In the Matter Of:

The Long-Term Care Homes Public Inquiry

DAY 34 / VOL 34

August 09, 2018

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77 King Street West, Suite 2020
Toronto, ON M5K 1A2
1.888.525.6666 | 416.413.7755

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9 THE LONG-TERM CARE HOMES PUBLIC INQUIRY
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12 PUBLIC HEARINGS
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17 --- This is Day 34/Volume 34 of the Public
18 Hearings in the above Inquiry proceedings taken
19 at the Elgin County Courthouse, Court Room 201,
20 4 Wellington Street, St. Thomas, Ontario, on
21 the 9th day of August, 2018, commencing at
22 9:30 a.m.
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27 BEFORE: The Honourable Justice Eileen E.
28 Gillese, Commissioner
29
30
31 REPORTED BY: Helen Martineau, CSR
32 & Olivia Arnaud, CSR

1 A P P E A R A N C E S:
2
3 Lara Kinkartz, Esq., Commission Counsel
4 & Megan Stephens, Esq.,
5 & Alexandra Campbell, Esq.,
6
7 Darrell Kloeze, Esq., Her Majesty the
8 & Kristen Smith, Esq., Queen in Right of
9 & Meagan Williams, Esq., Ontario
10
11 David M. Golden, Esq., Caressant Care
12 Nursing and
13 Retirement Homes
14 Limited, Caressant
15 Care - Woodstock
16
17 Denise Cooney, Esq., College of Nurses
18
19 Paul H. Scott, Esq., Jon Matheson,
20 Pat Houde,
21 Beverly Bertram
22
23 Shaun Singh, Esq., Registered
24 Practical Nurses
25 Association
26
27 Nicole Butt, Esq., Ontario Nurses
28 Association
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1 A P P E A R A N C E S (CONT'D):
2
3 Jane Meadus, Esq., Ontario Association
4 of Residents'
5 Councils
6
7 Karyn Wasserstein, Esq., Local Health
8 Integration Networks
9
10 Judith Parker, Esq., Ministry of Health
11 and Long-Term Care
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5 STEVEN CARSWELL; Under Prior Affirmation

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09:31:27 1 --- Upon commencing at 9:31 A.M.
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09:31:27 3 THE COMMISSIONER: Morning,
09:31:29 4 Mr. Kinkartz.
09:31:29 5 MS. KINKARTZ: Morning,
09:31:31 6 Commissioner. So I think we'll
09:31:33 7 pick up where we left off with
09:31:35 8 Steven Carswell's testimony.
09:31:35 9 THE COMMISSIONER: Excellent.
09:31:39 10 Thank you.
09:31:39 11 STEVEN CARSWELL: PREVIOUSLY
09:31:43 12 SWORN
09:31:43 13 EXAMINATION IN-CHIEF BY
09:31:48 14 MS. KINKARTZ:
09:31:48 15 Q. Morning, Steven.
09:31:52 16 A. Morning.
09:31:54 17 Q. When we left off yesterday,
09:31:56 18 we were talking about your ETMS system and how
09:32:01 19 people go about entering events into ETMS. So
09:32:05 20 can you tell us now when the CCAC learns about
09:32:11 21 a complaint or a risk event it gets entered
09:32:14 22 into ETMS, what are the responsibilities of the
09:32:17 23 CCAC and the service provider in terms of
09:32:20 24 addressing and resolving that issue.
09:32:22 25 A. So the role of the CCAC and
09:32:26 26 the service provider is typically a
09:32:29 27 collaborative effort in addressing the issues.
09:32:31 28 So depending on the nature of the particular
09:32:33 29 event we might ask the service provider
09:32:36 30 organization to do some internal follow-up and
09:32:38 31 review. And then on our end as a CCAC we would
09:32:43 32 also conduct our part of that review.

09:32:45 1 And that might involve having
09:32:46 2 discussions with patients and families, or
09:32:49 3 other people within the healthcare system, to
09:32:53 4 doing chart reviews, all the way up to
09:32:55 5 reporting those issues to the various parties,
09:32:57 6 where we need to report them to, depending on
09:33:00 7 the circumstance and really doing our due
09:33:01 8 diligence.
09:33:02 9 I think the most important part
09:33:04 10 for us is firstly addressing the issue as it
09:33:06 11 relates to the patient, whether that's
09:33:10 12 attempting to the best of our ability to
09:33:12 13 resolve the complaint itself, or in the case of
09:33:14 14 a risk event to try to understand the nature of
09:33:17 15 that event, the impact that it's had on the
09:33:20 16 patient and the family, and what corrective
09:33:22 17 action that we need to take.
09:33:24 18 In a lot of cases we would
09:33:25 19 dictate a certain level of review and follow-up
09:33:28 20 that we would require of the service provider
09:33:31 21 and expect them to document that response
09:33:33 22 directly into ETMS.
09:33:33 23 Q. Can you give an example of
09:33:36 24 what you mean by dictating a level of review
09:33:39 25 and response by a service provider?
09:33:42 26 A. Yeah. So depending on the
09:33:43 27 nature of the incident it might be something as
09:33:46 28 simple as asking them to review a certain
09:33:48 29 policy or procedure with their staff.
09:33:51 30 A good example might be in the
09:33:53 31 home care sector we see a lot of events where a
09:33:56 32 nurse or a PSW will show up to a patient's home

09:34:00 1 and the patient's not there. So we have
09:34:01 2 specific protocol on how to address that
09:34:03 3 situation to make sure that the patients are
09:34:05 4 safe, which may or may not include calling the
09:34:08 5 patient, or following up with the police or
09:34:11 6 checking with local hospitals. So that might
09:34:13 7 be an example where if that practice wasn't
09:34:16 8 followed we might remind them do an education.
09:34:19 9 Then in more serious instances
09:34:21 10 we might ask them to do a complete root cause
09:34:24 11 analysis and provide us with the details.
09:34:26 12 An example I can think of that
09:34:28 13 of in some cases where we have medication
09:34:31 14 errors we might work to pull logs from our
09:34:33 15 electronic pumps to understand what happened at
09:34:35 16 each stage. When the nurse programmed the pump
09:34:39 17 was it programmed correctly? And then that
09:34:40 18 might lead a further investigation either on
09:34:43 19 our part or on the part of the service
09:34:45 20 provider.
09:34:45 21 Q. If you have a complaint or a
09:34:49 22 risk event that's related to a particular
09:34:52 23 service provider nurse, or service provider
09:34:54 24 staff member, who would it be that would be
09:34:56 25 dealing with that staff member?
09:34:58 26 A. So the responsibility to deal
09:35:00 27 directly with the performance of the staff
09:35:02 28 member would lie with the service provider
09:35:04 29 organization. In some cases though the CCAC
09:35:07 30 can and has dictated a certain level of
09:35:10 31 response that we would expect them to have.
09:35:14 32 For example, in some cases where

09:35:15 1 we see poor practice as it relates to care we
09:35:18 2 might ask that the service provider ensure that
09:35:21 3 staff has appropriate training and to report
09:35:23 4 that back to us.
09:35:25 5 All the way up until asking that
09:35:27 6 staff member to be removed from providing care
09:35:29 7 to CCAC patients.
09:35:30 8 Q. Where does the CCAC get the
09:35:35 9 authority to ask a service provider not to use
09:35:38 10 a particular nurse to serve CCAC patients?
09:35:41 11 A. That's contained in our
09:35:42 12 contract with our contracted service providers
09:35:45 13 and we are able to do that either on a
09:35:46 14 temporary or a permanent basis.
09:35:49 15 Q. And are there certain
09:35:50 16 conditions that have to be met before the CCAC
09:35:53 17 can ask that a staff member no longer serve
09:35:56 18 CCAC patients?
09:35:57 19 A. I believe, if I'm remembering
09:35:59 20 all the details of the contract correctly, that
09:36:01 21 we have to have reasonable grounds to think
09:36:03 22 that there was an issue with their skills or
09:36:05 23 ability but it is the discretion of the CCAC of
09:36:08 24 when to use that.
09:36:09 25 Q. But you do summarize those
09:36:11 26 conditions in paragraph 41 of your affidavit.
09:36:13 27 Would it be helpful to pull that up?
09:36:14 28 A. It would, yes. Thank you.
09:36:16 29 Q. And so it's at the top of
09:36:18 30 page 17. And so if you can just scroll up so
09:36:30 31 we can see the bottom of the page before,
09:36:32 32 Laura?

