Chapter 18
Social Services—Monitoring Quality of Care in Homes Supporting Adults with Intellectual Disabilities

1.0 Main Points

The Ministry of Social Services funds and licenses privately-owned group homes and approved private service homes to provide accommodation, meals, and care to about 1,600 adults with intellectual disabilities. At August 2021, the Ministry licensed about 245 group homes and 200 approved private service homes in Saskatchewan.

The Ministry needs to better monitor whether group homes and approved private service homes provide quality care to adults with intellectual disabilities. In order to enhance its licensing practices, the Ministry needs to:

- Update its home inspection checklists to cover all key risk areas
- Annually inspect each group home assessing whether it meets minimum care standards
- Oversee timely resolution of deficiencies resulting in conditional licences
- Centrally track inspection dates, as well as identified and rectified deficiencies

The Ministry expects all homes to create person-centred plans for each client at least every two years, driven by clients' goals, dreams, and aspirations to enhance their development and quality of life. However, the Ministry monitors neither the quality nor fulfillment of these plans, and the majority of plans we assessed (70%) did not meet the required quality, or show plan fulfillment.

Moreover, the Ministry does not meet with clients regularly to see whether clients live a quality and fulfilling life. We found 19 out of 30 client records (or 63%) showed that Ministry staff did not have any direct contact with clients in the last two years. Without meeting a client, the Ministry may be unaware of client-care issues or quality of life concerns.

The Ministry does not analyze serious incidents to identify particular homes with ongoing issues. In 2020–21, group homes reported 748 serious incidents and approved private service homes reported 111 serious incidents. Also, the Ministry does not monitor whether any homes implemented recommendations based on serious incident investigations. For example, we found no evidence of Ministry follow up on four out of 13 investigations we assessed. The Ministry needs information about recommendation implementation in order to know effective actions are taken to prevent future serious incidents.

Effective monitoring of care provided at Ministry-funded, licensed homes helps adults with intellectual disabilities to live meaningful and fulfilling lives, free from safety and health threats.

2.0 INTRODUCTION

This chapter outlines audit results of the Ministry of Social Services' processes to monitor whether Ministry-funded group and approved private service homes provide quality care to adults with intellectual disabilities for the 12-month period ended August 31, 2021.

Adults with intellectual disabilities are people with impaired intelligence who have a significantly reduced ability not only to understand new or complex information, but also to learn and apply new skills. Beginning before adulthood, this impaired social functioning results in a reduced ability to cope independently with a lasting effect on development. Group and approved private service homes typically provide care 24/7 to adults with intellectual disabilities.

2.1 Ministry Relationship and Responsibility for Group and Approved Private Service Homes

The Ministry of Social Services provides support for persons with intellectual disabilities. The main objective of the Ministry's Community Living Service Delivery area is to ensure adults with intellectual disabilities' physical, emotional, and social needs are met and they live and function as independently as possible within their own communities.

The Ministry funds and partners with community-based organizations and other service providers across the province to deliver residential services and day programs including: group homes, approved private service homes, group living homes, and supportive living programs.[1]

For adults with intellectual disabilities, the Ministry, along with the individuals, their families and other key people in the person's life determine a housing option suited to the individual based on their assessed need. In 2020–21, the Ministry spent about $176 million on funding for residential and day programs provided to almost 4,500 adults with intellectual disabilities.

As shown in **Figure 1**, residential programs—group and approved private service homes—receive the majority of the $176 million Ministry funding. At March 2021, group homes had 1,206 spaces and approved private service homes had 398 spaces for adults with intellectual disabilities.

Figure 1—Ministry-Funded Residential Services for Adults with Intellectual Disabilities

Residential Program	Description`	March 31, 2020			March 31, 2021		
		# of homes	# of spaces	Funding (in millions)	# of homes	# of spaces	Funding (in millions)
Group Homes	Staffed to provide personal care, supervision, and support for adults Located in residential neighbourhoods throughout the province	241	1,175	$94.6	253	1,206	$102.4

[1] Group living home is a home shared between adults who are individually responsible for paying basic shelter costs. Homes may receive Ministry funding for support staff as needed. Supported living programs provide adults living in their own homes with limited support and supervision so they can live as independently as possible.

Residential Program	Description`	March 31, 2020			March 31, 2021		
		# of homes	# of spaces	Funding (in millions)	# of homes	# of spaces	Funding (in millions)
	Receive Ministry funding for support staff and day-to-day living expenses. Subject to annual Ministry licensing and inspection						
Approved Private Service Homes	Provide a supportive, family-living environment in a community setting Give residents the opportunity to develop social and life skills Receive Ministry funding for day-to-day living expenses. Subject to annual Ministry licensing and inspection	210	423	$9.0	206	398	$9.0

Source: Based on information provided by the Ministry of Social Services.

The Residential Services Act and *The Residential-service Facilities Regulations* give the Ministry authority to license, fund, and monitor residential service facilities (group homes) providing residence, services, and care to people with intellectual disabilities. Similarly, *The Private-service Homes Regulations* gives the Ministry authority to certify, fund, and monitor approved private service homes' facilities and services provided to people with intellectual disabilities.

Typically, adults living in Ministry-funded group and approved private service homes require greater needs for care.

Group homes are staffed homes providing personal care, supervision, and support for adults with intellectual disabilities (on average, four to five clients per home) with an average client age of 48 years old.

Approved private service homes are homes providing a supportive family-living environment to adults with intellectual disabilities (usually one to three clients). They are to provide residents with opportunities to develop social and life skills. The average age of clients living in approved private service homes is 45 years old.

2.2 Adults with Intellectual Disabilities Deserve Quality Care and Quality of Life

Saskatchewan people experiencing disability face significant difficulties for inclusion, accessibility, and respecting, protecting and fulfilling basic human rights. They encounter limited access to goods, services, and facilities; greater experiences of discrimination; poorer health; and higher rates of poverty and abuse.[2]

The most recent Canadian Survey on Disability (2017) states that one in five (22%) Canadians aged 15 years and over (about 6.2 million) had one or more disabilities.[3]

[2] Government of Saskatchewan, 2015, *People Before Systems: Transforming the Experience of Disability in Saskatchewan. Saskatchewan Disability Strategy*, p. 4.
[3] Statistics Canada, *Canadian Survey on Disability Reports. A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017*. www150.statcan.gc.ca/n1/daily-quotidien/181128/dq181128a-eng.htm (4 June 2021).

