

FOR THE RECORD

Ontario unveils regulations for retirement homes

Ontario has moved to standardize care for retirement home inhabitants by unveiling draft regulations that will substantially tighten the rules under which such facilities can operate, according to the Ontario Seniors' Secretariat.

The proposed regulations fall under the rubric of the Retirement Homes Act, 2010, whose fundamental principle was that "a retirement home is to be operated so that it is a place where residents live with dignity, respect, privacy and autonomy, in security, safety and comfort and can make informed choices about their care options" (www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_10r11_e.htm).

There are more than 700 retirement homes in Ontario, which house more than 40 000 seniors, a "number that is expected to grow as our population ages," states the Notice of Proposed Initial Draft Regulations (www.seniors.gov.on.ca/en/retirement_homes/Proposed_Initial_Draft_Regulations_RHA.pdf).

The enabling legislation had seven parts, including the establishment of a Retirement Homes Regulatory Authority (RHRA), responsible for enforcing the act; educating retirement home owners, consumers, and the public about matters pertaining to it; and advising the Minister Responsible for Seniors on policy issues.

The act also outlined a "Resident's Bill of Rights," which states that retirement home inhabitants are entitled to, among other things:

- a safe, clean, and respectful living environment
- know what services are provided in the home, and how much they cost
- be informed of any increases in care service costs
- apply for publicly funded care services and assessments

- not be restrained in any way that is not in accordance with common law
- give or refuse consent to any treatment or care, for which consent is required by law; and to be informed of the consequences of doing so
- raise concerns and/or changes in policy, without fear of reprisal
- participate fully in any decisions concerning any aspect of his or her care.

Among the proposed initial draft regulations, which were unveiled for public consultation, are ones that set standards for the temperature control, cleanliness, maintenance and safety of the facilities. The quality of each home's food preparation, administration of drugs, and assistance with regards to feeding, dressing, bathing, personal hygiene and ambulation would also be strictly monitored, while new infection control and prevention programs would be implemented.

The act also outlined a policy of "zero tolerance of abuse and neglect," which encompasses abuse of a physical, sexual, emotional, verbal or financial nature. Under the regulations, licensees "would be required to train all staff of the retirement home on the relationship of power imbalances between staff and residents; the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and situations that may lead to abuse and neglect; and how to avoid such situations."

The legislation also obligated all retirement home owners to apply to a registrar for a license to operate their facilities, and made them subject to inquiries and investigations if there were not "reasonable grounds" to believe the home would be run properly. The act also mandated that all new retirement home staff providing direct care to residents must first undergo a recent background check, including a vulnerable sector screen, and disclose any criminal charges and convictions that have occurred since their last check.

The new authority will enforce the legislation. Violations are subject to fines or revocation of an operator's license, the notice states.

Responses to the proposed regulations must be received by the Ontario Seniors' Secretariat before Apr. 8.

The regulations were developed in response to Ontario Ombudsman André Marin's findings that standards used to monitor nursing homes were interpreted inconsistently and applied in different ways by different inspectors (www.ombudsman.on.ca/media/161447/ltr%20for%20web-en.pdf). — Jennie Russell, Ottawa, Ont.

Financial penalties for preventable medical errors in United Kingdom

The United Kingdom's Department of Health has expanded the list of serious medical errors, such as wrong gas administration, for which hospitals and other health facilities will be financially penalized for occurrences on their premises.

The list of incidents of preventable incidents, or so-called "never events," has been expanded to 25 from 8 and will be included in National Health Service (NHS) contracts, so payments will be withheld if the level of care falls short of acceptable standards, the government indicated.

Never events are "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers," according to the report, *The List of "Never Events" for 2011-12: Policy framework for use in the NHS* (www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124580.pdf).

To qualify as a "never event," an incident had to meet defined criteria: "The incident has clear potential for or has caused severe harm/death; There is

evidence of occurrence in the past (i.e. it is a known source of risk); There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation; The event is largely preventable if the guidance is implemented; Occurrence can be easily defined, identified and continually measured.”

The level of cost recovery to be sought is essentially left to negotiations between national health trusts and commissioners, the report added, noting that cost recovery “is not about punishment.”

“Commissioners and providers should therefore seek to identify in as simple terms as possible, what the care episode was in which the error occurred and what subsequent treatment was required as a direct result (if appropriate). They can then recover those costs. They should not be looking to forensically examine every possible aspect of care for links to the event in order to recover those costs. Equally they should not view this simply as an opportunity to recover the costs of many months of care due to a ‘never event’ occurring at some point during that care. This misses the point of the ‘never events’ policy, which is about reporting and learning. Cost recovery must be proportionate and appropriate.” To that end, the report suggests caps on the maximum amount of money that can be recovered, possibly “the equivalent of a month’s inpatient stay, or at a monetary level of, for example, £10,000.”

The 25 “never events” (including the 8 existing or modified “never events”), which were crafted in consultation with the medical profession, are:

- “Wrong-site surgery (existing)
- Wrong implant/prosthesis
- Retained foreign object post-operation (existing)
- Wrongly prepared high-risk injectable medication
- Maladministration of potassium-containing solutions (modified)
- Wrong route administration of chemotherapy (existing)
- Wrong route administration of oral/enteral treatment
- Intravenous administration of epidural medication
- Maladministration of insulin

- Overdose of midazolam during conscious sedation
- Opioid overdose of an opioid-naïve patient
- Inappropriate administration of daily oral methotrexate
- Suicide using non-collapsible rails (existing)
- Escape of a transferred prisoner (existing)
- Falls from unrestricted windows
- Entrapment in bedrails
- Transfusion of ABO-incompatible bed rails
- Transplantation of ABO or HLA-incompatible organs
- Misplaced naso- or oro-gastric tubes (modified)
- Wrong gas administered
- Failure to monitor and respond to oxygen saturation
- Air embolism
- Misidentification of patients
- Severe scalding of patients
- Maternal death due to post partum haemorrhage after elective caesarean section (modified).” — Caroline George, Ottawa, Ont.