09:36:34 1 Okay. So you're talking about
09:36:35 2 article 3.3 of the contract?
09:36:38 3 A. Uhm hmm.
09:36:39 4 Q. And then down on the top of
09:36:42 5 17 that's where you're listing the conditions?
09:36:43 6 A. Correct. So those would be
09:36:45 7 where we feel that they've made an error, a
09:36:47 8 serious misconduct or being charged with
09:36:49 9 criminal action, or we're dissatisfied with
09:36:53 10 their performance. And those two things can be
09:36:55 11 either where we feel that they might not have
09:36:57 12 the skills necessary to perform a certain
09:36:59 13 clinical task, or as it's laid out there some
09:37:04 14 sort of misconduct or negligence on behalf of a
09:37:07 15 particular staff member.
09:37:07 16 Q. And you've said that that
09:37:09 17 request could be made on a temporary basis or a
09:37:11 18 permanent basis. So if you're making it on a
09:37:15 19 temporary basis, for example, you're saying we
09:37:17 20 want you to make sure the staff has appropriate
09:37:19 21 training before they resume providing care.
09:37:22 22 Who gets to decide when that staff member can
09:37:26 23 start serving CCAC patients again?
09:37:27 24 A. So typically that role would
09:37:28 25 fall to the service provider organization, but
09:37:32 26 depending on the nature of the specific issue
09:37:34 27 that we have we might ask for proof that those
09:37:38 28 training -- that training or follow-up has
09:37:40 29 occurred, or on maybe the less or lower risks
09:37:44 30 we might ask them to just ensure that that
09:37:47 31 would happen.
09:37:48 32 So a good example would be an

09:37:49 1 issue around wound care practices. We might
09:37:52 2 ask the service provider to provide additional
09:37:55 3 wound care training and report to us that that
09:37:57 4 has been completed. All the way to, you know,
09:38:01 5 not providing care to wound care patients until
09:38:03 6 that has occurred.
09:38:06 7 So depending on the nature of
09:38:07 8 the issue we might leave that in the hands of
09:38:09 9 the service provider organization to deal with
09:38:12 10 in maybe the lower risk situations, to where we
09:38:15 11 would request specific documentation or proof
09:38:18 12 that that action has occurred until can
09:38:20 13 continue to provide care to all patients or a
09:38:22 14 certain subsection of our patients.
09:38:24 15 Q. So I take it it would be the
09:38:25 16 most serious cases where the CCAC would ask
09:38:28 17 that a staff member never provide services to
09:38:31 18 CCAC patients again?
09:38:32 19 A. Correct. So an example of
09:38:34 20 that would be where there's been abuse from a
09:38:39 21 staff member towards a patient. Another
09:38:42 22 example I can think of where a staff member was
09:38:45 23 in an inappropriate relationship with a
09:38:47 24 patient. So those would be examples where we
09:38:50 25 wouldn't consider that person fit to serve CCAC
09:38:53 26 patients.
09:38:53 27 Q. Does the CCAC have any input
09:38:56 28 into whether the staff member is disciplined or
09:38:59 29 terminated?
09:39:00 30 A. No.
09:39:00 31 Q. And would it be the CCAC or
09:39:04 32 the service provider who decides whether the

09:39:06 1 incident should be reported to the College of
09:39:09 2 Nurses or the appropriate regulatory body?
09:39:11 3 A. It would be the role of the
09:39:12 4 employer, but in certain circumstances where we
09:39:15 5 have asked the service provider to report and
09:39:17 6 we feel that they have not or won't the CCAC
09:39:21 7 may choose to take on that role as well.
09:39:23 8 Q. And has that been done during
09:39:25 9 your time at the CCAC or the LHIN?
09:39:26 10 A. It has, yeah.
09:39:27 11 Q. Are the processes for dealing
09:39:32 12 with complaints and risk events that we've just
09:39:35 13 talked about in terms of the division of
09:39:36 14 responsibilities between the CCAC and the
09:39:39 15 service provider, is that the same under the
09:39:41 16 LHIN as it was under the CCAC?
09:39:43 17 A. It is currently but, as I
09:39:46 18 spoke to a little bit yesterday, those are the
09:39:48 19 processes that we really want to improve and
09:39:51 20 ensure that they're working effectively,
09:39:53 21 knowing that there are multiple parties
09:39:54 22 involved in these types of processes.
09:39:56 23 Q. Can you tell us a bit about
09:40:00 24 what kind of changes are being looked at in
09:40:02 25 terms of that aspect of the process?
09:40:05 26 A. Can you clarify or maybe
09:40:09 27 expand on your question?
09:40:10 28 Q. Sure. So I think you just
09:40:13 29 said that one of the things that's being looked
09:40:16 30 at in terms of changing or updating processes
09:40:19 31 is the responsibility of the CCAC and the
09:40:22 32 responsibility of the service provider in terms

09:40:24 1 of following up and addressing complaints and
09:40:28 2 risk events?
09:40:28 3 A. Uhm hmm.
09:40:29 4 Q. So I'm wondering if you're
09:40:31 5 able to tell us what kinds of changes are being
09:40:34 6 contemplated there?
09:40:35 7 A. So as part of our sort of
09:40:39 8 more fulsome review we want to take the
09:40:42 9 foundation that has appeared in the policy
09:40:44 10 documents and the events management framework,
09:40:46 11 which we would have seen yesterday, and expand
09:40:48 12 on that to create more clarify for staff and
09:40:51 13 management on what are the expectations of
09:40:54 14 follow-up on particular types of events.
09:40:57 15 So, as I stated yesterday, a
09:40:59 16 good example is the response to different
09:41:01 17 events are different. So how to respond to a
09:41:05 18 patient fall or an instance of missed cared is
09:41:07 19 significantly different than how we would
09:41:09 20 respond to abuse of a patient.
09:41:11 21 So we really want to get, I
09:41:13 22 think, a level deeper in our understanding with
09:41:14 23 our providers and help support a common
09:41:16 24 understanding of expectations. So, for
09:41:19 25 instance, when there is a medication error a
09:41:21 26 common set of questions that will dictate what
09:41:24 27 follow-up is necessary.
09:41:25 28 The other important point that I
09:41:27 29 think I would add to this is we're also working
09:41:29 30 on what we're currently at this time calling a
09:41:32 31 "duty to report process". So there are a lot
09:41:35 32 of specific obligations that healthcare

09:41:37 1 professionals would have, or us as an
09:41:39 2 organization to report to various bodies,
09:41:42 3 whether that's the various Colleges or to the
09:41:46 4 Long-Term Action Line or Retirement Home
09:41:48 5 Association. We want to really clarify what
09:41:51 6 those reporting obligations are and whose
09:41:53 7 responsibility it is within the organization to
09:41:55 8 make those reports.
09:41:56 9 So I think we have those pieces
09:41:57 10 in an informal way now and I believe it's
09:42:00 11 important that we formalize those.
09:42:02 12 Q. The next area I wanted to
09:42:05 13 talk to you about, and we touched on it a
09:42:08 14 little bit yesterday, but you indicated that
09:42:10 15 the CCAC, and now the LHIN, does some work in
09:42:13 16 terms of tracking and looking at trends in
09:42:16 17 complaints and risk events. First of all
09:42:20 18 what's the purpose of doing that?
09:42:21 19 A. So I think sort of secondary
09:42:26 20 to responding to an initial complaint or
09:42:30 21 incident the most important part after that,
09:42:33 22 for my team and practically the rest of the
09:42:35 23 organization, is to look at the improvement
09:42:37 24 part of that. So either trying to prevent an
09:42:39 25 issue like from occurring, or to try and
09:42:42 26 understand where that might be occurring in
09:42:44 27 different segments of the organization.
09:42:46 28 So tracking and trending really
09:42:48 29 allows us to look at in a lot of different ways
09:42:50 30 where instances of complaints and risk events
09:42:52 31 are coming through; what their content and
09:42:55 32 theme are; and whether they're related to a