The Canadian Association for Community Living (Inclusion Canada) estimates that between 100,000 and 120,000 adults with intellectual disabilities face a housing and support gap. Almost 25,000 Canadians with more significant intellectual disabilities had core housing needs (e.g., inability to afford housing) in 2016.[4] While research indicates that although Canadian adults with intellectual and developmental disabilities often want to live independently, 50 to 60% live with family members for various reasons.[5]

While no current data is available to show how many people in Saskatchewan have disabilities, a 2012 Statistics Canada census identified 116,640 people in Saskatchewan aged 15 and over with disabilities. This translates to a 15% disability prevalence rate in Saskatchewan compared to 13.7% nationwide in 2012.[6]

In 2020–21, Saskatchewan's group homes reported 748 serious incidents and private service homes reported 111 serious incidents—a 12% increase from the prior year (see **Figure 7**). The majority of these reported incidents related to unexpected illness (for both group and private service homes) and medication abuse (for group homes).

Research shows people with intellectual disabilities are also a more vulnerable health population with greater prevalence for diseases such as hypertension, heart disease, respiratory disease, and diabetes; all of which are identified as risk factors for poor outcomes from COVID-19.[7] In 2020–21, the Ministry recorded 56 serious incidents in group homes and two serious incidents in approved private service homes due to COVID-19 (see Disease Outbreak in **Figure 7**).

A 2021 report by the Saskatchewan Advocate for Children and Youth reported inadequate monitoring of quality of care provided in group homes for cognitively challenged children in the Ministry's care, as well as systemic oversight issues in the Ministry of Social Services.[8] These Ministry oversight issues may also extend to group homes providing care to adults with intellectual disabilities.

Providing safe housing and quality support for adults with intellectual disabilities contributes to a meaningful quality of life. Adults with intellectual disabilities shape their quality of life by defining how they want to live; directing the services and supports they receive; leading a life enriched by social connections; experiencing life-long learning; developing decision-making skills; working in a personally meaningful job; and receiving support to live in a healthy and safe environment.[9] Effective monitoring of care provided in group and approved private service homes to adults with intellectual disabilities is crucial in contributing to their safety and wellbeing.

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[4] Alzheimer Society of Canada, ARCH Disability Law Centre, Canadian Association for Community Living, Canadian Mental Health Association, Toronto Branch, Council of Canadians with Disabilities, Institute for Research and Development on Inclusion and Society, Social Rights Advocacy Centre, and Wellesley Institute. *Housing Issues for People with Disabilities in Canada. March 2017*. Submitted to: The UN Committee on the Rights of Persons with Disabilities for its review of Canada's initial report under the CRPD. inclusioncanada.ca/wp-content/uploads/2018/05/Canada-Right-to-Housing-for-Persons-with-Disabilities-May-15-2017.pdf (4 June 2021).

[5] Verseghy, J., Atack, L., Maher, J., Herie, M., Poirier, M., MacNeil, F., McCauley, D., Grimley, M., 2019, *Attainable Dreams and Harsh Realities: Housing for Individuals with Intellectual and Developmental Disabilities*, Journal on Developmental Disabilities. 2019, Vol. 24 Issue 2, p. 3.

[6] Statistics Canada, *Number and percentage with and without disabilities, aged 15 years or older, Canada, provinces and territories, 2012*. www150.statcan.gc.ca/n1/pub/89-654-x/2015001/tbl/tbl01-eng.htm (4 June 2021).

[7] Turk M. A., Landes S. D., Formica M.K., Goss K. D., 2020, *Intellectual and developmental disability and COVID-19 case-fatality trends: TriNetX analysis*. Disability and Health Journal, 13 (2020) 100942.

[8] Saskatchewan Advocate for Children and Youth, *Someone to Watch Over Us. Special Investigation Report* (2021). www.saskadvocate.ca/sites/default/files/pdfs/reports/Someone_to_Watch_Over_Us_Special_Report_Final_March_2021.pdf (30 April 2021).

[9] *Joint Position Statement of American Association on Intellectual and development disability and The Arc, Quality of life*, (2015). www.aaidd.org/news-policy/policy/position-statements/quality-of-life%20 (8 June 2021).

3.0 AUDIT CONCLUSION

We concluded the Ministry of Social Services had, other than the following areas, effective processes to monitor whether Ministry-funded group homes and approved private service homes provide quality care to adults with intellectual disabilities for the 12-month period ended August 31, 2021.

The Ministry needs to:

- **Regularly meet with clients in the homes and assess the quality and fulfillment of their person-centred plans**
- **Update the home inspection checklist to cover key risk areas and annually inspect each group home to assess whether minimum program standards are met**
- **Centrally track key information about homes and monitor timely resolution of deficiencies at conditionally licensed homes**
- **Analyze serious incidents for ongoing issues in homes and ensure incident recommendations from investigations are implemented**
- **Verify completion of periodic criminal record checks for those people in homes supporting clients**

Figure 2—Audit Objective, Criteria, and Approach

Audit Objective:

To assess the effectiveness of the Ministry of Social Services' processes to monitor whether Ministry-funded group homes and approved private service homes provide quality care to adults with intellectual disabilities for the 12-month period ended August 31, 2021.

Audit Criteria:

Processes to:

1. **License eligible homes to care for adults with intellectual disabilities**
   - Establish appropriate care standards
   - Issue appropriate licences to eligible homes (e.g., include requirements to meet care standards and establish appropriate person-centred plans)
   - Communicate care standards
2. **Periodically assess quality of care delivered by homes**
   - Conduct risk-based inspections of licensed homes
   - Regularly assess whether homes are fulfilling person-centred plans
   - Investigate critical incidents reported by homes and serious complaints reported by clients/families/public timely
   - Address identified non-compliance timely
3. **Analyze information on homes providing care to adults with intellectual disabilities**
   - Maintain quality control processes (e.g., monitor Ministry staff compliance with inspection requirements)
   - Regularly analyze information about homes' quality of care (e.g., aggregated results of complaints, incidents, reviews of person-centred plans) to help guide decision-making
   - Report on homes' care for adults with intellectual disabilities to senior management

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Ministry of Social Services' processes, we used the

above criteria based on our related work, review of literature, including reports from other auditors, and consultations with management. Ministry's management agreed with the above criteria.

