be listening here, '22, '23 was the time of the four regional health authorities, all of whom had different policies and different ways of dealing with various issues, and the

department had to deal with the four regional health authorities in terms of what was going on.

Also, Central, Western and Lab-Grenfell Health have big problems with human resources, and big problems with access to home supports. They have personal care facilities, but they function in a different manner, I think.

In April of 2023, the NLHS started and then had the responsibility of bringing five zones together in a provincial program to ensure that, in essence, the provincial program is to ensure equity of access to everybody to the same types of interventions and the delivery of care was the responsibility of the zones. That doesn't happen fast.

So in the first year that was brought together and, in fact, we're 18 months, by the time the audit was done, into that new provincial zone approach towards care delivery. I think that the fact that the provincial authority has been put together allows us to have a much more coherent approach about responsibilities on care delivery and the various zones.

I think that's a benefit and the solution that we've come up with, to me, is a solution that will be able to be accountable and have impact.

CHAIR: Thank you.

The hon. the Member for Lake Melville.

P. TRIMPER: Thank you, Chair.

Still a couple of things on my mind, I'm going to start though, first of all, could you speak to the application process for a new personal care home? Just roughly what that entails, but more importantly I'm wondering how now this whole series of events – the Auditor General's report and so on – how that might influence a change, tighten that up and so on.

D. WADDLETON: Thank you.

The new operational standards do have a strengthened licensing process as well. We have a requirement for operators to have some things related to business pieces that Justin has helped us develop. In addition, specifically for the care-related things, it does require new operators to give more information about the type of care that they're going to provide, so to provide a care-management plan.

There have been revised regulations, which really looked at where personal care homes are being built. So, really, it's in alignment with the demand for service within a particular area. I think that particularly around the re-licensing process, there's lots of strength and pieces there around the performance of operators, and really that NLHS would be having conversations with operators around quality improvement and performance to inform the re-licensing process.

P. TRIMPER: Really informing them of the expectations they're going to have to fulfill and so on.

D. WADDLETON: Yes. Currently, what does happen is when a person wants to operate at home, if they are an existing operator, the new standards do allow the NLHS, in whatever zone, to review any information from other operations. So if you're an operator in Eastern-Urban and you have poor performance, now information can be shared – if you were interested in opening a home in Central – to help inform the licensing decision.

We also have included the requirement for outcomes, really to help inform that from a quality improvement perspective for operators in compliance reporting, et cetera – so when somebody applies for a new licence, in submitting the application and signing, consent is implied that information can be shared across any entity. Even if they have an operation outside the

province, they would need to disclose that and NLHS in its licensing decision could consult outside out the province as well for information.

P. TRIMPER: Is it a check-box type application? I haven't seen it. Or do they need to explain how they're going to structurally manage such a facility, the responsibilities and so on?

D. WADDLETON: So there definitely are some check-box pieces. There are documents that need to be provided and NLHS does use a form that does indicate whether or not they are available. NLHS staff would have the discussion, have an interview with the operator, make sure that they understand what is involved in providing older adult care and make a licensing decision based on the outcome of that interview, references and the review of all the documentation that's required as part of licensing.

P. TRIMPER: Okay, so all good stuff, important regulatory oversight, operating standards.

I want to follow from my colleague from the beautiful District of Cape St. Francis, his comments about the third party role. I'm trying to understand – and as I said a few minutes ago, I'm such a fan of what I've seen in the collapse of the regional health authorities. One entity, the buck stops there, responsibility is there. I'm trying to understand where is the precedent for establishing a third party to yet come in and play some other role.

I'm seeing increasing complexity. I'm seeing maybe future PAC investigations, reports, interactions and so on. I'm struggling with, again, who is responsible? Do we have precedent for this in this province, elsewhere in the country? I'm just looking, again, just for that whole aspect of the rationale around why we need this third party.

P. PARFREY: I'm not in the position to comment more than to say that there's a conflict in the jobs that are done in NLHS between case management and monitoring and licensing. We would feel that they should be separated. In terms of how this evolves, et cetera, there's not enough work been done to be able to come up with a proposal, at the present moment, that can be taken on by government and the Department of Health and Community Services.

P. TRIMPER: Okay.

I'm just reflecting back on my own time, serving as a minister in a regulatory capacity and again just ensuring that that oversight was there. I remain to be convinced that that's an appropriate way to go, but I'll wait to see what transpires.

But I guess I'll also go back to my first question, which was about the outstanding recommendations. Again, say, years from now, we still have outstanding recommendations from this exercise. I'm just trying to help future generations get to the bottom of making sure that there is both regulatory direction, the oversight, the monitoring, and compliance reporting and so on. Anyway, I remain a little concerned there; maybe a lot concerned.

I wanted to go to – I don't know if anybody has a comment.

J. MCGRATH: No, I just wanted to say good point. I can certainly say that this is a focus for the department; we do have a detailed action plan in place. I think when Pat is talking about the third party as well, what we want to make sure at the department is that there is proper oversight; there is proper monitoring in place by NLHS.

When he talks about that inherent risk, I guess, of case managers also being the ones kind of intertwined with licensing – an inherent conflict there – that just needs to

be addressed through segregation of duty. So I just want to keep that there, that's kind of – you good?

P. TRIMPER: Okay – maybe, I'm encouraged. So this is more like an ISO-9000 role –

J. MCGRATH: Right.

P. TRIMPER: – somebody coming and making sure that the steps are there, but not actually doing that work.

J. MCGRATH: Right. So I think that, conceptually, we're getting hung up on the words sometimes with third party. So making sure that you have good segregation of duties; making sure there is no inherent conflict there; making sure that there are good structural reporting relationships and solid monitoring, and good oversight.

You talk about ISO and good standards and proper controls are in place; that's what we want to make sure of moving forward, from a control perspective, from a monitoring perspective, from an oversight perspective, so I hope that provides a bit more – now, what that mechanism is, that needs to be discussed.

P. TRIMPER: Let the record show that there are more thumbs-up over here, okay. Absolutely.

Yeah, to be honest with you, we were chatting in the break and we were thinking that perhaps somebody else is going to be doing these inspections, somebody else is going to be doing this evaluation as to whether or not they're complying. If it's staying within the department, you're just getting outside advice as to whether your structure is appropriate, fine, and your reporting. That's great, thank you. That's really helpful.

