Ministry of Long-Term Care

Reporting Requirements for LTC Homes

October 2022 (Updated June 2023)

Overview

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 have replaced the previous *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 as the governing legislation for long-term care in Ontario.

As of April 11, 2023, the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia has been revoked—its requirements are now embedded in Ontario Regulation 246/22.

This fact sheet provides updated legislative references to the requirements around reporting complaints, critical incidents, and other specific matters to the ministry. Readers are encouraged to familiarize themselves with this summary document and refer to the FLTCA, 2021 and its Regulation for the complete requirements.

1. Reporting Procedures

There are two different reporting procedures that may apply to situations involving complaints, critical incidents, and other matters. As this document addresses various situations in detail, it will regularly refer to the **Report Immediately procedure** and the **Report in 1 Business Day procedure**, which are both outlined below.

Report Immediately Procedure:

- If during business hours (Monday to Friday, 8:30 a.m. to 4:30 p.m.), submit a Critical Incident System (CIS) report,
- If outside of business hours or during a statutory holiday, call the Service Ontario After-Hours Line (1-888-999-6973), and submit a CIS report the next business day,
- Investigate and report findings of the investigation via an amendment to the original CIS report within 10 days.

Report in 1 Business Day Procedure:

- Report via the Critical Incident System (CIS) within one business day. Do not call the after-hours telephone line.
- Investigate and report the findings of the investigation via an amendment to the original CIS report within 10 days

Reminder: Homes use the Critical Incident System to report complaints, critical incidents, and other specific matters outlined in legislation. For more guidance on making a report to the Director, see section 4. Information to Include in a Report below.

1. Reporting Complaints

Staff must follow the Report Immediately procedure when the home receives a complaint that **alleges harm** or **a risk of harm** to one or more residents. Please note that staff are not required to report complaints that do not allege harm or risk of harm to one or more residents.

Ontario Regulation 246/22, s. 109

2. Reporting Critical Incidents

The reporting procedure for critical incidents depends on the nature of the incident—some must be reported immediately, while others must be reported within one business day. In all cases, the home conducts an investigation and updates the original report with their investigation findings within ten business days.

Use the Report Immediately procedure for the following incidents:

- An emergency within the meaning of section 268, including fire, unplanned evacuation, or intake of evacuees,
- An unexpected or sudden death, including a death resulting from an accident or suicide,
- A resident who is missing for three hours or more,
- Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing,
- An outbreak of a disease of public health significance or communicable disease as defined in the *Health Protection and Promotion Act,*
- Contamination of the drinking water supply.

Ontario Regulation 246/22, s. 115 (1)

Use the Report in 1 Business Day procedure for the following incidents:

- A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
- An environmental hazard that affects the provision of care or the safety, security, or well-being of one or more residents for a period greater than six hours, including: a breakdown or failure of the security system; a breakdown of major equipment or a system in the home; a loss of essential services, or flooding.
- A missing or unaccounted for controlled substance.

- Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition. Subsection (4) states:
    - Where an incident occurs that causes **an injury to a resident for which the resident is taken to a hospital**, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's condition, the licensee shall:
        - Contact the hospital within **three calendar days** after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition, and
        - Where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than **three business days** after the occurrence of the incident, and follow with the report required under subsection (5) [s. 115 (5)]
- A medication incident or adverse drug reaction in respect of which a resident is taken to hospital
- The use of glucagon that results in a resident being taken to hospital.
- An incident of severe hypoglycemia or unresponsive hypoglycemia in respect of which a resident is taken to hospital.

Ontario Regulation 246/22, s. 115 (3)

3. Reporting Certain Matters

Use the Report Immediately procedure if there are reasonable grounds to suspect that any of the following has occurred or may occur:

- Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
- Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
- Unlawful conduct that results in harm or a risk of harm to a resident.
- Misuse or misappropriation of a resident's money.
- Misuse of misappropriation of funding provided to a licensee under this Act, the *Local Health System Integration Act, 2006*, or the *Connecting Care Act, 2019*.

Fixing Long-Term Care Act, 2021, s. 28 (1)

4. Information to Include in a Report

When making or amending a report via the Critical Incident System, it's important to include a description of the incident, the actions taken in response, and the planned follow-up actions, as required in Ontario Regulation 246/22 s. 112(1).

Incident **descriptions** should include names of all residents involved, names of any staff who were present or who discovered the incident, and names of staff who responded or who are responding to the incident.

Equally important are the **actions taken in response** to the incident. Address the following questions when writing your report:

- What care was provided as a result of the incident and by whom?
- Was a physician or a Registered Nurse in the extended class contacted?
- What other authorities were contacted, if any?
- Was the family, a person of importance, or substitute decision maker contacted? Provide their name.
- What is the status of the individual involved?

Finally, conduct an **analysis** of the situation and list **follow up actions** that will prevent the incident from recurring. Consider preventative actions that can be done both immediately and in the long-term.

Also, be sure to include the name, title, and contact information of the person making the report.

Incomplete Information

If the licensee cannot provide the material listed above within 10 days, the licensee must submit a preliminary report with the information available. The final report must then be submitted within 21 days of becoming aware of the incident, or earlier if required by the Director.

5. REMINDER: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia

The Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia has been revoked—its requirements are now embedded in Ontario Regulation 246/22.

As a reminder, there is a requirement for homes to notify the Director of the following incidents using the Report in 1 Business Day procedure:

- A resident who is administered glucagon which results in the resident being taken to a hospital.
- A resident who experiences severe hypoglycemia or unresponsive hypoglycemia which results in the resident being taken to a hospital.

When reporting via the Critical Incident System, homes will no longer select the "Medication incident/adverse drug reaction" option. Two new options, "Glucagon",

and “Severe and unresponsive hypoglycemia” have been added to the Critical Incident System.

Also, ensure that the resident’s substitute decision-maker and any other person designated by the resident are promptly notified.

This document is for informational purposes only. It is intended to highlight some of the new aspects and requirements of the Fixing Long-Term Care Act, 2021 *and its regulation. Licensees are responsible for ensuring compliance with the requirements of the* Fixing Long-Term Care Act, 2021 *and its regulation. In the event of a conflict or inconsistency between this document and Act or regulation, the Act or regulation will prevail.* ***This document does not constitute legal advice or interpretation. Users should consult their legal counsel for all purposes of legal advice and interpretation.***