We examined Ministry policies and procedures relating to the provision of quality care to adults with intellectual disabilities. We assessed the Ministry's processes to license home operators for consistency with legislation. We tested a sample of licensing packages, person-centred plans, and serious incidents to assess whether staff followed the Ministry's established processes. In addition, we used an independent consultant with subject matter expertise in the area to help us identify good practice and assess the Ministry's processes.

4.0 KEY FINDINGS AND RECOMMENDATIONS

4.1 Monitoring Expectations Established

The Ministry of Social Services established requirements to license and monitor group homes and approved private service homes providing supportive living environments for adults with intellectual disabilities.

Homes providing supportive living to adults with intellectual disabilities are privately operated and must operate according to the requirements under legislation.

At July 2021, the Ministry had licences with 247 group homes and 202 approved private service homes. A group home operator, often referred to as agency, service provider, or community based organization, may operate a number of group homes. For the purposes of this report, unless otherwise specified, the term home operators refers to both an agency running group homes and an individual or a family operating approved private service homes. At July 2021, 202 home operators run approved private service homes, and 64 home operators run 247 group homes. Group homes usually care for four to five clients; approved private service homes about one to three clients.

Under legislation, the Ministry is responsible for monitoring homes to ensure the clients who live there receive safe and appropriate care. The Ministry monitors this through various mechanisms:

- **Physical Standards Report:** to be completed annually by a Ministry community service worker or a Ministry community-based organization consultant inspecting the home for certain physical requirements (see **Figure 4**).

- **Program Standards Report:** to be completed annually by a Ministry community service worker for each home operator by visiting one of their homes to observe certain client-care requirements (see **Figure 4**).

- **Serious Incident Reporting:** homes are required to report all serious incidents to a Ministry community service worker within 24 hours of the incident. The Ministry investigates as needed.

In addition, the Ministry established the *Comprehensive Personal Planning and Support Policy* outlining expected standards home operators must follow when supporting clients living in their home. The policy requires homes to develop person-centred plans every two years and document a client's progress. The Ministry's community service worker is expected to observe practice and provide guidance to the home operator for person-centred planning processes.

Having clear expectations for Ministry staff to monitor homes providing supportive living is critical to contributing to the safety and wellbeing of adults with intellectual disabilities.

4.2 Homes Licensed Annually

The Ministry of Social Services annually licenses homes providing care for adults with intellectual disabilities.

The Residential Services Act, The Residential-service Facilities Regulations and *The Private-service Homes Regulations* outline licensing requirements for homes.

When licensing a new home, the Ministry requires a package of documentation from the applicant. We found the required documentation aligns with legislative requirements. For example, in order to become an approved private-service home operator, an applicant must provide three references, criminal record checks for all adults living in the home, a home floor plan, a fire inspection report, a health inspection report, and undergo at least five interviews with Ministry staff.[10] The Ministry uses a checklist to ensure staff collect, and ensure appropriateness of, all the required documents prior to issuing a licence.

After assessing an applicant's eligibility (e.g., adequate space, appropriate insurance), Ministry staff inspect the home before granting a licence. The Ministry usually licenses about 10 to 15 new homes each year with licences typically effective for one year.

We tested documentation of four new homes the Ministry licensed during our audit period (September 2020–August 2021) and found all four homes adequately met the Ministry's requirements for licensing and received appropriate licences to operate a home.

In addition, the Ministry requires annual renewal for licences. In practice, to renew an annual licence, home operators must provide the Ministry with third-party reports such as fire and health inspection reports (for group home operators only), as well the homes must be physically inspected by Ministry staff prior to licence expiry. See **Figure 3** for a list of documentation required for annual group and approved private service homes' licensing. We found the required documentation aligns with legislative requirements.

Figure 3—Documents Required for Annual Licensing

Group Homes	Approved Private Service Homes
• Health inspection report[A,B] • Sprinkler inspection report (only required if a home has equipment installed)[C] • Alarm panel inspection report (only required if a home has equipment installed)[C] • Alarm monitoring certificate report (only required if a home is equipped with alarm panel)[C] • Fire inspection report[A,C] • Insurance policy[A]	• Health inspection report (when worker deems necessary)[A] • Fire inspection report[A,C] • Annual review by Ministry staff covering program and physical standards • Annual resident/family interviews completed by Ministry staff

[10] The Ministry conducts interviews with the applicant and their family to discuss roles and responsibilities, as well as provide an overview of program and care standards.

Group Homes	Approved Private Service Homes
• Program standards report[A] (Ministry completed client-care report) • Physical standards report[A] (Ministry conducted physical inspection)	

[A] Required by *The Residential-service Facilities Regulations* (group homes) or *The Private-service Homes Regulations* (approved private service homes)
[B] Completed by the Saskatchewan Health Authority. We note that the health inspection report provided by the Authority covers the public health order requirements due to COVID-19 (e.g., hand hygiene practices, availability, and use of personal protective equipment).
[C] Completed by a third-party contractor.

We tested 20 existing homes with licences renewed in our audit period (September 2020 – August 2021) and found all of them appropriately licensed. None of the tested homes operated with an expired licence. We also reviewed the list of all licences and associated expiry dates and found all were current.

Once a new home operator receives their licence, the Ministry enters into an agreement with them. The agreement clearly states that home operators must follow legislative requirements in its operations, including an annual licensing requirement. Group home operators annually sign addendums to their agreements while approved private service home operators only sign an initial agreement.

Annual licensing ensures only those homes meeting requirements continue to operate and provide care to adults with intellectual disabilities.

4.3 Untimely Resolution of Deficiencies in Conditional Licences

The Ministry issues conditional licences when deficiencies or delays in receipt of documentation result during the annual licence renewal process. However, the Ministry continued to issue conditional licences even though deficiencies remained unresolved.

A conditional licence allows a home operator to continue to operate, however, the licence expires earlier than an annual licence because of a deficiency or outstanding documentation. For example, the Ministry issues a conditional licence when it finds a home operator not compliant with an inspection requirement (e.g., a faulty fire alarm), or certain reports required for licence renewal remain outstanding by the licence expiration date (e.g., health inspection report not provided on time).