Can I go over to – and this is a bit of a nuance, but I'm not sure how may be most appropriate to address it. It's one in the last few months as we've worked as a PAC, we've met several times on this particular audit, and we've all had our own share of stories, observations of the repercussions of bringing forward issues that – I wouldn't say that we've observed, because that tends to be something we bring forward, but we'll have constituents, we'll have relatives of constituents, others that are very nervous about bringing forward issues, realizing that the source could be identified immediately, and then back to this eviction strategy and so on.

Many of these things are tied together, but I wondered if you could perhaps comment more so on how your action plan now going forward could really get these concerns to bed or addressed.

J. MCGRATH: I can certainly start and say that I hear you. I've heard the same, anecdotally, from others as well, and I'm sure as MHAs you guys hear that more so than others.

Confidentiality and having the ability to bring forward those concerns to decision-makers and to those who support decision-makers is of the utmost importance. I'm going to let Deena speak to – I think what you're getting at is the complaint management process and making sure that confidentiality is integrated in that. So I think that is part of our standards moving forward there and we would expect compliance with that. Because, to your point, that is extremely important, and you're not going to get the information come forward if people don't feel safe and supported in bringing it forward.

I'll let Deena reflect on the standard there.

D. WADDLETON: Thank you for your question.

That is something that we did hear as well through the long-term care and personal care home review that was completed by

the expert panel and our external consultant. It is something that we at the department hear, as well, when we receive calls from families and clients, and it's very concerning.

In our new operational standards, we have outlined that operators should have mechanisms for confidential reporting. We have a strengthened complaints and incident reporting standard that allows for anonymous reporting, that NLHS will follow up on anonymous reports. There are, of course, challenges when everyone wants to remain anonymous. That can sometimes impact the ability to really get all the information, but there is an expectation that anonymous complaints are followed up on as well.

We have, in our complaints protocol, the standard operating procedure within the department that I just mentioned. We have also indicated there that anonymous complaints are brought forward to NLHS. Again, we are also requiring in the standards that all clients need to know who their case manager is and be comfortable with going back and relaying their concerns to NLHS, as well as the operator.

In our standards, we do ask that clients follow up with the operator, when they're comfortable, to address day-to-day issues that do come up. But where there are concerns, they can be followed up by NLHS directly, and certainly people can also come to the department when they feel that they need to do that.

CHAIR: Thank you.

The MHA for Exploits.

Medication Storage and Administration: The Auditor General found there were medication storage non-compliance in four of 13 homes; that's 31 per cent. Twelve of 13 of those homes had medication-related incidents. That's 92 per cent. Isn't that alarming, really?

P. PARFREY: Yes, it is.

CHAIR: Are there precautions being taken, or what precautions are in place or being implemented to avoid those happenings?

P. PARFREY: That's the whole intent now. We're going to go forward with our provincial approach to doing this and to implement the standards and to be able to have a more accountable system in dealing with the personal care homes, yes. That's our intent.

CHAIR: Okay, thank you.

The AG also found negative results on employee's certificate of conduct, including assault charges. Again, are precautions being put in place to avoid those situations with regard to conduct?

P. PARFREY: I'll give the same answer. All those things that relate to the pieces that the Auditor General brought forward, which included staffing, would need to be dealt with by our standards, by our monitoring and by our responses on a provincial basis and applying those standards across each zone equally.

CHAIR: Okay, thank you.

Once the training plan is developed and a module is prepared to be administered, how many weeks will it take to administer the training throughout personal care homes?

J. MCGRATH: Our target is to have the standards implemented, and that includes the training performed in September 2025, so between now and then. We do have the training developed and we plan on rolling it out between now and then. That is the target, and I do feel like we're on track for that target as well.

CHAIR: Okay.

With the restructuring of Cabinet, has there been any consideration of including the

Department of Seniors alongside the relevant HCS roles for the Seniors' Advocate recommendations May 15?

J. MCGRATH: I think that report is still being reviewed, so I wouldn't be able to comment on that. I think the minister spoke to that.

CHAIR: Okay, thank you.

Under Recommendation 2, development and serious incident operating procedures, what are the implemented improvements in information management processes?

J. MCGRATH: I'm going to let Deena speak to that, but I just want to highlight that is something, serious incident reporting, and there were gaps in documentation that was identified by the Office of the Auditor General that we have remedied since that report.

There is a standardized procedure in place now that has been implemented and I'll Deena speak to the specifics of it.

D. WADDLETON: Two pieces, we have the new, strengthened standard on complaints and incident reporting. That will be, as the deputy mentioned, implemented in September. We have sent a new document to NLHS around filling out, completing a form with all of the information that we feel we need around our review of serious incidents.

We have a standard operating procedure that we have developed that outlines specifically who within our department is looking at the serious incident. There's an inclusion in that that for serious incidents, we would report those to our deputy and executive and on to the minister.

There is a requirement within that for myself, as director of seniors' health care, to review all of those serious incidents that come in. I'm already very much involved in those, but to document exactly what happens, is there any policy changes that are required as a result of those and if there are any follow-up within NLHS about how they have handled the serious incident follow-up.

J. MCGRATH: We want to make sure that each serious incident is documented. We want to make sure that the remedial action is taken. All that documentation should be kept in a repository and it should be used to inform future decision-making and it should also be used to inform if our operational standards need to be revised, moving along, so if we need to issue an addendum.

I think that is of the utmost importance. I would say that the serious incidents, they were all being addressed. They were addressed appropriately. I think where we really fell down is that whole documentation piece, making sure we have a repository set-up, making sure that remedial action is taken in a timely manner, making sure that it's all documented, and that we are using that information that we do collect to help inform future better decision-making.

CHAIR: Okay.

Will the standards be published?

J. MCGRATH: Yes.

CHAIR: Okay.

Another question pertaining to that: When will inspection reports be available online?

J. MCGRATH: So I believe in our action plan, we are targeting the fall. We want that to look, similar to food inspections, that is certainly the goal. We want to be as transparent to the public as possible, have that conversation with the chief information officer. We think there's a solution there moving forward. You might be familiar with the AMANDA system that they use in DGSNL.