09:42:57 1 particular region, a particular service or even
09:43:00 2 a particular service provider organization.
09:43:02 3 Q. Where does the CCAC get the
09:43:07 4 data from that they use to look at whether
09:43:10 5 there's a trend in a particular area?
09:43:12 6 A. So primarily the ETMS system,
09:43:15 7 you know, is the reporting system so all of our
09:43:18 8 data comes from there and is really the
09:43:20 9 starting point for those investigations.
09:43:22 10 And so every ETMS event that is
09:43:25 11 reported to us we have access to the data
09:43:27 12 across all the fields that are contained in
09:43:30 13 that to really track and trend. So that's not
09:43:33 14 only the way we report but how we track and
09:43:35 15 trend that over time.
09:43:36 16 Q. And are there any reports
09:43:38 17 generated outlining the trend on a particular
09:43:41 18 area like in a region, or for a particular
09:43:43 19 service provider, or anything like that?
09:43:46 20 A. Yup. So we do have a suite
09:43:47 21 of reports that look at trends in risk events
09:43:51 22 and complaints in a few different areas.
09:43:53 23 A few examples of that would be
09:43:56 24 trends of events by the category of which
09:43:58 25 they're reported on; trends related to high,
09:44:02 26 medium and low risk; and then trends relates to
09:44:05 27 particular teams or services. So, for
09:44:08 28 instance, the complex team or a service PSW or
09:44:12 29 nursing. And then we also look at all that
09:44:14 30 data broken out by service provider.
09:44:17 31 So it's not uncommon for myself
09:44:19 32 or members of my team to look at data, for

09:44:22 1 example, the rate of complaints for one
09:44:26 2 particular service provider, if we're hearing
09:44:28 3 anecdotally that there is a concern. So we
09:44:32 4 might do that in response or in a pro-active
09:44:35 5 manner on an ongoing basis.
09:44:36 6 Q. And I think you said
09:44:38 7 yesterday that ETMS doesn't have a specific
09:44:41 8 field dedicated to the staff member's name
09:44:46 9 who's concerned. So are you able to look at
09:44:48 10 trends in terms of complaints or risk events
09:44:52 11 that a given staff member is involved in?
09:44:54 12 A. There's no dedicated field so
09:44:57 13 we wouldn't be able to track and trend
09:44:58 14 complaints related to a specific service
09:45:00 15 provider staff. I will add though that often
09:45:03 16 times when we do look at trends our root cause
09:45:06 17 analysis, as I talked to you yesterday, may
09:45:09 18 identify a particular staff member as being
09:45:11 19 involved in multiple events. But those are
09:45:13 20 typically, when we find out, around knowledge
09:45:16 21 and skills of a particular worker.
09:45:18 22 Q. Do you think it would be
09:45:20 23 useful to help identify those quality of care
09:45:24 24 concerns sooner if you were able to monitor
09:45:28 25 trends related to staff members?
09:45:30 26 A. I do think it would be
09:45:34 27 helpful for the system to be able to track and
09:45:37 28 trend events specifically related to
09:45:38 29 individuals.
09:45:40 30 I think with us and our service
09:45:45 31 provider organizations I think it's really
09:45:45 32 important that we come to a common way of doing

09:45:48 1 that. So, as an example, other service
09:45:53 2 providers have their own internal events
09:45:55 3 tracking system where they report events. And
09:45:57 4 how do they track and trend and monitor that
09:45:59 5 piece. And then how would the CCAC either
09:46:01 6 support that, work with that or conduct that on
09:46:02 7 our own? So that's not an area we're explored
09:46:05 8 in great detail as of yet.
09:46:07 9 Q. Okay. Now, who is it within
09:46:10 10 the CCAC who's looking at the reports on
09:46:14 11 trends?
09:46:14 12 A. So the trends on -- are
09:46:18 13 primely the responsibility of my team, or the
09:46:20 14 quality team. So that would be myself who
09:46:22 15 would look at the trends on a very frequent
09:46:25 16 basis up to weekly. Then the management that I
09:46:28 17 would have within my team. So the manager of
09:46:31 18 patient safety and risk now, and then our
09:46:33 19 patient relations co-ordinator position. So
09:46:37 20 those directly involved with the response to
09:46:39 21 complaints would be primarily the ones to see
09:46:41 22 those reports.
09:46:42 23 I will add that on a quarterly
09:46:44 24 basis our service providers do get reports
09:46:47 25 related to their trends of issues. And that
09:46:51 26 information is also reported to our senior
09:46:53 27 leadership team and our Board quality committee
09:46:55 28 as well.
09:46:55 29 Q. When you say the service
09:46:57 30 providers get those trends quarterly do you
09:47:00 31 mean you're providing the information to them?
09:47:02 32 A. Correct.

09:47:02 1 Q. And you mentioned a few
09:47:05 2 people on your team who are looking at these
09:47:07 3 reports. Do you all look at them in the same
09:47:09 4 way or for the same purpose?
09:47:11 5 A. So we use a common reporting
09:47:14 6 suite so we all have access to the same
09:47:17 7 information. And I would say generally we're
09:47:19 8 looking at them for the same purpose, which is
09:47:21 9 to identify trends.
09:47:24 10 Within my role I would be
09:47:25 11 looking more at a higher level and looking
09:47:27 12 through the lends of service provider
09:47:30 13 performance, or areas where we might need to
09:47:32 14 dedicate resources for quality.
09:47:34 15 And I would say the front-line
09:47:36 16 staff, the patient relations co-ordinators
09:47:38 17 would be looking at it mostly through the lens
09:47:41 18 of what they're hearing in their day-to-day
09:47:43 19 interactions with staff and patients and trying
09:47:45 20 to identify other trends and things. So I
09:47:48 21 would say theirs is maybe a more reactive role
09:47:50 22 in that -- and mine would be a more pro-active,
09:47:55 23 larger role.
09:47:55 24 Q. You mentioned that those
09:47:57 25 trends would be shared with CCAC leadership as
09:48:00 26 well. Are they shared with the LHIN
09:48:04 27 leadership now that the LHIN has taken over
09:48:08 28 the CCAC's responsibility?
09:48:09 29 A. So the data -- as a LHIN
09:48:11 30 we're working to -- as a new organization
09:48:14 31 understand all the reporting requirements in
09:48:17 32 various pieces. So that information has been

09:48:19 1 shared at a very high level with our Board
09:48:22 2 quality committee, as a new Board quality
09:48:24 3 committee. So they've received some initial
09:48:27 4 education and some initial data on that, but
09:48:29 5 the intent is to continue to provide that data
09:48:31 6 to the board quality committee and the senior
09:48:33 7 leadership team on a regular basis, as was the
09:48:37 8 case with the CCAC.
09:48:38 9 Q. I understand that in
09:48:41 10 preparing for the Inquiry the Southwest LHIN
09:48:45 11 prepared a chart outlining the types of
09:48:47 12 complaints and risk events related to home care
09:48:50 13 going back all the way to 2005 and up to the
09:48:52 14 end of July last year. I think that's at tab G
09:48:56 15 of your affidavit. So if we could pull that
09:48:58 16 up? It's 56810.
09:49:18 17 Now, first of all, does this
09:49:19 18 include all of the different categories we
09:49:22 19 looked at yesterday in the events management
09:49:24 20 framework?
09:49:25 21 A. No, this report specifically
09:49:27 22 does not contain all the categories. So this
09:49:30 23 report was produced specifically for this
09:49:33 24 purpose and it only at this point captures
09:49:35 25 information where the -- as we call it the
09:49:40 26 "regarding" field or who is responsible for
09:49:42 27 the event is deemed as the service provider
09:49:42 28 organization.
09:49:45 29 So there are some categories and
09:49:46 30 data that's not reflected in here, but we would
09:49:49 31 have that trending information on all the
09:49:52 32 categories in the events management framework

09:49:54 1 for all parties that would report events to us.
09:49:56 2 Q. Now, can you tell us what
09:49:59 3 categories of complaints are most common?
09:50:03 4 A. So the ones that are most
09:50:08 5 common for us as an organization are the
09:50:12 6 category of complaint regarding the quality of
09:50:14 7 service. So that I believe is the one up on
09:50:16 8 the screen now. So that would be where we
09:50:18 9 receive directly from the patient or their
09:50:20 10 family a concern around the quality of care
09:50:22 11 that they're receiving from either the CCAC,
09:50:26 12 now the LHIN, or the service provider
09:50:27 13 organization. So that's one where it can take
09:50:30 14 on a lot of different types of complaints under
09:50:34 15 that category.
09:50:36 16 I believe another category that
09:50:37 17 we see a lot of is issues around the safety of
09:50:42 18 the staff entering into the home; and that
09:50:45 19 information is not reflected in this chart
09:50:47 20 because it wouldn't be regarding the service
09:50:49 21 provider.
09:50:49 22 Q. When you say "the safety of
09:50:54 23 the staff entering into the home" can you tell
09:50:56 24 us a bit about what those safety issues are
09:50:59 25 and why they might be coming up so commonly?
09:51:02 26 A. So in addition to the sort of
09:51:03 27 the quality of care, which I think is our
09:51:06 28 primary focus as an organization, we
09:51:09 29 unfortunately do see quite a lot of instances
09:51:12 30 where either a nurse or a personal support
09:51:15 31 worker is entering a home that may be unsafe;
09:51:21 32 and that can range from unsecured animals in