Issuing a conditional licence means Ministry staff will return to the home sooner than annually to inspect the home and assess whether a home operator resolved a deficiency. Conditional licences can be issued for a period up to six months. Although, we found if deficiencies persisted, the Ministry continued to issue conditional licences.

During the COVID-19 pandemic, the Ministry issued more conditional licences as many homes could not undergo third-party inspections (e.g., fire inspections) or in-person inspections by Ministry staff as the Government imposed visiting restrictions. At July 2021, about 45% of 247 group homes and about 70% of 202 approved private service homes held conditional licences, mostly relating to COVID-19 pandemic restrictions (e.g., inability to obtain fire inspection report from third-party who needed to visit the home).

In-person Ministry inspections resumed in July 2021 and the Ministry indicated it will complete in-person inspections as conditional licences expire. However, the Ministry does not centrally track key information for issuing conditional licences (e.g., not receiving a fire inspection report versus identifying an existing deficiency such as a faulty fire extinguisher) to help prioritize inspections (see **Recommendation 4**).

We tested 20 homes licensed in 2020–21 and found all of them appropriately received either conditional (up to six months) or annual licences; with 11 conditional licences (55%) and nine annual licences issued. We found reasoning for conditional licences included health and fire inspection report delays due to the COVID-19 pandemic's impact or deficiencies found during fire inspections needing to be resolved.

As the Ministry does not keep data on previously issued licences, we could not assess how many homes in total held conditional licences for more than a year (see **Section 4.6**). We assessed 20 homes and found one approved private service home operating with a conditional licence since October 2019 due to deficiencies found during a fire inspection and then due to the impact from the COVID-19 pandemic (i.e., awaiting follow up fire inspection). As at September 2021, this one approved private service home with a conditional licence still did not have a fire inspection report completed two years later. Fire inspections confirm whether homes' fire detection systems run properly.

Not tracking and addressing significant deficiencies identified during inspections within a reasonable timeframe (e.g., after six months), may result in clients living in unsafe conditions (e.g., home not protected by a working fire alarm).

1. **We recommend the Ministry of Social Services monitor resolution of deficiencies stated in conditional licences for group and approved private service homes within a reasonable timeframe.**

4.4 Home Inspection Checklist Lacks Key Risk Areas

The Ministry of Social Services uses inspection checklists to summarize areas examined during home inspections. However, the checklist does not cover all key risk areas requiring evaluation as part of an inspection.

The Ministry's inspections assess homes' compliance with legislative requirements for home operation using checklists. We found the checklists align with the Act and regulations.

Using checklists, Ministry staff inspect numerous areas as set out in **Figure 4**. For group homes, the Ministry uses two inspection checklists, the physical standards report and program standards report; while staff use one checklist called an Annual Review for inspecting approved private service homes. The physical standards report inspection checklist focuses on the home's physical safety and design and the program standards report inspection checklist focuses on the daily care a client receives in the home.

Figure 4—Summary of Areas Covered During Home Inspections on Checklists

Physical standards report inspection

- Location (e.g., accessible to public transportation, parks)
- Required designated areas (e.g., areas for dining, sleeping, and food preparation used only for those purposes)
- Sleeping accommodation (e.g., one bed per client, no more than two clients in one bedroom)
- Bedroom furnishings (e.g., storage for personal belongings)
- Washroom facilities (e.g., at least one wash basin and a toilet for every five clients)
- Exits (e.g., all exits equipped with easy-to-use hardware)
- Safety equipment (e.g., where required: nightlights, non-skid bath mats)
- Appropriate spaces for day room, study space, yard
- Accessibility (e.g., appropriate equipment for clients with physical disabilities)
- Medical treatment (e.g., first aid supplies available)
- Medication (e.g., locked medicine cabinet)

Program standards report inspection

- Services and programs (e.g., home provides care in a family-like setting)
- Meals (e.g., nutritionally balanced)
- Social/Recreational interaction and program supplies (e.g., opportunity to enjoy social life)
- Personal records (e.g., complete records of individual programing for each client)
- Medical treatment protocols (e.g., call physician in case of serious illness,)
- Medication (e.g., only medication authorized by a physician given to a client)
- Staff training in client-care policies, personal planning for clients

Source: Based on information provided by the Ministry of Social Services.

While the checklists align with the Ministry's legislative requirements, we also compared them to the checklist the Ministry of Health uses for licensing personal care homes.[11] Personal care homes house the elderly; another vulnerable group. We found the Ministry of Social Services does not assess group and approved private service homes in the following safety areas outlined in personal-care home checklists that could impact clients' health and safety:

- Adequate handling of medication (e.g., retaining medication in original packaging, returning unused or expired medication to pharmacy). We noted one serious incident in 2020–21 with inappropriate disposal of medication at a group home.

- Setting maximum water temperature for clients' use (e.g., water accessible to clients does not exceed 49 degrees Celsius). We noted one serious incident at a group home where the water gauge did not work and a client was immersed into hot water, resulting in injury in 2021–22.

- Safety measures for clients at risk of wandering (e.g., alarm system). We noted 34 serious incidents of missing/wandering persons in 2020–21.

- Waste disposal (e.g., toxic and poisonous substances stored and disposed appropriately)

In addition, checklists did not prompt Ministry staff to check whether clients appear dressed and groomed appropriately for the day.

A comprehensive checklist assessing key home safety areas potentially impacting clients' health and safety is necessary to determine deficiencies and correct them before serious incidents occur.

[11] The checklists do not prompt Ministry staff to check and document conclusions for display of licences at group homes.

In addition, we found the Ministry does not have written guidance on items required for examination by third-parties during a fire inspection. We found that fire inspection reports for all 20 homes we tested contained different information; fire inspection reports for homes in urban areas offered more details than those inspected in rural areas. For example, some inspection reports provided details on what was inspected (e.g., home access, exit signs, smoke alarms) whereas other reports provided only a summary stating no deficiencies identified. We note the Ministry must work with the Ministry of Government Relations to establish required content of a fire inspection report (i.e., detailed inspection checklist).