Exploding myths

Private health care, rather than medicare, is the real cost driver of Canadian spending on health, according to a report from Canadian Doctors for Medicare.

Spending on medically necessary hospital and physician services, as a percentage of Canada’s gross domestic product, are relatively unchanged over the past few decades, unlike spending on private health care, such as pharmaceuticals, private prescription drug insurance, dental care and private dental insurance, according to the report, *Neat, Plausible, and Wrong: The Myth of Health Care Unsustainability*.

“The overall cost of care has been driven most significantly by the rising cost of pharmaceuticals. In fact, the rising share of privately financed health care would be much more modest were it not for the impact of pharmaceutical costs. Canada’s drug costs are higher than the per capita costs of all Organisation for Economic Co-operation and Development (OECD) countries with the exception of the United States and

Switzerland, and 30% higher than the OECD average. Drug costs overall rose from \$4 billion in 1985 to an estimated \$26.5 billion in 2007. During that time, Canadian drug prices rose an average of 9.2%, far faster than in any other OECD country,” states the report (www.canadiandoctorsformedicare.ca/images/stories/Neat_Plausible_and_Wrong.pdf)

“The private insurance market, if anything, makes the system less sustainable, as well as less equitable,” the report adds. “Canada’s private insurance system has seen some sharp increases in costs. Private health insurance spending has grown rapidly since the late 1980s, rising from \$139 per capita in 1988 to \$591 per capita in 2007. Even adjusted for inflation, (giving a per capita constant dollar cost of \$377) this represents an impressive 369% increase, outpacing almost all other categories of health care. It is hard to see how this increasingly costly system can be expected to reduce cost in health care overall.”

Models of health care based primarily on private health insurance “have not produced measurable savings” and open the door to “runaway cost increases similar to those seen in the United States, where private sector health insurance costs have increased especially rapidly, driven by inflated executive compensation policies and staggering administrative costs.”

Among measures recommended to reduce costs are ones to curb the endless upward spiral of pharmaceutical costs, including one to regulate prices by pegging them to those “based on comparisons to the average prices in the OECD, instead of using only a few, high cost comparators would also lower drug costs by \$1.43 billion nationally.” Others include the elimination of \$933 million in tax subsidies for private drug insurance plans and the adoption of more effective mechanisms for identifying cost-effective drugs.

Other measures recommended to reduce health costs include the provision of more guidelines and information to doctors and clearer government policies on the use of prescriptions so as to manage “the unnecessary growth in pharmaceutical use.” As well, the report recommends measures to reduce overuse of diagnostic imaging, as well as such reforms as “greater emphasis

on primary prevention and health promotion; integrated patient-centred primary care by multi-disciplinary teams; enhanced scope of practice for allied health professionals; shared care with increased coordination between family doctors and specialists; national pharmacare including national procurement processes; better uptake of evidence-based guidelines for diagnosis and treatment; stronger patient safety protections; and deployment of the long-awaited electronic health record.”

But the report also notes that many of needed changes are only possible through “greater regulation of the system, for example, through the creation of a national pharmacare program,” and may require new models of funding such as “direct taxation, tied taxes, and social insurance.” — Wayne Kondro, *CMAJ*

Your tired, your poor, your huddled masses

It seems the famous inscription of Emma Lazarus’ sonnet on the Statue of Liberty applies less and less to health care in America as a new government report indicates that disparities in quality and access to care continue to worsen along racial and socioeconomic lines.

But there have been small gains in the quality of care for some groups of Americans in some categories of treatment, such as the number of heart

attack patients who received treatment to unblock arteries within 90 minutes (to 81% in 2008, from 42% in 2005), according to the *2010 National Healthcare Quality Report* and the *2010 National Healthcare Disparities Report* (www.ahrq.gov/qual/nhdr10/nhdr10.pdf). Annually mandated by Congress and traditionally separated into two documents, the reports were prepared by the United States Department of Health and Human Services’ Agency for Healthcare Research and Quality and released as a combined entity for the first time.

Health care quality and access for minority and low-income groups remain “suboptimal,” the report states. “The gap between best possible care and that which is routinely delivered remains substantial across the Nation.”

Assessing 22 “core” measures of “quality of care,” the agency found that “Blacks and American Indians and Alaska Natives received worse care than Whites for about 40% of core measures; Asians received worse care than Whites for about 20% of core measures; Hispanics received worse care than non-Hispanic Whites for about 60% of core measures; and Poor people received worse care than high-income people for about 80% of core measures.”

The disparities were almost as pronounced with respect to access to care. For example, “Blacks had worse access to care than Whites for one-third of core measures,” while the poor had

worse access for all core measures. “Across the 22 measures of health care access tracked in the reports, about 60% did not show improvement and 40% were headed in the wrong direction. Median rate of change was — 0.6% per year, indicating no change over time.”

Among other trends identified by the agency:

- There are significant regional variations across the 179 measures of health care quality, with central states lagging well behind their eastern and western counterparts. “New England did best on preventive care and acute treatment; western States did best on outcomes of care.”
- Residents of inner-city and rural areas receive worse care for about 30% of the quality measures.
- Residents of inner-cities had 50% less access, while residents of rural areas had 40% less access, to core care measures than did residents of large city suburbs.

The same disparities related to race, ethnicity and socioeconomic status were also apparent among measures related to eight designated “national priority areas.” In the area of patient safety, for example, there was no significant change in the disparities in preventable and premature hospital-level mortality rates. — Wayne Kondro, *CMAJ*

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