09:51:24 1 the home, which is something that can be fairly
09:51:26 2 easily addressed, to all the way up to violence
09:51:32 3 from a patient at a member of the staff. So
09:51:34 4 that's something that we unfortunately see a
09:51:35 5 lot of in the organization. Not to quite the
09:51:38 6 extent of the quality of service which, again,
09:51:41 7 is our main focus.
09:51:41 8 Q. You said a minute ago that
09:51:43 9 quality of service complaints capture a fairly
09:51:47 10 broad range of things. Can you give us an idea
09:51:49 11 of what spectrum of complaints we'd be looking
09:51:53 12 at under that category?
09:51:55 13 A. It's difficult to say but I
09:51:57 14 can provide maybe a few examples.
09:52:01 15 It might range to that the
09:52:04 16 service workers have arrived late or not on
09:52:08 17 time; or might be concerns around the personal
09:52:11 18 relationships and the personality conflict that
09:52:14 19 might occur between a patient and their staff
09:52:16 20 member; to, you know, specific items related to
09:52:21 21 they don't believe they're getting the
09:52:23 22 appropriate wound care and their wound healing
09:52:27 23 is not going as expected.
09:52:28 24 Q. If we turn over to the
09:52:32 25 second page there in the middle of the page it
09:52:36 26 has the category related to medication errors.
09:52:42 27 It seems like those are relatively low. We've
09:52:45 28 heard at least in home medication errors are
09:52:50 29 fairly common. Do you have any thoughts on
09:52:52 30 why the rate of medication errors in home care
09:52:54 31 might be as low as it seems to be here?
09:52:57 32 A. So I think -- I'm certainly

09:53:03 1 not an expert on medication errors but I can
09:53:06 2 speak to the data piece of this where we're
09:53:08 3 asking our service provider staff and our CCAC
09:53:12 4 staff to report incidents where our
09:53:15 5 organization is for the delivery of medication.
09:53:18 6 What I would say is -- a lot of
09:53:20 7 the medication errors that we do see refer to
09:53:24 8 infusion therapy or things related to infusion
09:53:28 9 therapy through our electronic pumps, which we
09:53:30 10 provide to patients in the community.
09:53:32 11 Q. And when you say that a lot
09:53:35 12 of the errors relate to those infusion pumps
09:53:38 13 what kind of errors are we talking about?
09:53:41 14 A. So in the community we have
09:53:42 15 an infusion pump that has caused, in the past,
09:53:46 16 challenges for our nursing staff in the
09:53:48 17 community to use. Where it is, by all
09:53:52 18 accounts, a complex device to use it's referred
09:53:54 19 to as a "smart pump". So there are checks and
09:53:58 20 balances related to ensuring that medication is
09:54:02 21 not over-delivered to a patient, but in a lot
09:54:03 22 of cases those smart pumps will alarm or make
09:54:06 23 noise when there's an error. And it is often
09:54:09 24 complicated to know what the error is, what it
09:54:12 25 was caused by and how to correct the error.
09:54:14 26 So over the course of the last
09:54:15 27 couple of years that's been a big focus of us
09:54:19 28 as an organization is to understand the
09:54:20 29 practices related to that, ensure that our
09:54:23 30 staff and our service provider staff have the
09:54:26 31 knowledge and the skills about how to use that.
09:54:28 32 And we have done things like

09:54:29 1 introduce additional, nonelectronic pumps into
09:54:31 2 the community that have dropped the rate of med
09:54:34 3 errors in the community.
09:54:35 4 Q. Now, if we go over to the
09:54:38 5 third page, the third row down relates to
09:54:43 6 missed visit. And as I'm looking across here
09:54:45 7 it seems like the numbers vary widely from
09:54:49 8 just over 100 to almost 4,500. Can you
09:54:52 9 explain why we might be seeing that kind of
09:54:55 10 variation?
09:54:55 11 A. So in the past missed visits
09:54:59 12 would have now -- now called "missed care",
09:55:04 13 would have been an event that was reported in
09:55:06 14 ETMS in every instance. Since that time, and
09:55:10 15 around the time you'll see the drop, we've
09:55:12 16 actually used a different system to capture
09:55:15 17 instances of missed care.
09:55:17 18 And the missed care that we are
09:55:18 19 asking our staff to report now in ETMS is where
09:55:20 20 there was risk to the patient related to missed
09:55:22 21 care, where perhaps missed care led to a missed
09:55:26 22 dose of medication or the patient fell, those
09:55:29 23 types of things.
09:55:30 24 So that trajectory is not that
09:55:31 25 we have significantly improved in that area but
09:55:35 26 that we have different reporting structures to
09:55:36 27 do that. So now missed care is reported from
09:55:39 28 the service provider to the CCAC through the
09:55:42 29 automated provider reports that I believe we've
09:55:45 30 talked about a little bit, and Donna talked
09:55:47 31 about as well.
09:55:47 32 Q. I think we're done with that

09:55:54 1 document. Thanks, Laura.
09:55:55 2 In your affidavit you say that
09:55:56 3 you monitor trends for a couple of purposes,
09:56:00 4 both to determine if there's a systemic issue
09:56:03 5 across multiple service provider and related to
09:56:07 6 a specific service provider. So I want to talk
09:56:10 7 about both of those. And let's start by the
09:56:14 8 systematic issues. What do you do if you're
09:56:16 9 looking at trends and there seems to be a
09:56:19 10 broader systemic issue across multiple service
09:56:22 11 providers?
09:56:22 12 A. I think within my role in
09:56:26 13 quality I do lean quite heavily on the other
09:56:29 14 leaders from the organization once a trend has
09:56:31 15 been identified to begin the initial
09:56:35 16 conversation on does this match with their
09:56:37 17 experience of what's going on in the
09:56:39 18 community? To understand has there been a
09:56:43 19 change in the number of patients that would
09:56:44 20 lead to a significant jump in instances of an
09:56:47 21 issue? And really start to begin the
09:56:49 22 conversation.
09:56:52 23 From there, there are various
09:56:53 24 different ways that we can address a systematic
09:56:55 25 issue. But primarily we try as best as
09:56:58 26 possible to work collaboratively with our
09:57:02 27 service provider organizations to understand
09:57:03 28 the causes of those particular issues. Whether
09:57:07 29 it's a challenge in the community care sector
09:57:10 30 or if it's a performance issue and work through
09:57:11 31 the solutions on how to best address that.
09:57:14 32 So the example that I previously

09:57:15 1 gave around medication and the challenges with
09:57:17 2 our electronic pumps in the community was a
09:57:21 3 collaborative effort between us as a CCAC and
09:57:25 4 the service providers. So we brought them all
09:57:28 5 together and did what we call a "failures made
09:57:30 6 and effects analysis", which a very arduous
09:57:34 7 process of walking through each and every step
09:57:36 8 in the process and trying to find all the
09:57:39 9 potential sources of error.
09:57:40 10 So in this case there are errors
09:57:43 11 that could originate from the pharmacy, from
09:57:46 12 the improper storage of education to the
09:57:49 13 knowledge and skills and ability of the nurse
09:57:51 14 to information that the CCAC is providing to
09:57:54 15 the service provider organization.
09:57:56 16 So that example led to a series
09:57:59 17 of recommendations on how to improve.
09:58:01 18 So we generally try to bring in
09:58:02 19 as many of those subject matter experts and
09:58:07 20 people directly response to address that
09:58:09 21 particular issue.
09:58:11 22 Q. You speak in your affidavit
09:58:12 23 about a couple of different committees that
09:58:15 24 the CCAC might use to address these issues.
09:58:18 25 Can you tell us about those?
09:58:20 26 A. So within the CCAC there are
09:58:24 27 primarily three committees that have
09:58:26 28 responsibility for improvement. So that would
09:58:28 29 be looking at concerns and issues, including
09:58:31 30 those received through our trending and data.
09:58:35 31 And those are referred to as the provider
09:58:37 32 operational meetings, or POMs, as they're