I'm fairly confident that we can get that information up, available online, and that's in accordance with the recommendation that came from the AG's office. So we're hoping the fall, as soon as possible.

CHAIR: Okay.

Will this be a searchable database, like the food establishments, bridge inspections, or child care centres?

J. MCGRATH: That's the goal, yes.

CHAIR: Will this be a custom technology build?

J. MCGRATH: We always kind of look internally to see what we can leverage that's existing. So to say it's a custom build, I don't think so because I think these things are already published similarly through the department – or the new department now is Government Modernization, formerly DGSNL.

I suspect that we can leverage that technology. There might be some customization on that technology, but I don't suspect that it's going to be a stand-alone buy. We want to expedite that as fast as we possibly can, to be as transparent as we possibly can.

CHAIR: Okay.

Under the fourth recommendation by the Auditor General, development and key performance indicators, what are the key performance indicators which will be used?

J. MCGRATH: So I'll let Deena speak to the specifics of the KPIs, but that is going to be in the standards. We do want a fairly robust quality framework, as well as key performance indicators, because I think as other MHAs have mentioned, we don't want this to fall by the wayside. We want to have KPIs in place to help inform ourselves of what needs to change when it comes to policies.

If you look at those KPIs and if you are doing that effective oversight, you are doing that effective and timely monitoring, that's going to help you inform policies in the department and how we need to improve the standards, if at all, and how we need to support Newfoundland and Labrador Health Services, whether it be through staffing or whether it be through training, or whether it be through education.

So that's just a preface to say that the KPIs is a huge part of this. We want to have a very robust set of KPIs to help inform that moving forward.

Deena, can you want to speak to the specifics?

D. WADDLETON: Sure.

The new standards do have a number of indicators that will be reported to the department. NLHS already does collect a lot of data for the department on personal care homes demographics, as well as operations. The standards, again, with the new quality assurance framework, have additional indicators included in there.

What we've identified, though, is that we do need to do some work with NLHS to really identify what are the four or five key performance indicators, because there are already a lot of things that are collected, what are the four or five key performance indicators that we will really, really monitor closely to inform, like the deputy indicated, operations and process.

So we will do a piece of work with NLHS in the coming weeks to develop that piece. Again, this is something to set up a standard. The accountability and reporting mechanism around this, we do feel we need to have the new standards in place before identifying what those key KPIs are.

But we certainly have a lot of those outlined. We have a number of indicators outlined within the new standards. It's about meeting

with NLHS now to identify which are the ones we want to identify as the key performance indicators to report on first.

CHAIR: Okay, thank you.

The Member for Mount Pearl North.

L. STOYLES: Thank you, again.

I thank you for elaborating on the third party policy and what you're looking at putting in place. I just want to elaborate on that a little bit.

Are there individuals in companies that's out there right now that can take on this work? The other part of the question is, have you looked at other provinces to see what they've actually been doing in this regard?

J. MCGRATH: Excellent question.

So a jurisdictional scan, we always would look at other jurisdictions to see what the form and substance is of how the administration of personal care homes would be. So that is part of ongoing work that is always happening. It changes from year to year, month to month.

With regard to inspections versus case managers and the roles within the Newfoundland and Labrador Health Services, what I think we're speaking to is you want to make sure that they're unbiased and there's good segregation of duties, like I kind of spoke to before, and make sure there's good controls in place.

The case managers, we really want to make sure that they have a role to play in collecting information when it comes to inspections and things like that, but they should be clearly delineated from the piece around that decision at the end of the day, if that makes sense. So it's more around segregation of duties and controls up through the operations piece.

L. STOYLES: You're talking about case managers now. Case managers and social workers, we're talking about two different groups of people, right?

J. MCGRATH: (Inaudible.)

L. STOYLES: Okay, I just wanted to clarify that.

The other question I wanted to talk about are the other concerns I have with social workers. I know in my area, and I have probably one of the highest – a lot of seniors in my district compared to most districts, so I deal with a lot of the seniors on a regular basis going in nursing homes and some of them staying at home.

What I'm hearing a lot of is social workers – some families who are staying at home, they're deciding if they're going to send their loved ones to a home, even in nursing homes, in personal care homes, social workers change on a regular basis. Some families have dealt with two, three, up to five different social workers.

Can you give us an update on that and why – like, one time, back a number of years ago, you got a social worker and you had them for the life of when you were in the home. That doesn't happen anymore, and now that they're changing, now with social workers not assigned to an individual, it depends on the need, because some people might need a social worker – maybe that's the reason why you've done it.

To me, it seems like it's very difficult when you try and explain it over and over again to different social workers.

P. PARFREY: Well, we have a hospital-based system where more social workers are involved in the hospital system than in the community system. With the Family Care Teams, it's our intention that there be a social worker associated with the Family Care Teams. They would deal with the issues that relate to the social factors that

influence health both in people who are in their home or in a personal care home.

So I think that that's the way that we would see this moving forward best in the community.

L. STOYLES: Okay.

So staying in this line of questioning, the Auditor General will come back within three years, unless she's asked to come back sooner. Do you think that's a reasonable time? I mean, especially when we look back at 2014 and 2015 and everything wasn't implemented. Do you think the Auditor General should wait or can we get a report in nine months to a year?

I'm just looking at the scenario that has happened in the past. I know it's all new people and that. When you said this morning and you give your update, it sounds that you're on top of everything and you're going to – don't worry about it. We've got it looked after and all that good stuff, but I'm just concerned if it's not done, what happens? How soon do you think she should be back?

J. MCGRATH: No, I take your point, and I think that's very reasonable. What I can say right now is we do have an action plan in place, and I am fine to provide regular updates to the Committee or however, or to the office. I think that's being transparent and that's something that I'm not opposed to.

L. STOYLES: Okay.

P. PARFREY: I think that's it very reasonable to expect that we set up a provincial approach with the capacity to monitor the standards that have been put into effect and that we're capable of obtaining the data that allows us to act appropriately.

In fact, it was a good example of what we call a learning health and social system, where we're using data to be able to change the way we deliver care in such a way that it's more effective. I think that what we're proposing has the capacity to be able to allow that to happen within the next three years, yes.