A detailed checklist comprising the Ministry's expectations required in a third-party report would help to clearly explain inspection and reporting requirements. Furthermore, if Ministry staff consider the reports unclear, they may not identify, and seek to rectify, deficiencies.

2. **We recommend the Ministry of Social Services update home inspection checklists to cover key risk areas at group and approved private service homes.**

4.5 Not Every Group Home Assessed Annually to Evaluate Program Standards

The Ministry requires staff to annually assess each group and approved private service home's physical standards. However, the Ministry does not require staff to visit every group home at least annually to assess each home meets minimum program standards.

Two Ministry divisions (contract administration unit and community services unit) are involved in inspecting group homes. The Ministry's community-based organization consultants inspect each group home annually and complete a physical standards report (see **Figure 4** for details of the physical standards report). While Ministry community service workers are responsible for completing an annual program standards report (see **Figure 4**) for a group home operator, they are not expected to inspect each group home.

One group home operator may operate more than one home (e.g., one group home operator in Saskatoon operates 12 group homes). The Ministry uses the program standards inspection as a primary tool to assess aspects of care for clients such as meals, social interactions, and properly storing personal records.

For 10 group homes tested, we found the Ministry completed the physical standards report for each home, but the Ministry only completed the program standards report for a singular home operator and not each of the homes they operate. Thus, we do not know whether Ministry staff visited the particular group homes we assessed.

During 2020–21, often, Ministry staff would not physically inspect homes, but rather complete a virtual update (e.g., video or phone call). Virtual updates do not allow for interaction with clients living at the homes. In-person inspections resumed in July 2021, when the Government lifted the state of emergency for the province. As the Ministry does not keep centralized data on homes, we could not assess how many homes were inspected in the past year—in-person compared to virtually (see **Section 4.6**).

For 19 out of 20 homes we tested, we found all had a completed program standards report and a physical standards report. One approved private service home did not have a recent Ministry inspection with its latest reports issued in 2019 because of delays in obtaining a fire inspection report. The Ministry repeatedly issued the home six-month conditional licences without the required third-party inspection.

Without regularly inspecting each group home to assess program standards, the Ministry may not know whether clients receive appropriate and quality care. This may lead to licensing group homes that do not meet minimum standards of care (e.g., medication inappropriately administered, poorly balanced meals).

3. **We recommend the Ministry of Social Services annually inspect each group home to assess if it meets the minimum program standards requirements.**

4.6 Central System to Track Licensed Homes Needed

The Ministry of Social Services lacks a centralized tracking system for compiling current and historical information about licensed homes (e.g., required licensing documentation, home inspection reports).

Annual home-operating licence renewal requires numerous documents with the majority of documents maintained in multiple, manual files. In addition, licensing and inspecting of homes caring for adults with intellectual disabilities involves multiple Ministry staff resulting in manual files dispersed across the province.

More than 30 staff conduct group homes' annual inspections and licensing, including: 15 community-based organization consultants, one Community Living Support Division administrative support staff and one program consultant, as well as 12 to 15 community service workers at various regional offices.[12] For approved private service homes, 14 staff at various regional offices conduct annual inspections and licencing, including: 13 community service workers, and one Community Living Support Division program consultant.[13]

Two program consultants are responsible to assess all documentation for home licensing and, when satisfied, issue the licence. Both consultants keep a spreadsheet with a list of homes and licence expiration dates. However, no centralized system exists to track each home's key information including: inspection dates, third-party reports, identified deficiencies, and deficiency remediation dates.

The Ministry collects information on serious incidents each year (see **Section 4.10**), but it does not track and compile the data by home. This lack of information inhibits Ministry management from accurately assessing the magnitude of issues at homes.

Having a centralized system to track documentation and steps completed in the home licensing process each year would aid in monitoring whether licences are expired, assessing whether inspections are completed, and determining if required documentation

[12] Total of 253 group homes as of March 31, 2021.
[13] Total of 206 approved private service homes as of March 31, 2021.

is obtained and reviewed. It would also allow the Ministry to collate and analyze common data about each licensed home and identify any persistent issues that may impact client care.

4. **We recommend the Ministry of Social Services use a central system to track key information about group and approved private service homes.**

4.7 Verification of Periodic Criminal Record Checks Lacking

The Ministry of Social Services neither verifies criminal record checks for staff working at group homes upon initial licensing, nor does it require proof of periodic criminal record checks at group homes or approved private service homes.

An approved private service home requires a criminal record check for initial licensing. In order to operate an approved private service home, an applicant needs to present a criminal record and a vulnerable sector check for all adults living at the home.[14] However, the Ministry does not require periodic checks after initially approving the private service home. We found approved private-service home operators delivered services for 13 years on average (as of July 2021: ranging from a few months to 51 years).

The Ministry requires group home operators to establish policies requiring criminal record and vulnerable sector checks every two years for management, staff, and volunteers working with clients. However, the Ministry does not have a process to verify whether this occurs (i.e., it does not periodically assess whether group home staff completed criminal record checks as required).

Good practice in other jurisdictions require periodic criminal record checks. For example, in British Columbia, anyone who works directly with vulnerable adults needs to provide a criminal record check once every five years.

Lack of verification of periodic criminal record checks for people providing services to vulnerable populations such as adults with intellectual disabilities increases the risk of financial, physical, or sexual abuse.

5. **We recommend the Ministry of Social Services verify completion of periodic criminal record checks for people caring for adults with intellectual disabilities living in group and approved private service homes.**

4.8 Appropriate Policies Communicated to Homes

The Ministry of Social Services communicated to home operators appropriate care standards for adults with intellectual disabilities living at Ministry-funded homes.

[14] A Vulnerable Sector Verification is used to determine the possible existence of a criminal record and/or a sexual offence conviction for which an individual has received a pardon. *The Criminal Records Act* defines vulnerable members of society as persons who, because of age, a disability, or other circumstances, whether temporary or permanent are in a position of dependence. Any individual applying to work in a paid or volunteer position where they will be in contact with a vulnerable person may be required to complete a Vulnerable Sector Verification. Some examples of positions who work within vulnerable sectors are: teachers, social workers, daycare workers, coaches and volunteers. www.reginapolice.ca/resources/criminal-record-check/ (23 July 2021).