09:58:44 1 affectionately called. And there is three of
09:58:45 2 those. One is related to nursing and medical
09:58:47 3 supplies, one is related to personal support
09:58:49 4 services and the third is related to therapy
09:58:52 5 and medical equipment.
09:58:54 6 So those would be groups where
09:58:55 7 there would be representation from my team as a
09:58:58 8 quality team, from the Home and Community Care
09:59:00 9 team, and leaders from the service provider
09:59:02 10 organizations. So primarily the supervisor or
09:59:07 11 manager level of those organizations.
09:59:11 12 So those groups would meet
09:59:13 13 monthly or bimonthly, depending on the
09:59:17 14 committee, to try and discuss common issues
09:59:18 15 that impact the service providers across the
09:59:20 16 board.
09:59:22 17 So, for instance, in the nursing
09:59:24 18 POM that was the group that decided a smaller
09:59:26 19 working group was required to address the
09:59:28 20 issues with the electronic pain pumps. So they
09:59:31 21 were instrumental in that.
09:59:33 22 Q. You also talk about an
09:59:34 23 interagency leadership partnership. Can you
09:59:37 24 tell us about that?
09:59:38 25 A. So that is a different
09:59:40 26 committee with a more of a strategic purpose I
09:59:43 27 would call it.
09:59:43 28 So that is a committee that is
09:59:45 29 chaired by myself and the regional manager of
09:59:48 30 contracts, now the director of provider
09:59:51 31 contracts and allocation, and it includes one
09:59:54 32 member from each of our service provider

09:59:56 1 organizations. And that member is the most
10:00:00 2 senior leader of that particular SPO in the
10:00:04 3 organization.
10:00:05 4 So it's a group of about 14
10:00:07 5 people. And the intent of that group is to
10:00:10 6 provide direction and priority setting, and to
10:00:14 7 gather recommendations on how to proceed with
10:00:17 8 challenges.
10:00:18 9 A good example I think I
10:00:20 10 captured in my affidavit was around the
10:00:23 11 southwest having challenges with PSW capacity
10:00:26 12 and PSW missed care. So we used that group to,
10:00:30 13 at a strategic level, discuss what are some of
10:00:33 14 the things we can do across organizations to
10:00:35 15 address that issue.
10:00:36 16 Q. About how often does that
10:00:39 17 group meet?
10:00:39 18 A. That group meets on a monthly
10:00:41 19 basis.
10:00:42 20 Q. And were both the interagency
10:00:47 21 leadership partnership and the POMs did those
10:00:50 22 happen both under the CCAC and now under the
10:00:52 23 LHIN?
10:00:52 24 A. The ILP, as it's referred to,
10:00:56 25 has continued throughout. Over the last couple
10:00:59 26 of months the POMs haven't been meeting while
10:01:03 27 there's been a transition of staff in our
10:01:04 28 organization but the intent is to restart those
10:01:07 29 in the fall.
10:01:08 30 Q. Now, you said that you also
10:01:09 31 look at trends relates to a particular service
10:01:13 32 provider to determine if there are performance

10:01:16 1 issues there.
10:01:18 2 Can you give us an example of
10:01:20 3 where that's come up recently? Where you've
10:01:23 4 noticed a trend with a particular service
10:01:24 5 provider?
10:01:26 6 A. So we do notice trends
10:01:28 7 related to particular service providers on a
10:01:31 8 fairly regular basis. The most recent example
10:01:36 9 that I can think of is we did see a trend of a
10:01:41 10 particular service provider related to the
10:01:42 11 quality of care, so the complaint around the
10:01:46 12 quality of care. So that process both led us
10:01:49 13 to believe that there were issues around the
10:01:50 14 quality of the care being delivered by that
10:01:52 15 organization. And in this instance primarily
10:01:55 16 in their PSW services.
10:01:57 17 And that when receiving
10:01:59 18 complaints we did not feel that the service
10:02:02 19 provider organization was effectively
10:02:04 20 responding to them in terms of their actions to
10:02:07 21 address the issue or their actions to prevent
10:02:10 22 that issue from occurring again.
10:02:12 23 So from that process we began a
10:02:14 24 formal contract management process with that
10:02:16 25 organization.
10:02:17 26 Q. So let's talk about the
10:02:19 27 performance management process. When you have
10:02:23 28 an issue with a particular service provider
10:02:25 29 organization I understand there are various
10:02:28 30 options available. So what -- what's
10:02:30 31 generally the first step the CCAC does when it
10:02:34 32 notices there's an ongoing issue or a

10:02:37 1 performance issue?
10:02:38 2 A. So the steps involved in that
10:02:40 3 process would relate to the severity, or the
10:02:44 4 urgency, or the risk of a particular issue.
10:02:47 5 But our -- the Southwest CCAC does really like
10:02:52 6 to approach these from a collaborative effort
10:02:55 7 first. So that might begin conversations from
10:02:57 8 a, here are the trends that we're noticing, and
10:02:59 9 do a collaborative conversation on what could
10:03:02 10 be some of the solutions.
10:03:04 11 So an example of that is we
10:03:06 12 recently saw some concerns in one particular
10:03:10 13 region in our area related to nursing provided
10:03:13 14 by one particular agency. So given some of the
10:03:18 15 challenges with recruitment and retention in
10:03:21 16 that particular area we're working very closely
10:03:23 17 with them to address that; and they've
10:03:25 18 developed a quality improvement plan in a
10:03:28 19 collaborative manner.
10:03:29 20 So those are the informal tools
10:03:31 21 that are available to us is to collaborate with
10:03:33 22 partners and attempt to improve as a
10:03:35 23 collective.
10:03:36 24 If those options are not
10:03:37 25 appropriate given the issue, or the severity,
10:03:40 26 or the performance of a provider, we do have
10:03:43 27 various steps under our contract performance
10:03:46 28 framework that we can take.
10:03:48 29 Q. So when would the CCAC
10:03:50 30 decide to move to those more formal steps? I
10:03:54 31 think you've given us a couple of examples but
10:03:56 32 is there any kind of policy about that?

10:03:59 1 A. So we have guidance on when
10:04:02 2 and how. And, you know, it relates a lot of
10:04:05 3 times to the performance of the providers in
10:04:08 4 key performance areas. So if we are seeing
10:04:11 5 higher instances of missed cared by a
10:04:15 6 particular provider over a sustained period of
10:04:17 7 a couple of months or a couple of quarters we
10:04:20 8 would then trigger a formal process.
10:04:23 9 It's less straightforward when
10:04:25 10 it has to do with issues around the quality of
10:04:27 11 care, which is not as easily measured in the
10:04:30 12 performance standards contained within the
10:04:32 13 contract.
10:04:33 14 So that decision to move forward
10:04:34 15 with more formal structures would be a
10:04:37 16 collaborative decision between myself, the
10:04:39 17 regional manager of contracts and members of
10:04:43 18 the home care team.
10:04:44 19 Q. Now, I understand that when
10:04:47 20 you are moving into that formal process under
10:04:49 21 the contract performance framework there's a
10:04:52 22 series of escalating steps. Was the CCAC
10:04:55 23 required to follow those steps in order?
10:04:59 24 A. No, the CCAC is not required
10:05:00 25 to follow steps in order. So we have the
10:05:04 26 opportunity, depending on the nature, to use
10:05:06 27 those at our discretion.
10:05:07 28 Q. What's the first step under
10:05:09 29 the contract performance framework?
10:05:11 30 A. So after the more informal
10:05:16 31 meetings the first step for us would be what we
10:05:19 32 call a "Quality Improvement Notice". So this