L. STOYLES: As I said earlier, I have three nursing homes in my district. The recreation programs are probably state-of-the-art recreation programs, because I'm there and I attend a lot of their recreation programs and the exercise programs that they do. Is there a standard for the recreation programs?

I grew up in rural Newfoundland and I've been in visiting relatives in other homes and they have very little recreation programs. Then some of them are doing fundraising to pay for the recreation programs, and that sort of blew my mind that they're saying well, we can't afford to offer the recreation programs so they're doing 50/50s or they're selling chips and bars to the residents to make money. Is that allowed? Just asking.

D. WADDLETON: Just to answer the question on the recreation, so the operational standards do have a standard with respect to recreational activities within a personal care home. It is expected that the home provides opportunities for recreation.

Through the long-term care and personal care home review, as I mentioned earlier, there was a lot of feedback that we received about recreation in both settings, actually. This is part of the quality of life framework that we will develop for both sectors, with an expectation of enhancing recreational opportunities in the sector.

Also, through our Dementia Care Action Plan work, we have done a piece of work across NLHS and the community, other government departments involved in recreation around guidelines for communities, including home care and personal care homes, for how to deliver

recreational opportunities. So that's under development now. So lots of work is happening on that, recognizing the value of social interaction and really trying to strengthen in personal care homes opportunities that are available.

We would recognize that there are differences in homes. Homes range in size from five people to 100, and in small communities and in larger communities. So the recreation opportunities do look different, but the new standard does strengthen the process and creates the expectation that this is delivered in all homes.

L. STOYLES: All right.

The other question I have is related to overnight, and I know the standard is there and in a lot of the homes there's only one person there all night, depending on how many residents are in the home. Is that standard going to change? Because I'm assuming, depending on the care that is needed for some of the individuals, one person doesn't seem to be enough for 15 or 16 residents.

What is the standard for overnights in all the homes?

D. WADDLETON: The amount of staff depends on the number of residents that are in a home. For homes under 30, at least one staff has to be present at all times, one to 10 beds. As you go up with number of beds, then there's an increased number of staff that are required.

So in beds that are 10 residents, then yes, there would be only one staff on at night. The standard in the new manual is as the old standard for staffing. As we've introduced new models of care, so enhanced care, the allowance for a level 3 in a personal care home while they're waiting, we have added additional hours of care that's expected as part of providing that level of service.

I think there is some work that we plan to do within NLHS over the summer to look at the staffing model in more detail. There's also some work that was identified as gaps within the Auditor General report around calculating the staffing hours that do exist in homes, so we are working with the health authority to help them in being able to calculate some of those pieces. There is some work under way there.

L. STOYLES: My time is up.

CHAIR: Thank you.

The hon. the Member for Labrador West.

J. BROWN: Thank you, Chair.

I want to touch on the assessments that are being done and the backlog of assessments and the timelines of assessments. My first thing I'm asking, has there been an improvement since, I guess, the release of the report on getting the assessments done in a more timely manner, and what kind of backlog are we currently looking at on getting these assessments done in a timely fashion?

C. DAVIS: Thank you.

I can't speak to improvement in the numbers since the report has been released, April 1. I do know there have been improvement in the number of backlogs of assessments since last year and I think the deputy referenced earlier that we added 17 additional resources last year to assist with getting the initial assessments and the reassessments completed, so there has been improvement. There is still work to be done. Unfortunately, we haven't been able to fill all 17 of the positions that were allocated to ensure we've been able to, I guess, complete all the assessments.

Work is continuing on that, but there is still a backlog of assessments that we continue to work towards completing.

J. BROWN: Thank you.

Inside the standard, what is the timeline that you aim for to get an assessment done on an individual?

D. WADDLETON: For completing of assessments, an initial assessment, there is a provincial policy on completion of assessments. For an initial assessment, it should be done within 10 days of receiving all of the information. Sometimes it's clients themselves that aren't providing or maybe not making themselves available for the assessment. There could be pieces like that. So sometimes there are delays, really, on both ends.

We're using a standardized, internationally recognized assessment tool. The kind of timelines around use of that are recommended from the research body that's involved with that assessment tool. So reassessment should be completed at least annually, unless there's a significant change in an individuals health status and, in that case, they should be done more frequently with the change in health needs.

J. BROWN: Perfect.

So the standard is to have it done 10 days within receiving all the information. Currently, what is the average right now of an assessment? What is it currently taking the department and NLHS to actually get these assessments done? What is your data showing you?

D. WADDLETON: That activity actually rests with NLHS, so I'm not sure they would have that data, but it's not something I have information on.

C. DAVIS: I wouldn't have that data with me right now, but I can certainly get it for you. I'm just trying to reflect on the report of the Auditor General. I know it was in there. It talked about what the standard wait time was. I want to say it was 36 days to get the initial assessment done at that time. But I don't have an update on that at this moment.

J. BROWN: Perfect, thank you.

I guess you're looking at three times the time that it actually should take, and these are recommendations that were made back in 2015. So given that we're looking at 2015 – and I know that a lot of people over there have changed over since 2015, but given that this was something that was pointed out a decade ago, what was the reasoning for taking so long to staff up and try to get the backlog done? What was preventing the department and I guess the old entities and now the new entity on actually getting the work done to get these recommendations in? Now this is the second time these recommendations have been made.

P. PARFREY: That's a reasonable comment.

Action is now taking place in terms of those 17 positions have been funded, and they're gradually being put into place. It actually has a big effect on acute care as well, because people in acute care who are going to go to long-term care or to personal care home needs a RAI done and they're kept in hospital until the RAI is actually performed, which is a waste of an acute-care bed.

I think it's a reasonable comment to make, but now we're taking action on it and have already made the policy decision to do so. I think that we will be doing better over the next few years and trying to make sure that that happens.

J. MCGRATH: I can't speak to since 2015 obviously, but I can say that we talked about key performance indicators. Certainly, if the standard says you want to do it within 10 days, I think that's something we need to monitor moving forward and making sure that we have the resources put in place, so if there's funding mechanisms to hire them.