The Ministry's *Comprehensive Personal Planning and Support Policy* provides general principles and standards for supporting clients: treating them with dignity and respect, supporting them in decision-making, and aiding them in developing person-centred plans based on their goals, dreams, and aspirations to enhance their development and quality of life.

In addition, the Ministry established client anti-abuse policies describing acceptable staff conduct in homes and serious incident reporting requirements relating to clients' health and safety, including abuse allegations.[15]

We found the policies align with good practice in supporting adults with intellectual disabilities.

The Ministry adequately communicates these standards by providing these policies to approved private service home operators through its *Approved Private Service Homes Program Proprietor's Reference Manual* and to group home operators through training packages. Agreements with home operators clearly state they must follow Ministry's policies.

We found all 20 homes tested had signed agreements.

We found the Ministry provides training for approved private service home operators on policies and reviews key points with them during annual inspections.

For group home operators, the Ministry provides training packages and supports group home operators as they lead training for their staff. The Ministry also receives a report annually on whether all group home operators' staff received training on key policies related to clients' provision of care. For 10 group homes tested, we found that group home operators reported to the Ministry a rate of about 95% of staff trained on the *Comprehensive Personal Planning and Support Policy* and the *Participant Abuse Policy*.

In addition, the Ministry offers other training courses for home operators to help support clients in a positive way like how to support people successfully, positive behaviour support, professional assault response training, and other courses.

Appropriately communicating care standard policies and providing training on them helps ensure those who care for adults with intellectual disabilities understand their role and responsibilities.

4.9 No Regular Assessment of Homes Fulfilling Clients' Person-Centred Plans

The Ministry of Social Services expects home operators to develop and fulfill person-centred plans, directing the care and support for a client, but it does not assess whether plans are adequate and fulfilled.

[15] Participant Abuse Policy for group home operators at www.creativeoptionsregina.ca/wp-content/uploads/2015/11/CLSD-Participant-Abuse-Policy.pdf; Approved Private Service Homes Abuse Policy at pubsaskdev.blob.core.windows.net/pubsask-prod/78769/APSH-Program-Manual.pdf (30 August 2021).

The Ministry's *Comprehensive Personal Planning and Support Policy* requires group and approved private service homes' staff to develop person-centred plans with their clients and review them at least every two years. The Ministry's community service workers may provide support in developing person-centred plans. The policy indicates the person-centred plans should include clear objectives, actions, responsibilities, and timeframes, and planning should be client-centred (e.g., client decides who participates in planning and all objectives of the plan should be client-driven) but does not provide specific, detailed guidance.

For example, if a client desires to increase swimming activity, some of the planned actions should address this desire. This client's support team (e.g., family, home operator, day-program staff) would set actions to visit a swimming pool on a regular basis.

The Ministry expects person-centred planning as an ongoing process with regular reviews to ensure it provides appropriate supports to execute the plans. To support home operators in creating person-centred plans, the Ministry maintains a webpage with resources to aid home operators in supporting clients and develop plans that fit their specific setting.[16]

The Ministry has also jointly with home operator representatives developed a website with numerous resources on creating a person-centred culture.[17] While the website does not have a template or specific guidance on what a quality person-centred plan should include, it does outline components of a person-centred culture. See **Figure 5** for a list of good practice on what a quality person-centred plan would include.

Figure 5—Components of a Quality Person-Centred Plan

- What people appreciate about the client (strengths)
- What is important to the client now, and in the future
- What is important for the client to stay healthy, safe and hold a valued role in society (support needs)
- What is working and not working in a client's life from different perspectives
- Clear outcomes directly connected to what is important to and for the client
- Detailed action plan that takes all potential supports (using support sequence) into account with specific dates and people responsible as well as a specific review date

Source: Helen Sanderson Associates, *Care and Support Planning*.

We tested 30 client records at the Ministry and found:

- Seven out of 30 (23%) client records did not include any person-centred plans
- Nine out 23 (39%) client records had existing plans at least four years old; with the most recently developed plan in 2017 and oldest plan developed in 2013

In addition, the Ministry does not review the person-centred plans for adequacy. We reviewed the 23 plans against the Ministry's policy and good practice (see **Figure 5**) and found:

- Sixteen out of 23 plans (70%) did not meet any or most components of a quality person-centred plan and the Ministry's policy

[16] pubsaskdev.blob.core.windows.net/pubsask-prod/78769/APSH-Program-Manual.pdf (30 August 2021).
[17] *Person-Centred Saskatchewan—Nurturing person-centred cultures of support across Saskatchewan* (personcentredsk.ca) (5 October 2021).

- Seven out of 23 plans (30%) met either all or most components of a quality person-centred plan and the Ministry's policy

The plans did not include what is important for a client rendering the plans generally inadequate; no specific supports identified; no action plans and accountability present; and when actions were present, there was no connection to what is known about the client.

The Ministry does not have any process to periodically (e.g., annually, every two years) assess the quality and completion of plans. We found the Ministry did not, for 15 out of 23 plans (65%), evaluate previous plans or actions.

Management indicated it hired a contractor in May 2021 to develop outcomes for home operators, a performance management framework, and related tools. This may result in the Ministry better monitoring whether home operators support improved outcomes for adults with intellectual disabilities (e.g., through person-centred plans).

In addition, we tested records of the same 30 clients and found 63% of these clients (19 out of 30 records) did not have any documented contact with the Ministry's community service workers in the last two years. The Ministry expects community service workers to see clients in group homes at least once a year and clients in approved private service homes once every quarter to assess whether clients receive quality care.

Management indicated it is currently working on establishing new standards for seeing clients based on a risk-based approach—seeing clients with higher needs on a more frequent basis.

Without periodic review of person-centred plans and periodically meeting with clients, the Ministry does not know whether clients receive quality care and live quality and fulfilled lives. Furthermore, the Ministry may not know whether any issues or concerns exist if Ministry staff does not visit or contact clients periodically.

6. **We recommend the Ministry of Social Services periodically assess the quality and fulfillment of person-centred plans for adults with intellectual disabilities living in group and approved private service homes.**

7. **We recommend the Ministry of Social Services have regular contact about the person-centred plans with adults with intellectual disabilities living in group and approved private service homes.**

4.10 Serious Incidents Tracked

The Ministry of Social Services tracks serious incidents reported at homes supporting adults with intellectual disabilities.