10:05:22 1 is a formal notice to an organization around an
10:05:24 2 issue that we're having and asking for
10:05:26 3 specific, documented plans to address those
10:05:29 4 issues. So that's referred to as a "Quality
10:05:32 5 Improvement Notice", or a "QIN" as we sometimes
10:05:35 6 refer to it.
10:05:37 7 And the process for that is that
10:05:39 8 we would meet with the service provider
10:05:42 9 organizations, explain the issue and show them
10:05:43 10 data, whether that's from our ETMS system or
10:05:45 11 other pieces of information; generally walk
10:05:47 12 through a few patient stories to really
10:05:51 13 highlight the issue and how that's impacting
10:05:54 14 patients, and then move into what our
10:05:57 15 expectations are. From that meeting the
10:05:59 16 provider is responsible for developing an
10:05:59 17 action plan for improvement, as part of that
10:06:05 18 Quality Improvement Notice, for us to review,
10:06:07 19 contribute to and ultimately approve.
10:06:10 20 During that quality improvement
10:06:12 21 notice process we would then meet with the
10:06:15 22 service provider on a regular basis to review
10:06:18 23 their progress against that action plan and
10:06:20 24 make any adjustments as needed.
10:06:24 25 So those meetings sometimes
10:06:25 26 occur on a weekly basis, or if they are maybe
10:06:28 27 of a lesser concern or less risk be on a
10:06:32 28 quarterly or monthly basis.
10:06:34 29 Q. And I think we've included a
10:06:37 30 sample quality improvement notice in your
10:06:39 31 affidavit. So, Laura, it's 70439. And,
10:06:43 32 Steven and Commissioner, it's at tab I. There

10:06:46 1 are several documents in there but the
10:06:48 2 document ID numbers on the bottom, right-hand
10:06:50 3 corner are in numerical order. So it's about
10:06:56 4 three-quarters of the way through the tab at
10:06:58 5 70439.
10:07:13 6 Is this the kind of blank
10:07:16 7 template of the Quality Improvement Notice?
10:07:16 8 A. Yes.
10:07:18 9 Q. And who would be filling this
10:07:20 10 out?
10:07:20 11 A. So the top section, which you
10:07:24 12 can see here, would primarily be filled out by
10:07:27 13 the CCAC, and now the LHIN, and it's intended
10:07:29 14 to capture exactly what the Quality Improvement
10:07:33 15 Notice is related to.
10:07:33 16 So it might be that they're
10:07:36 17 failing to meet their key performance indicator
10:07:38 18 on five-day wait time. Which is we have
10:07:43 19 expectation that they see patients -- a certain
10:07:46 20 percentage of our patients within five-days of
10:07:48 21 when we've sent them a referral, to they are
10:07:52 22 not meeting the contractual provisions around
10:07:54 23 quality.
10:07:56 24 So that first section would be
10:07:57 25 just containing some information, and then
10:08:00 26 there's more specific detail on what are the
10:08:02 27 performance standards not being met by those
10:08:05 28 organizations.
10:08:06 29 So we would begin by completing
10:08:08 30 that section as an organization, but the
10:08:10 31 following section which specifically details
10:08:12 32 the action and responsibility I think --

10:08:17 1 Q. Go down to the second page
10:08:19 2 please, Laura.
10:08:20 3 A. Yes, please. Would be the
10:08:22 4 responsibility of the service provider to
10:08:24 5 identify, first, their action plan to improve.
10:08:29 6 These documents, depending on
10:08:30 7 the issue, can be fairly straightforward to
10:08:33 8 multiple, multiple pages. Some of them can be
10:08:36 9 four, five pages of actions across multiple
10:08:39 10 different areas.
10:08:41 11 There are specific fields here
10:08:43 12 around measurement. So what kind of data and
10:08:46 13 information can we use to validate that they're
10:08:49 14 moving forward on that? When it's going to be
10:08:51 15 completed and how.
10:08:53 16 Often when we receive those from
10:08:54 17 the providers the CCAC will make additional
10:08:58 18 requests for them to add additional steps or
10:09:01 19 items within the plan, or the CCAC might
10:09:05 20 actually have some actions to take, from our
10:09:08 21 own perspective, to help support the
10:09:11 22 improvement.
10:09:11 23 Q. The final page of the
10:09:14 24 document refers to a CCAC action plan if
10:09:17 25 applicable. When would you be using that
10:09:21 26 section?
10:09:22 27 A. So because in the delivery of
10:09:24 28 care in the community the role of the CCAC and
10:09:27 29 the role of the service provider is so closely
10:09:30 30 linked in terms of how we interact with
10:09:32 31 patients and the processes, there are some
10:09:34 32 cases where the causes of a particular issue,

10:09:38 1 though related to the performance of a
10:09:41 2 provider, have some impacts in terms of the
10:09:43 3 role of the CCAC.
10:09:45 4 So we might conduct some
10:09:48 5 education to our staff to remind them to ensure
10:09:52 6 they're putting proper information around
10:09:54 7 patients that may impact a service provider's
10:09:57 8 ability to carry out their obligations.
10:10:00 9 The other things is we might
10:10:01 10 have some specific actions such as in one case
10:10:05 11 we invited the service provider organization to
10:10:08 12 do a town hall with our staff because their
10:10:12 13 reputation and their -- the confidence that our
10:10:15 14 staff had with the service provider was not as
10:10:18 15 good as we'd like it to be. So our action was
10:10:22 16 to set up a town hall where we could work
10:10:26 17 through some of those issues with that
10:10:27 18 particular provider.
10:10:27 19 Q. If we scroll down to the
10:10:30 20 bottom half of this page it talks about
10:10:30 21 closure of a quality improvement notice and
10:10:35 22 duration of sustained improvement. How long
10:10:35 23 do quality improvement notices stay open?
10:10:39 24 A. So within the contract
10:10:41 25 performance framework there indicates that
10:10:43 26 these notices should be closed only after
10:10:47 27 there's been a sustained improvement.
10:10:50 28 So for items that are really
10:10:52 29 related to something small and measurable we
10:10:55 30 like to see two consecutive quarters of meeting
10:11:00 31 the standards. So a good example might be if a
10:11:03 32 provider agency is not providing their

10:11:06 1 discharge reports to us on a timely basis, or a
10:11:10 2 timely manner, we would want to see that they
10:11:12 3 do that consistently for two straight quarters
10:11:16 4 before we closed a quality improvement notice.
10:11:18 5 For issues that are more severe
10:11:20 6 or more concerning around the quality the care
10:11:22 7 being delivered, and it is more difficult to
10:11:24 8 measure, that would be a decision that would
10:11:26 9 lie primarily with myself and the regional
10:11:28 10 manager of contracts to determine, in
10:11:30 11 consultation with data and others around the
10:11:32 12 organization, if they've made sustainable
10:11:37 13 improvements.
10:11:38 14 So some issues have been open
10:11:40 15 for a year and some have been open for a couple
10:11:42 16 of quarters, and then there's some that we
10:11:45 17 continually revise and are open for a year or
10:11:47 18 two years at a time.
10:11:48 19 Q. I think we're done with that
10:11:53 20 document. Thank you, Laura.
10:11:56 21 What's the next step in the
10:11:59 22 contract performance framework if the quality
10:12:04 23 improvement notice doesn't seem to be working?
10:12:05 24 A. So if the quality
10:12:09 25 improvement notice isn't working, or we're not
10:12:10 26 seeing the sustained improvement that we would
10:12:12 27 like, or the issue is of an extremely serious
10:12:16 28 concern for us, we will bring in the senior
10:12:20 29 leadership of one of our service provider
10:12:21 30 organizations into a meeting that we call a
10:12:24 31 "contract management meeting".
10:12:26 32 And so that meeting would be an

10:12:27 1 example where we often times will bring
10:12:30 2 executive level, including CEO level leadership
10:12:33 3 from the organizations into our offices to
10:12:35 4 discuss, you know, the work that's been done to
10:12:40 5 date; and our concerns that the improvements
10:12:41 6 that the organization has agreed to in the
10:12:45 7 improvement notice haven't been action-ed or
10:12:48 8 haven't been action-ed effectively.
10:12:49 9 The most recent example I can
10:12:50 10 think of that is we had the CEO and executive
10:12:53 11 leadership from one of our agencies with three
10:12:56 12 members of the LHIN's executive team, and our
10:12:58 13 clinical lead, sitting down and indicating that
10:12:59 14 we were not satisfied with the improvements and
10:13:03 15 that we were going to take more remedial action
10:13:06 16 to address that.
10:13:07 17 So the purpose of that meeting
10:13:08 18 is to really instill into those providers that
10:13:12 19 the seriousness of the issues that we're facing
10:13:14 20 and the CCAC, or now the LHIN's willingness to
10:13:18 21 take remedial contract actions.
10:13:20 22 In some cases at that point we
10:13:22 23 would begin those remedial actions or provide a
10:13:24 24 little bit more time for that organization to
10:13:27 25 improve.
10:13:27 26 Q. So let's talk about those
10:13:30 27 remedial actions. I understand that under the
10:13:34 28 contract, the contract management framework
10:13:39 29 and the contract they both -- the services
10:13:42 30 agreement, they both refer to a few options
10:13:45 31 that are a little bit more serious. Can you
10:13:47 32 walk us through what those are?