It's not always an issue of bodies as well. I think we need to dig into the details at the health authority level to make sure that the number of assessments that can be performed are being performed by the staff. So sometimes it's efficiency as well. Again, that goes back to collecting the data, collecting the information, making sure we have the KPIs, and then holding ourselves accountable moving forward with that too.

J. BROWN: Going forward, you're going to strive for 10 days, and you're going to work towards that. You put resources in effect. What resources will also be available to monitor, to make sure that you are meeting your key performance indicators and that you're not holding up acute-care beds and things like that?

What monitoring tools are you going to be implementing to make sure that these targets are met and that they're done efficiently and to make sure that there are no gaps in the system like there has been previously?

J. MCGRATH: That's a really good question.

I think, moving forward, we do have the mechanisms in place, and I think Pat spoke to it a bit earlier, but this comes with a lot of alignment. You really do need to work hand-in-glove with the operational arm like the health authority.

So we need to make sure that we have the mechanisms in place where we're talking to them and that data is being reported to us and we also listen to them to say how we're going to make improvements on it. It's not just a matter of dropping it on your desk and saying here you are, here's the data and do what you want with it.

We've integrated those resources through what's called a health transformation table. That's essentially where a vice-president level, executive level will co-chair it with an executive at the department. We have a number of these tables set up and one is around community supports and one is around seniors.

One of the things Newfoundland and Labrador Health Services has done recently is to identify a single VP to sit with an assistant deputy minister at that level and have that sub-table set up so these types of things are consistently monitored. That information then flows up to the chief executive officer and the deputy minister so that we can make sure that the resources that they need and the remedial action is being taken.

There has also been a strategic health network that has been put in place at the Newfoundland and Labrador Health Service level to kind of focus on that provincial approach, if that gives you some comfort, but there has been some significant action to make sure that alignment and folks are aligned to deal with those issues and they're not forgotten about.

P. PARFREY: I'd just like to – I doubt very much – I mean, you may have seen one of these RAIs, resident assessment forms. They're pretty detailed. They take an hour to do. So if you've got to move to various places to get these done, there's a limited number you can do as a social worker with those things.

They're very effective if we act on the information that we get from them. So efficiency in doing them but also action on what we find is probably pretty important as well. They're very detailed.

J. BROWN: Yes, absolutely. I understand, because the complexities of a region like mine, where we don't have personal care homes, and we have only 10 long-term care beds, but these forms are filled out regularly. I understand, and you are correct, and it is about resourcing but also about time and time management, and also to make sure that all your things are lined up.

I guess going with that, the deputy minister talked about the hand-in-glove with operations and policy and you're talking very high level with the transformation table; but down on the lower rung, between department and with policy and operations at the health authority, what monitoring is done at that level to make sure that the day-to-day stuff is done, like assessments and making sure you're meeting your timelines and your goals down on that level? What monitoring is done on that operational level to make sure that things are getting done?

C. DAVIS: Thanks.

I guess it's really about, again, moving forward for us. As has been alluded to a couple of times this morning, we're setting up a strategic health network within NLHS for long-term care and community supports, a provincial approach. Up until now, we had different zones doing their work and we weren't really collecting the data or reporting that data up through one office or one function in NLHS, which then would report to the CEO.

Going forward now, we will have that in place, as Dr. Parfrey alluded to, a senior director and a director, who will be working with the directors in the zones and the managers in the zones to collect that data on a regular basis and that will then report up through myself, as the VP responsible to the health sub-table, and then ultimately to the CEO and the deputy minister.

P. PARFREY: I'd just like to make a comment about Labrador, because you brought it up there in terms of access to personal care homes. Within the model that we have, which is a privately funded, profit-making health care delivery system, that being able to achieve that in smaller communities, particularly in Labrador, is a problem and I think we've got to be more innovative about how we get an approach to personal care homes within communities where the responsibility is shared between the communities and Health and Community Services and local resources are used to provide the care.

I think that's an area that we need to develop, particularly for Labrador, for Nunatsiavut, the Innu Nation, the Straits and Lab West, et cetera, and southeast Labrador.

CHAIR: Thank you.

The hon. the Member for Cape St. Francis.

J. WALL: Thank you, Chair.

I want to go back to Recommendation 3. As my colleagues are asking questions and responses are coming from you, there are other things that are coming to mind. With Recommendation 3, with respect to publicly available information, Dr. Parfrey, I know you said earlier in your testimony this morning – and I jotted down what you were saying; it's not word for word, but I jotted down what you were saying. You said you want to bring the standards into the public arena, have associated metrics to monitor those standards and appropriate actions taken from there.

I'm just wondering with respect to the enhancing publicly available information, how will you ensure that such information is going to be made available to the public? Is that going back to what my colleague from Exploits said earlier, with respect to the searchable data base that you're going to bring forward, for example, food establishments and bridge inspections? Is that how you're going to do that or how – could you please explain how you're going to bring it available to the public?

P. PARFREY: Well, I think, reading the Health Accord, you could see that the Health Accord strongly recommended an NL health quality council. This would be an ideal place in which that reporting could be undertaken with a direct link to various government entities and would be a good arena for dealing with the issues that arise

in long-term care facilities, in personal care homes and also in the home supports arena. The logic behind that proposal still exists for this particular problem.

J. WALL: Okay. Thank you for that.

I want to go back to Ms. Waddleton and my colleague from Lab West brought up the timeline standard for reassessments, you mentioned the internationally recognized assessment tool for annual reassessments. Am I correct in saying that? They were reassessments we did on an annual basis?

P. PARFREY: Right.

J. WALL: I have another incident with a constituent of mine, not in my district now. She did live there earlier, moved to a personal care home outside the district and, unfortunately, deteriorated rapidly where she needed to move to long-term care.

Once at long-term care, it was noted that her rapid decline was as a result of medication that she should not have been taking for quite some time. At that time, the medication was removed and the individual drastically improved. However, she was on a dementia ward and the family couldn't get a reassessment for their loved one because they said it would take up to a year. She remained on the dementia ward. In all honesty and seriousness, a call should not have to come from a Member's office to ask for reassessment.