The Ministry implemented policies to protect clients from abuse and neglect and established a reporting system for home operators to self-report any serious incidents. A serious incident is a severe or unusual event involving a client living at a Ministry-funded home, which impacts a client's health and safety. For example, home operators and staff are to report any hospitalizations, unexpected illnesses, and abuse or neglect allegations (e.g., emotional, physical) within 24 hours to Ministry staff. In addition, family of clients or

day-program staff working with clients may report any concerns about a client's care to the Ministry (via phone, email, or in-person).

Once a Ministry community service worker receives a serious incident notification, they complete a serious incident form (see **Figure 6** for information tracked) and determine whether the incident requires an investigation. The community service worker forwards the serious incident form to the Ministry consultant responsible for centrally tracking incidents. Beginning May 2021, the Ministry began to compile serious incidents by home operator and incident type, and then report to directors and supervisors for their review.

Figure 6—Information Requirements of Serious Incident Reporting

The reporting form requires the following information:

- Upon notification:
  - Incident type (e.g., unexpected illness, see **Figure 7**)
  - Date of incident (but not date reported, see **Section 4.12**)
  - Sector (e.g., group home)
  - Region (e.g., Central area)
  - Home operator (but not specific home, see **Section 4.12**)
  - Client's name
  - Action taken (e.g., taken to hospital)
  - Findings (founded, pending, unfounded)
  - Summary of incident
- Upon completion of investigation
  - Updated findings (e.g., from pending to founded)

Source: Ministry of Social Services' Serious Incident Reporting and Tracking System.

As shown in **Figure 7**, each year, homes report various types of serious incidents to the Ministry.

In 2020–21, group homes reported 748 serious incidents and approved private service homes reported 111 serious incidents—in total an overall 12% increase from the previous year. The majority of these reported serious incidents related to unexpected illness (for both group and approved private service homes) and medication abuse (for group homes).

In 2020–21, the Ministry received 58 notifications of disease outbreaks at 15 home operators, all related to COVID-19. The Ministry provided support to the home operators where COVID-19 outbreaks were reported. For example, the Ministry partnered with the Ministry of Health and the Saskatchewan Association of Safe Workplaces in Health (SASWH) on initiatives to support home operators in enhancing infection prevention and control measures and had personal protective equipment available for home operators who had challenges obtaining them.

Figure 7—Serious Incidents in Group Homes and Approved Private Service Homes 2018–21

Incident Type	Group Homes			Approved Private Service Homes		
	2018–19	2019–20	2020–21	2018–19	2019–20	2020–21
Denial of Opportunity [A]	3	7	5	5	2	5
Disruption of Services	1	1	1	2	1	-
Disease Outbreak	-	-	56	-	-	2
Emotional Abuse	14	14	18	6	8	7
Expected Death[B]	5	10	5	2	1	1
Fall	29	42	47	12	9	4

Incident Type	Group Homes			Approved Private Service Homes		
	2018–19	2019–20	2020–21	2018–19	2019–20	2020–21
Medication Abuse	148	238	177	1	1	7
Missing/Wandering Person	22	17	18	7	11	16
Motor Vehicle Accident	1	3	1	-	-	1
Neglect	9	4	25	2	5	5
Other Injury	28	27	46	4	5	1
Physical Abuse	12	31	29	5	7	4
Poisoning	1	1	1	-	-	-
Property Abuse	16	2	1	5	1	4
Sexual Abuse	3	4	-	-	-	-
Suicide Attempt	-	1	5	-	-	-
Unexpected Death	10	13	18	4	2	3
Unexpected Illness	245	260	295	52	41	51
Total	**547**	**675**	**748**	**106**	**94**	**111**

Source: Based on information provided by the Ministry of Social Services.
Shaded rows indicate serious incidents the Ministry considers more critical and warrant an investigation.
[A] Denial of opportunity is a form of abuse when a client is prevented from accessing some preferred activity for no good reason. For example, staff purposefully stopping a client from joining other housemates in a pre-planned swimming activity, despite the activity being in the client's best interest or a client's favoured activity would constitute a denial of opportunity, especially if stopped for malicious reasons.
[B] An expected death refers to a client with a terminal illness diagnosis, or who receives palliative care.

The Ministry noted it is working on improving a definition of medication abuse (i.e., intentionally inappropriate use of medication or over-medication) to distinguish serious incidents from medication administration (e.g., single missed medication dosage). For 2020–21, we found many of the reported medication-abuse serious incidents related to a single medication dose missed or medicine not given on time (78 or 42% of reported medication-abuse serious incidents) or wrong medication given (e.g., inadvertently switched noon-hour medication for evening medication) (47 or 25% of reported medication-abuse serious incidents). Only three incidents reported would be considered truly medication abuse (e.g., allegation of staff over-medicating a client).

In cases of a client's death at a home, Ministry staff follow its client death protocol, which requires a formal report determining the cause of death if unexpected. Home operators must contact the police and the Ministry upon an unexpected client death. If necessary, the police or the Ministry contact the Chief Coroner's Office to determine the cause of death.

We tested three client death instances and found two occurred at a hospital, one at a home, and all deaths were from natural causes (e.g., a heart attack). In the case where the death occurred at a home, Coroners' staff determined the cause of death.

Centrally tracking serious incidents in a single comprehensive database can support organizational learning and enhance safer client care.

4.11 Implementation of Serious Incident Investigation Recommendations Not Monitored

The Ministry of Social Services does not know whether recommendations included in serious incident investigation reports are implemented and if clients receive safe care.

The Ministry considers any allegations of abuse and/or neglect as critical serious incidents and must be investigated, while other serious incidents (e.g., hospital visit, expected death) are tracked for informative purposes, but do not warrant an investigation unless the Ministry decides otherwise.

In cases of abuse or neglect allegations at approved private service homes, Ministry community service workers investigate the allegation to determine whether an allegation was founded and provide a final report detailing a conclusion and recommendations, if needed, within 30 days of an incident.

In cases of abuse or neglect allegation at group homes, a Ministry community service worker supports the group home operator in investigating the allegation (i.e., is part of the investigation team). The Ministry expects investigations are completed within 30 days of starting an investigation. A report outlining a conclusion and recommendations, if needed, is given to the Ministry at the end of the investigation.