10:13:49 1 A. So the two -- there's -- I
10:13:52 2 should say three available remedial measures
10:13:55 3 for us as a CCAC. The first one is we can
10:13:58 4 withhold payment from a service provider until
10:14:01 5 an issue has been addressed so that might --
10:14:04 6 and there are specific periods in which we can
10:14:06 7 do that.
10:14:07 8 The second one would be removing
10:14:09 9 a percentage of their market share. So, as we
10:14:11 10 talked about a little bit yesterday, each
10:14:13 11 provider has a certain market share in a
10:14:16 12 certain region. We have the ability to remove
10:14:18 13 market share and give that market share to
10:14:20 14 another organization.
10:14:21 15 And then the third and most
10:14:23 16 serious would be we can completely terminate
10:14:25 17 the contract for reasons related to the quality
10:14:27 18 of care or not meeting the contractual
10:14:30 19 obligations.
10:14:30 20 Q. Let's talk about withholding
10:14:32 21 payment first. You said that there's a
10:14:35 22 certain amount of time you can do that for.
10:14:38 23 Am I right that it's at 30 days that you can
10:14:41 24 withhold payment for?
10:14:42 25 A. Correct.
10:14:43 26 Q. And during that 30 days the
10:14:45 27 service provider is supposed to resolve the
10:14:47 28 issue, and then at the end of that 30 days the
10:14:52 29 CCAC has to pay that money back that they've
10:14:54 30 withheld?
10:14:54 31 A. Correct.
10:14:55 32 Q. Is that -- is that used often

10:14:57 1 by the CCAC?
10:14:58 2 A. That has not been used in my
10:15:01 3 time with the Southwest CCAC, or now the LHIN.
10:15:03 4 Q. And do you know why that
10:15:05 5 particular step hasn't been used?
10:15:07 6 A. In my thought process the
10:15:11 7 Quality Improvement Notice or the more serious
10:15:13 8 remedial measures I believe are a more
10:15:16 9 effective tool for addressing the seriousness
10:15:19 10 or the issue that we have, so we've chosen not
10:15:22 11 to use that particular provision.
10:15:23 12 Q. And when you say the more
10:15:25 13 serious remedial actions or more effective are
10:15:29 14 you talking about the reduction in market share
10:15:31 15 specifically?
10:15:31 16 A. Yes.
10:15:32 17 Q. So turning to that, would
10:15:34 18 that reduction of market share be temporary or
10:15:37 19 is that permanent?
10:15:37 20 A. We have the ability to do
10:15:39 21 both a temporary or a permanent market share
10:15:43 22 reduction.
10:15:43 23 Q. How do you decide which one
10:15:45 24 of those you're going to do?
10:15:47 25 A. That decision depends on the
10:15:49 26 seriousness of the issue and whether or not we
10:15:52 27 believe and have the confidence that the
10:15:54 28 service provider organization can make the
10:15:56 29 necessary improvements.
10:15:58 30 It may also be impacted with the
10:16:00 31 capacity of other organizations to take on that
10:16:03 32 market share and how that will impact other

10:16:06 1 organization and the care delivered to the
10:16:07 2 patients.
10:16:08 3 Q. How does the capacity of
10:16:12 4 other organizations to take on the market
10:16:14 5 share affect the decision about whether or not
10:16:16 6 you're going to withdraw market share at all?
10:16:18 7 A. So the decision of whether to
10:16:22 8 remove market share or not is not taken
10:16:26 9 thinking of the capacity of the other provider.
10:16:28 10 So if we make a decision to remove market share
10:16:31 11 it's based on our perspective of how the
10:16:33 12 organization is addressing issues.
10:16:37 13 In a practical sense once we've
10:16:39 14 made that determination it can often times be
10:16:42 15 difficult to reallocate that market share to
10:16:45 16 other organizations.
10:16:46 17 So in an example in one region
10:16:48 18 where two providers are operating they're
10:16:51 19 generally operating at capacity where they have
10:16:55 20 enough staff to be able to provide the services
10:16:57 21 that we've allocated to them, based on
10:17:00 22 estimates that we give them at the start of the
10:17:02 23 year.
10:17:02 24 So when we have made the
10:17:03 25 decision to move market share we would ask
10:17:06 26 other organizations in that region if they can
10:17:09 27 take it on and at which point they can take it
10:17:11 28 on. So if they're not able to immediately take
10:17:14 29 on extra services now how long would it take
10:17:18 30 for them to do that.
10:17:19 31 So a recent example would be
10:17:21 32 where we removed a 10 percent market share from

10:17:24 1 a particular organization. The receiving
10:17:25 2 organization of that 10 percent took on an
10:17:28 3 additional 1 percent a week for ten weeks. So
10:17:31 4 that's how we ensure that we are not putting
10:17:33 5 patients at risk where we're giving services to
10:17:36 6 an organization that doesn't have the capacity
10:17:39 7 to take on that additional volume.
10:17:41 8 Q. What do you do if you're in
10:17:43 9 one of the regions where there's only one
10:17:46 10 service provider that has a contract to
10:17:52 11 provide that type of service?
10:17:53 12 A. So if we're in a region where
10:17:56 13 there is no other provider currently providing
10:17:59 14 services in that area, we would first then go
10:18:01 15 out to other providers in other geographic
10:18:05 16 areas to see if they have the capacity to take
10:18:07 17 on that service. Or if that wasn't the case we
10:18:11 18 can go outside and do an RFP or Request for
10:18:13 19 Proposal for those services.
10:18:16 20 Q. So in that case I take it you
10:18:17 21 wouldn't immediately reduce the market share
10:18:19 22 until you had another organization lined up to
10:18:22 23 take that on?
10:18:22 24 A. Correct.
10:18:23 25 Q. The last option you mentioned
10:18:29 26 was termination of the contract. In what
10:18:34 27 situations would the CCAC or now the LHIN take
10:18:37 28 that step?
10:18:37 29 A. So that step is one that we
10:18:42 30 would take very cautiously, or it would be
10:18:45 31 related to very serious or ongoing issues
10:18:48 32 around a provider performance. The reason it

10:18:50 1 is a challenging tool to use is it does put the
10:18:54 2 care that's being received by patients and
10:18:56 3 their families at risk where that would be a
10:18:59 4 significant amount of services that we would
10:19:00 5 have to find another agency to provide.
10:19:03 6 So after a series of escalating
10:19:06 7 steps of reducing market share that would be
10:19:08 8 the time where we would make the decision to
10:19:11 9 remove an entire contract. Generally speaking
10:19:14 10 that decision would be to remove either a
10:19:16 11 particular service or remove a provider from a
10:19:19 12 particular geographic area.
10:19:20 13 Q. And has that been done
10:19:23 14 during your time at the CCAC or the LHIN?
10:19:25 15 A. It has not been done in my
10:19:27 16 time with the CCAC or the LHIN but I am aware
10:19:29 17 that the Southwest CCAC used that provision
10:19:32 18 before I joined organization.
10:19:34 19 Q. Now, I understand that from
10:19:37 20 reading your affidavit you say that the
10:19:39 21 contracts renew annually. Is that contract
10:19:44 22 renewal process used as a performance
10:19:47 23 management tool?
10:19:48 24 A. No.
10:19:48 25 Q. Why not?
10:19:50 26 A. With our providers we sit
10:19:53 27 down and have performance conversations with
10:19:55 28 all of them on a quarterly basis. So the
10:19:58 29 contract -- or the contract renewal process,
10:20:01 30 which happens on an annual basis, isn't the
10:20:04 31 appropriate venue for that type of
10:20:06 32 conversation. We feel it's more appropriate to