Given that example – that has been dealt with, and the lady has moved from long-term care back to personal care and is doing well, thank God – but how can NLHS or the Department of Health put parameters in place to deal with a reassessment that's needed, not just on an annual basis, because this was a clear indication, a one-off, that because of an error that occurred, her assessment at the time was done incorrectly and then she could not get a reassessment for up to 12 months.

So what can either the department or NLHS put in place going forward, if it's not already taken care of, so that it doesn't happen again to another loved one?

P. PARFREY: This is a medical issue, really. I mean, it's how we run our health care system and the responsibility that doctors have in making decisions over what drugs they put on patients and the effect of those drugs. The responsibility rests with the doctor in what he did. It also rests with the medical system to reverse that if it's clear that it's the wrong decision.

We in this province have inappropriate use of drugs like benzodiazepines and anti-psychotics that are given to seniors in far bigger quantities than they are in the rest of the country. It's one area that we as a health authority need to be able to improve which is the appropriate use of drugs and adhering to Choosing Wisely Canada guidelines. That is an educational system and an accountability system that we're trying to initiate to try and ensure that we do better in terms of the way we use drugs in the elderly.

So I think that it's not the assessment that's the issue here for this patient. This is the patient has been taken off the drugs and the medical decision should be that this patient is changed and needs to be given a different thing. I think it's much more about the medical care of the patient than it is about the standards we have.

J. WALL: No, I understand, Dr. Parfrey, but when the family, through no fault of their own, the social worker is telling them I cannot do an assessment because it's going to take up to a year; through no fault of the family or the individual, that individual remained on a dementia ward when she was basically back to Level I from Level III Enhanced.

That's where the family was caught, and of course, when they call my office, again an MHA should not have to intervene on a

reassessment for an individual when a social worker says that the individual is not getting one for up to 12 months.

P. PARFREY: Right, but to be honest I think this is much more about how our medical system is working rather than it is about the way we do RAIs. The RAIs are an ongoing way of being able to ensure that we get information from the patient on an annual level so that we can act on change.

Your example is a medical decision to give a patient drugs that had the wrong affect. As soon as the affect was observed, the system shouldn't be dependent on a social worker. It should be dependent on the medical system to ensure the right thing is done for the patient.

J. WALL: I agree, but the doctor can't do the reassessment from what I've been instructed. Again, I don't want to seem, you know – John?

J. MCGRATH: So I think what we can do is make sure there's a real quality process in place; so, making sure that the standards that we do have are updated regularly, first and foremost.

I know this has been outstanding since 2015. We need to make sure we're always doing a comprehensive review to make sure that we're following best practices, then we can update those standards. I've talked about that being a living document, so being able to issue addendums instead of waiting to do one big review because that's very cumbersome. It takes a lot of time. Once these standards are replaced, I think the idea is that we want to, first of all, make sure that there is regular updates ongoing all the time, especially when it comes to best practices.

Part of that then is going to be making sure that we do monitor key performance indicators. So I can't speak to specifics, but your example sounds like the assessment wasn't being done on a timely basis.

J. WALL: Correct.

J. MCGRATH: So at the department level, we want to make sure is that we have good processes set up and in place, something like that health transformation table I talked about, to make sure that we are looking at a zonal level on the time limits of something like reassessments. If that is not being done in a timely manner, then we need to make sure as a department that the health authority is being supported whether it be through additional human resources, whether it be through training or whether it be to make sure that the assessments are being done efficiently as well.

It's not always a human resource matter either. Sometimes it's making sure that the assessments are actually taking place. They are complex, like Dr. Parfrey talked about, but we need to monitor that to say, okay, we can do this better and we can do this more efficiently.

I think just to close the loop on all this is to make sure, to MHA Brown's point, that the information is being collected at the ground level and that we have strong mechanisms set up so that information comes up so that we can catch things like that, because you're right, the MHA's office shouldn't have to reach out for that. Now it's on us to make sure that they actually do the work.

J. WALL: Okay, thank you for that, and I appreciate the answer. I know you can appreciate the level of anxiety that the family were in dealing with up to that point and then, of course, changing of that level of care.

With respect to an individual going – I'm just thinking now out loud – from home care to a personal care home on to long-term care, that continuum, is that something that the department or NLHS would monitor for an individual basis? I know that would be a lot of work, no doubt, but for every resident that's either in personal care or long-term care, is there a continuum of care or is there

a report from beginning to end with respect to each individual person who can be followed and that can be monitored if need for reassessment?

J. MCGRATH: I'll speak to this in a higher level, I guess. From a policy perspective, one of the things we are doing is coming up with a new health information system. You want one patient and one record. So on its face, in theory, yes, you should be able to see that information for MHA Wall from cradle to grave, right? Then I guess the question is: Are we looking at that information in the manner that you're talking about?

What we're focused on now is the kind of policy that we're going with, it's Home First. We want to make investments, making sure that we are making the right investments to keep people aging at home. I think this year, we talked about Seniors' Well-Being Plan and investing in home repairs, modifications and Aging Well At Home Grant and there's the Caregiver Benefit that we put in place.

I don't know if we can say at the individual level, is that being looked at? I think a physician, or someone might, but we can aggregate it, and it's important to have the aggregated data to help inform policy decisions.

Does that make sense?

J. WALL: Yes, it does, and thank you for bearing with me through my little ramble.

P. PARFREY: I think that we ticked the box in terms of the RAIs, get it done, an hour's work, but the RAIs are created to ensure that stuff that's particular to seniors who are fragile gets examined and monitored, et cetera, and then gets acted upon.

The reality, I think, is that we do not make enough use of those RAIs. Somebody in the community who's frail and fragile, gets the RAI done, it should presumably be capable, if that's done every year, to actually predict the track in which they're going to ensure that they're at home, but they're getting supports. There are scores within the RAI that say how close they are to death, how close they are to requiring long-term care facility, et cetera.

We don't integrate those pieces appropriately, and I'm hoping that with the strategic health network as we go forward that we use these RAIs more appropriately from a clinical perspective rather than ticking the box.

J. WALL: No, that makes sense.

Thank you kindly.

CHAIR: Thank you.

The Member for Lake Melville.