We tested 30 serious incident records from both types of homes: 15 did not require investigations (e.g., illness) and 15 did (e.g., emotional abuse allegations). We agreed with the conclusion for the 15 incidents not warranting investigations. For the other 15 serious incidents related to abuse or neglect allegations, we found the Ministry and home operators took appropriate steps:

- Investigations completed for 13 serious incidents
- One serious incident was not investigated, but Ministry staff confirmed the allegation because they witnessed emotional abuse directly. Due to other allegations of abuse and subsequent investigations, the Ministry revoked the home's licence.
- For the other serious incident, the home operator, in collaboration with Ministry staff, decided not to complete an investigation as they found no evidence abuse occurred

The Ministry does not provide timelines for when investigations should start, but we found investigations usually started within a week of a reported incident.

We found out of 13 investigations tested, seven were completed later than the Ministry's expectation (i.e., later than 30 days), ranging from 39 to 60 days since the investigation started or the incident occurred. We did not find any explanations for delays. Having investigations take longer than expected, means recommendations from the investigations may not be implemented promptly.

All 13 investigations tested resulted in final reports with appropriate recommendations as required by Ministry policy. Recommendations included actions like refresher training for staff, terminating a home operator's employee with a previous history of concerns, and implementing specific procedures for a client (e.g., safe bathing procedures).

We found the Ministry does not have a formal process to monitor whether homes implement recommendations. In addition, Ministry policies do not include timelines for implementing recommendations.

The Ministry does not centrally record recommendations and expected actions, or implementation. The Ministry views group home operators as responsible for implementing recommendations and does not formally follow up on recommendation implementation. Ministry management told us recommendations may be informally discussed with group home operators.

In nine out of 13 investigations (69%), we saw evidence of the Ministry either receiving an update or following up with both types of home operators on recommendations, but the Ministry does not keep this information. This information is located in the clients' files held by individual Ministry staff; therefore, other Ministry staff are not aware of actions taken by the home operator. For four other investigations, we did not see any evidence of follow up.

The Ministry needs information about implementation status of recommendations in order to effectively oversee that actions are taken to prevent future serious incidents.

The Ministry not following up on and monitoring the status of serious incident recommendation implementation, may lead to similar incidents reoccurring. Identifying delays in implementing corrective actions would provide the Ministry with important information to consider when relicensing a home and determining whether it needs to support the home to prevent specific types of incidents.

8. **We recommend the Ministry of Social Services monitor for timely implementation of recommendations, set out in serious incident investigation reports, at group and approved private service homes.**

4.12 Analysis to Identify Homes with Continuous Serious Incidents Needed

The Ministry of Social Services does not analyze serious incidents' data to identify homes where more serious incidents occur.

As noted in **Section 4.10**, the serious incident reporting form does not require collecting information on the date the incident was reported to the Ministry, which inhibits the Ministry from knowing whether homes report incidents promptly. Also, the serious incident report form does not provide detailed information on incident location because it only tracks home operator names and not the specific home—often one group home operator operates more than one home in Saskatchewan. Thus, we were not only unable to identify if one specific home had ongoing serious incidents, but also the Ministry does not know which particular homes experience more serious incidents than others.

The Ministry consultant tracking serious incidents and investigations results began monthly reporting to management in May 2021, listing serious incident and investigation status (e.g., founded, unfounded, pending), but no analysis or trends.

Comprehensively analyzing serious incidents at each home would allow the Ministry to identify home operators who are no longer suitable to care for adults with intellectual disabilities, and should not be licensed.

9. We recommend the Ministry of Social Services analyze serious incidents related to adults with intellectual disabilities for systemic issues at each group and approved private service home.

We note the Ministry does not have any formal guidance to determine when to escalate reoccurring or persistent concerns with care provided at homes. A formal process describing the escalation of interventions to address poor service delivery would assist home operators in understanding the consequences of inadequate service provision as well as being more transparent. In practice, when Ministry management informally identifies a home operator with multiple, significant issues, the Ministry may perform a detailed analysis of the home operator and its operations to assess whether the home operator needs support or should stop providing care. We found the Ministry completed detailed analysis for 12 home operators in the past four years. The Ministry revoked one home's licence and transferred ownership of three homes out of 12 reviewed home operators.

The Ministry, in collaboration with home operators, uses this analysis to develop action plans to address any significant issues related to client care. For example, one detailed analysis indicated a need for a weekly meeting between the home operator and the Ministry to discuss any serious incidents warranting a response according to the abuse policy, as well as a need for training on how to support clients.

We also found the Ministry undertook one in-depth review in the past five years and provided recommendations to the group home operator. The review's purpose was to provide recommendations to strengthen the group home's governance and operational management to allow them to meet their goals for providing quality care. The Ministry assessed the group home operator's overall operations (e.g., governance, human resources, financial review) as well as the systemic issues occurring at the home.

4.13 Limited Reporting on Homes' Care for Adults with Intellectual Disabilities

The Ministry of Social Services' senior management receives some reporting related to clients living at group and approved private service homes, but needs more.

Without a central tracking system, management does not know or receive reports summarizing whether staff inspected homes, found deficiencies, as well as whether each client received a visit from Ministry staff each year (see **Recommendation 4**).

The Ministry receives annual self-reporting from group home operators on their *Comprehensive Personal Planning and Support Policy* implementation. For example, the reports include the number of staff trained on the policy and the number of person-centred plans developed.

Starting in May 2021, the Ministry's senior management receive a monthly serious incidents summary, however, this report lacks details on specific homes and analysis on trends and systemic issues (see **Recommendation 9**).

We also found senior management receives alerts on internal issues—sensitive issues usually from reported serious incidents or potential crisis situations that may attract public attention or require Ministry response. For example, in summer 2021, senior management received an alert relating to a home operator at risk of evacuation due to wildfires in a northern community. In 2020–21, the Ministry issued 119 internal issue alerts and 44 in 2021–22 as of July 2021.

Taking steps to develop a central tracking system for licensing and robustly analyzing serious incidents will allow Ministry staff to provide meaningful reporting to senior management to monitor quality care in group and approved private service homes.

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