P. TRIMPER: Thank you, Chair.

Just a couple thoughts remaining with myself. One of my first questions was about whether either of your entities had heard much from the public with the release of the information and so on, and I'm not sure I heard you, itemize anything. Some of the commentary that I was aware of was that, of course, some of the representatives of the industry and/or other private sector owners of these personal care homes were saying hey, that's not me, and so on.

A wise person said to me a little while ago, proactive reporting on their part would be a good way to put the cards on the table and say hey, that's not me, I'm not doing – I just wonder what your response would be to that, and how you might oversee that. Because that could, of course, get into an exaggeration. In some of these communities in parts of our province where we may have a luxury of a choice as to where we might go, I can see that competitive nature. Frankly, one might welcome that across the province if you had such a luxury, but just your thought on that point.

J. MCGRATH: My thoughts, I guess, is that that is in accordance with the recommendation from the report, and we have accepted that recommendation to make as much information, as appropriate, publicly available. I think of it, and I know I spoke to this earlier, but something similar to food inspections. I think that the more information that the public has, the more transparent that we can be, the better we will be. There is certain information out there now and we need to make more of it available so that the public, to your point, can make informed decisions as well.

P. TRIMPER: I was speaking more specifically from the perspective of the owner, the operator of the facility and them saying hey, we've got the best record, according to these new standards going out there. I just foresee that opportunity in response, again, to some of the complaints that we were aware of as a PAC saying hey, that's not me, that's not my facility.

P. PARFREY: Certainly, I am on record as saying that such public reporting and transparency is an intervention that would help improve the quality of care across from the community to the long-term care sector to the acute-care sector. I think that NLHS is going to go along that line of trying to be able to collect metrics that demonstrate the quality or lack of quality in the various interventions for which we're responsible for and in the equity of access that everybody in this province has to those particular interventions.

NL health quality council would be the one vehicle for doing that. I think, in this instance, it is clear that the Auditor General thinks that's a good idea for this particular intervention. I think it's a good idea for many interventions.

J. MCGRATH: So, in particular, as we get into having more robust reporting by home and you'll be able to see licensure status – for example, what I would envision is that someone is non-compliant when it comes to licensure, one of the homes or something along that nature, the public will be able to see that and I think that's when putting up your hands is one thing, but then you'll be able to be proactive in publishing that information for the public to see, I think that might get at kind of what you're speaking.

P. PARFREY: I've done research on the quality of care in the long-term care facilities, because the RAIs are available from the 44 facilities every year and you can evaluate the changes and quality of care that happen over time.

P. TRIMPER: I think I can tell from some of the nods in my colleagues that when you referenced an example of the restaurant inspections, it's a really good example and it's a great approach to what we're talking about.

J. MCGRATH: I think that's what we're striving for, and I think that's what the recommendations were kind of getting at as well. So we're committed to that.

P. TRIMPER: Thank you.

I have about two days left in this room, and I just wanted to say that what I see here and feel gives me great comfort that, going forward, I will have been a part of this change. I may be even speaking selfishly. Someday, let's face it, we're all going to seek the care of the State and we want to make sure this is done right. So we all have a self interest in this.

If you were us, when should we check back in to see how things are going, how things are doing? When would you feel comfortable that your standards are there, that you've got this ratcheted around that we could go and say, yes, that exercise in 2025 of May was very well done and we can all proudly say we did a good job?

P. PARFREY: Well, I think annual reporting is something that is good and the metrics are available, and progress should be made on

an annual level without making it so difficult or making it so inflammatory that whenever you report, there's going to be a big issue about it.

The key thing is that we're making progress and that the areas that we identify in which we want to make progress can be demonstrated and the metrics associated with it may be, in the year's time, is just a baseline. Then the year after, it's how things have occurred over the next year, and then two years later, it's how well have we done according to what the Auditor General dealt with.

I think the Auditor General is shining a light on the quality of care that's existing in this particular piece that we want to do well, and we have an obligation to do well. That's pure and simple. We accept that obligation at NLHS and I know we're totally aligned with Health and Community Services around trying to do better and to do good, in effect, is what we're trying to do. So we are committed to that.

J. MCGRATH: I definitely think more frequent is what I would say. A specific time frame, I'm going to leave that to you folks. But whether it's six months or a year, I think it's important to be held accountable on an action plan so that these things are done timely, because that is really important to make sure that the recommendations are implemented, done, in a timely manner. We do have a fairly robust action plan here now so I think to regularly report on that, there's no issues there. I would encourage it.

P. TRIMPER: I thank you very much.

Chair, that's it for me.

CHAIR: Thank you.

Just a few questions as I was going along there. I think we're just about getting ready to clue up, there are some questions I think from a few of us there, but some follow-ups to what was already said. I'm just going back to the medication storage and administration.

I know you said you were going to, as there were precautions coming in place, make sure that everything is done to standards so those things don't happen, but the fact is this report was done 2½ years from April 1, 2022, to September 2024.

So what was the department's responsibility? It did happen and there are staggering numbers there. Was there somebody in the department responsible for making sure that this didn't happen?

J. MCGRATH: I think at the department level, we want to make sure that each serious incident, so whether it's – I mean I can't speak to specific instances, but make sure that each serious incident is reported and is reported to the department, and that the corrective action and the appropriate action is taken.

During that period the appropriate action was taken. I think where we fell down and didn't do a great job was the documentation piece. Going back through that audit period, those serious incidents were reported but there was no procedure in place to make sure that we're capturing the documentation, to make sure that we're capturing the remedial action if necessary and that standard – make sure I have the word in place – operating procedure is now in place to make sure that we are capturing the information, that the information does flow up and the remedial action, if warranted, and the most appropriate action does take place.

CHAIR: Okay, thank you.

The Auditor General also had some findings around food quality and service. How many food safety sessions with the personal care home operators has taken place to date?

D. WADDLETON: Sorry, just to clarify your question, how many training opportunities? Is that what you're –

CHAIR: How many food safety sessions?

D. WADDLETON: Okay.

That's not information that I would have, around how many sessions. Digital Government and Services is responsible for the food safety inspections. The number of training opportunities for personal care home staff themselves is not information that we would have at the department. I don't know about NLHS.

CHAIR: So does NLHS get updates from Digital Government and Services on when this is done or not done?

D. WADDLETON: The requirement for food safety training in a personal care home is that one staff would have the training. There's one person on staff that would have the training. It's not a requirement that everybody who's doing food service has a food certified course. The requirement is that there is one person in the building that would have training. That's according to DGSNL standard or requirements.

CHAIR: Okay, thank you.

Personal care homes are private operators. What role does NLHS or the department have in staffing?

P. PARFREY: NLHS is responsible for the case management component of it and have nurses and social workers and dieticians that visit the personal care homes. The rest of it I think is the responsibility of the personal care homes, to hire people to do the rest of that part.

Am I right, Deena?

D. WADDLETON: Yes.

CHAIR: Okay. Thank you.

With regard to Recommendation 9, timelines for placing this decision, what will be the goals and timelines and how long someone will have to wait for an assessment?

C. DAVIS: So just to clarify, the time limits to wait for an assessment or the time limits for the assessment to be completed once they've been identified as asking for an assessment to go to a personal care home?

CHAIR: Okay, let's use that.

C. DAVIS: Okay.

I think, as Deena said, our goal will be to meet the 10-day requirement for the initial assessments once we have all the information. Then, within NLHS, we have to work with our teams to ensure we put plans in place so that our teams are able to meet those deadlines, report monthly on instances where we're unable to meet those deadlines and look at opportunities for improvements.

CHAIR: Okay. All right, thank you.

With that, I have no other questions, but I think my colleague from Mount Pearl North may have a couple of more questions. I'll let her clue up with a couple more questions and then we'll come back for clue up procedures.

L. STOYLES: Are there any personal care homes in the region that have more than two people in a room?

D. WADDLETON: There are a couple of personal care homes that would have more than two people in some of the rooms.

L. STOYLES: Okay.

The other questions I have, I mean, we're basically out of time for the morning because the House of Assembly is opened this afternoon. A couple of the things I wanted to focus on was loved ones staying

together when they go in homes. I know they have a strict policy for that because if they're not a level to go in a personal care home, they're not accepted, especially if there's no room available and that's normally the case.

The other thing is that every individual when they go in a home, I understand they get back, if they qualify for the subsidy. If they got their own money and they pay their own way it's not an issue, but they lose everything except for, I think, $150 a month. Is that the same or is that being looked at again to give them more money for their personal care?

D. WADDLETON: I can start, yeah.

To your first question about spouses, that was also a recommendation coming from the long-term care and personal care home program review. We've done a new operational standard with respect to how to support spouses in different settings.

Our goal, really, is to support spouses to stay together in their own homes. We have put allowances in that NLHS can go above regular policies for individuals in communities so, basically, more home care hours can be put in place to support people in community where possible. We've also allowed, where appropriate, for individuals in personal care homes to remain together. We already had a process in place where if one spouse met the requirements for a personal care home, that both spouses could be placed in the personal care home together and both would be eligible for a subsidy if they met the other financial eligibility criteria.

If it does come to it that there are no other options for individuals, there is the ability to have spouses placed together in long-term care. There is certainly operational challenges with that with respect to the demand for long-term care for individuals with higher care needs. So NLHS really is trying to support people to remain together in communities rather than going to long-term care together.

For the other question on the funding, seniors who are in receipt of OAS and GIS, which would be many of our clients, actually get to retain more than $150 a month. It's around $250 a month that people can retain. However, if an individual is in a personal care home and their income is lower than the OAS-GIS amount, then all individuals are guaranteed to have at least $150 that they retain, but the majority of people are actually retaining more than that based on our financial assessment policy.

L. STOYLES: If they haven't got their funeral paid for – I'm just asking the question if this is correct – can they go to a funeral home before they go in the personal care home and arrange to have money paid – my understanding was about $100 or $150 a month to pay for the funeral and that won't come off their money.

Is that a policy in the government or have you looked at the policy? I understood it was in place, and a lot of people don't know about it because you haven't informed the people – put enough education out about it.

D. WADDLETON: Right. Actually, the policy is that if it's in place before they come to the health authority, that it's allowed. We are looking at that. It has been identified as a bit of an inequity that individuals going into personal care homes, once they're in there, are not able to pay for the funeral and have it factored into their financial assessment, but that is something that we're looking at now to make a policy recommendation for a change.

L. STOYLES: Perfect.

The other item – so many other things I'd like to talk about – lockdown. Never before have I heard so many homes locking down. If they get any virus at all, they are locked down. Are you putting a better, clearer policy in place for lockdowns? Just asking

the question. I mean when COVID happened, everything locked down solid for months and months, but now it seems like every time you turn around, you are up visiting the homes, we're locked down for the next seven days.

I'm just concerned it's an excuse to lock them down for seven days and the residents can't have visitors in or anything. I'm just curious about that.

D. WADDLETON: Sometimes the decision regarding infection prevention and control measures in a personal care home are at the direction of clinical staff in the health authority within Public Health or infection prevention and control clinicians.

What the new standards require is that an operator does not make a unilateral decision about that themselves, so that they just don't decide to close the home, but they only close it when it is a recommendation like for visitor restriction by infection prevention and control clinicians.

There is also a requirement in the standards that if an individual resident is at end of life, that visiting will happen but just that the family visiting may need to wear personal protective equipment to enable the visit.

L. STOYLES: Okay, that's it for me, Chair.

CHAIR: Okay, thank you.

Thank you, everyone, for attending and being at the hearing today. I just would like to say on behalf of Pat, again, thank you, but I think we'll follow up probably quarterly which would start probably this fall with regard to the action plan and the recommendations just to get a follow-up report of where we stand at each time, probably quarterly for the next little while just to see where this happens.

With that, I would like to say, on behalf of the Committee, thank you to the witnesses appearing today, as well as the Auditor General, Denise Hanrahan and her team and their support, of course, each and every day and for their attendance here today.

I'd also like to thank all the Members of the Public Accounts Committee for their continued dedication and commitment to this important work, because they put a lot of time into it.

With that, if there's no further business, I would call for a motion to adjourn.

J. BROWN: So moved.

CHAIR: The Member for Labrador West.

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: Against?

The meeting is now adjourned.

On motion, the Committee adjourned.