10:20:10 1 have distinct and separate performance
10:20:12 2 conversations with those organizations.
10:20:13 3 Q. And there are a couple of
10:20:16 4 additional performance management tools that
10:20:18 5 you talk about in your affidavit. Can we pull
10:20:22 6 up, Laura, 69216? And, Steven and
10:20:29 7 Commissioner, this is tab A and it will be page
10:20:33 8 50 at the bottom, right corner.
10:20:48 9 And so this is the general
10:20:49 10 conditions to Saint Elizabeth General
10:20:51 11 Consolidated Services Agreement. And
10:20:55 12 subsection 3 there, I think it's 11.1
10:21:00 13 subsection 3, says that:
10:21:03 14 "The CCAC can inspect, survey or
10:21:07 15 otherwise review the services
10:21:08 16 performed by the service
10:21:09 17 provider under this agreement."
10:21:14 18 What is that tool used for?
10:21:16 19 A. So that tool would take on a
10:21:22 20 few different -- we would do that in a few
10:21:25 21 different ways.
10:21:26 22 So generally as part of our
10:21:27 23 review of an issue, or a Quality Improvement
10:21:32 24 Notice, we may choose to further investigate
10:21:34 25 the services provided by that organization; and
10:21:37 26 that could take the form of us pro-actively
10:21:41 27 calling patients of that particular provider,
10:21:44 28 having conversations with our own staff to
10:21:48 29 doing audits of particular instances.
10:21:51 30 So an example of that, as it
10:21:52 31 relates to a specific issue, would be that if
10:21:55 32 we were concerned that a provider was billing

10:21:57 1 for visits that didn't occur we may call the
10:22:01 2 patients and ask them, Did this person show up
10:22:03 3 on this particular day.
10:22:05 4 This provision also allows us to
10:22:08 5 do sort of larger, global audits, as we call
10:22:12 6 them, where we would actually, through a
10:22:13 7 particular topic, spend some time with a
10:22:15 8 provider either in person or electronically
10:22:18 9 reviewing certain provisions of our contract.
10:22:21 10 So examples of, we sat down with
10:22:23 11 staff of our service provider organizations a
10:22:27 12 few years back and did an audit on missed care
10:22:30 13 practices. Do their staff understand their
10:22:33 14 obligations? Are we certain that when missed
10:22:35 15 care is reported that it's being effectively
10:22:37 16 reported? And that when it occurs that we are
10:22:40 17 aware of it. So those are the type of
10:22:42 18 provisions where we would use that. That would
10:22:45 19 be the examples of when we would use that
10:22:47 20 provision.
10:22:47 21 Q. Would you use this to
10:22:49 22 address complaints or risk events related to
10:22:52 23 quality of care?
10:22:52 24 A. Yeah, we may. So, depending
10:22:54 25 on the seriousness of the issue we might
10:22:57 26 request additional documentation or, you know,
10:23:01 27 review chart audits or, in some cases, as I
10:23:04 28 spoke about before, pull an electronic piece of
10:23:08 29 equipment out of a home to audit the records of
10:23:09 30 when that pump was programmed, when it was
10:23:12 31 delivered and those types of things.
10:23:14 32 So, yes, we would use it

10:23:16 1 specifically around incidents or the review
10:23:18 2 after an incident.
10:23:19 3 Q. Now, we had some discussion
10:23:21 4 yesterday when Donna was testifying about the
10:23:24 5 fact that there isn't a formal inspection
10:23:26 6 program, per se, in the home care setting. So
10:23:30 7 how does the way in which this provision is
10:23:33 8 used differ from a formal inspection process
10:23:37 9 where you're sending inspectors out to either
10:23:40 10 to homes or to the service provider?
10:23:43 11 A. So at this point this
10:23:45 12 inspection is used to address specific issues
10:23:47 13 and is more used on a topic-by-topic or ad hoc
10:23:51 14 basis.
10:23:52 15 So there is -- in our
10:23:53 16 organization we do not have a formal audit
10:23:56 17 process that indicates on which schedule or at
10:24:00 18 which time we would audit particular pieces.
10:24:02 19 So this piece is used quite often to really dig
10:24:05 20 into individual issues.
10:24:08 21 I do believe there is value for
10:24:09 22 us as an organization to look at the notion of
10:24:12 23 a more formalized audit process.
10:24:17 24 The issue around inspections and
10:24:18 25 how that relates to our environment, I think it
10:24:22 26 is difficult for us, given the amount of places
10:24:25 27 and delivery of care and how that occurs, for
10:24:29 28 us to do a formalized inspection audit; and
10:24:32 29 there is no structure within the Southwest CCAC
10:24:35 30 to do that.
10:24:36 31 Q. And so when you say given
10:24:38 32 where care is delivered that's difficult, I

10:24:41 1 take it you mean because most care is spread
10:24:43 2 out amongst thousands of patients' homes as
10:24:47 3 opposed to in one institutional setting?
10:24:47 4 A. Right. That's been the, I
10:24:50 5 think, ongoing dialogue that the organizations
10:24:51 6 have is the difficulty around, you know,
10:24:54 7 1.8 million PSW visits on an annual basis and
10:24:57 8 how to effectively review and audit that, both
10:25:01 9 from the perspective of a service provider and
10:25:04 10 from the CCAC.
10:25:05 11 So, you know, I think provisions
10:25:06 12 like this allow us to look into organizations
10:25:09 13 in terms of their processes and their policies,
10:25:12 14 or to inspect a particular instance as they've
10:25:14 15 occurred, and that is very helpful for us in
10:25:17 16 our review of specific incidents.
10:25:19 17 Q. I understand that Section 56
10:25:25 18 of the Home Care and Community Services Act
10:25:27 19 also lets the Minister of Health and Long-Term
10:25:30 20 Care order a service provider to suspend or
10:25:32 21 cease an activity, in particular if the
10:25:35 22 service provider is doing something that's
10:25:37 23 causing harm or is likely to cause harm. Do
10:25:41 24 you know if that power has ever been in the
10:25:43 25 Southwest CCAC, Southwest LHIN area?
10:25:46 26 A. I'm not aware of any
10:25:48 27 instances where that's occurred, no.
10:25:49 28 Q. In practical terms is it the
10:25:52 29 Minister or is it the CCAC that monitors the
10:25:56 30 day-to-day performance of a service provider?
10:25:58 31 A. It is the CCAC and now the
10:26:00 32 LHIN.

10:26:00 1 Q. You've mentioned a few times
10:26:09 2 today key performance indicators. So I'd like
10:26:12 3 to talk for a minute about what those are and
10:26:14 4 what performance indicators the CCAC looks at.
10:26:17 5 What do you mean when you're talking about key
10:26:20 6 performance indicators?
10:26:20 7 A. So within our contract with
10:26:27 8 the agencies, and in our contract performance
10:26:29 9 framework, there are a series of measures, or
10:26:32 10 key performance data that we use to assess the
10:26:35 11 performance of a provider and would serve as
10:26:37 12 the foundation of the performance conversation.
10:26:41 13 And if an organization is not meeting those
10:26:43 14 standards those would typically be what would
10:26:46 15 start a Quality Improvement Notice.
10:26:49 16 So a few examples of those, I'm
10:26:50 17 happy to give them, would be we have
10:26:54 18 requirements around, as I spoke to earlier, the
10:26:57 19 percentage of patients that a provider is able
10:27:00 20 to see within five-days. So we want to ensure
10:27:04 21 that when we send a referral to a service
10:27:07 22 provider organization that they're seeing those
10:27:09 23 patients within five-days.
10:27:11 24 Another example would be
10:27:12 25 reporting complaints, or providing timely
10:27:17 26 discharge reports to us. Those would be some
10:27:19 27 examples of the measures that we would use, or
10:27:22 28 the key performance indicators.
10:27:23 29 Q. I think you list them at
10:27:25 30 paragraphs 57 and 58 of your affidavit so
10:27:28 31 maybe we can pull that up? It's at pages 21
10:27:33 32 and 22.

10:27:44 1 Paragraph 57 talks about
10:27:48 2 indicators in the performance standards
10:27:50 3 schedule. So are these -- are these called
10:27:53 4 "key performance indicators"?
10:27:53 5 A. Yes.
10:27:54 6 Q. So you've talked about the
10:27:57 7 wait time to first visit. It looks like you
10:28:02 8 also look at referral acceptance rate, missed
10:28:06 9 care, the submission of discharge reports and
10:28:08 10 patient satisfaction measures. Can you tell us
10:28:11 11 about that last one? What you're looking at in
10:28:14 12 terms of patient satisfaction and how that's
10:28:15 13 measured?
10:28:16 14 A. So "patient satisfaction" is
10:28:18 15 a measure that the CCAC uses to understand how
10:28:23 16 patients feel about the services they receive
10:28:26 17 in multiple different areas, and discussing key
10:28:29 18 practices that an organization should be doing
10:28:32 19 from the perspective of a patient.
10:28:34 20 So on an ongoing basis we do
10:28:37 21 survey patients, our patients and patients of
10:28:40 22 the service provider, and each service provider
10:28:43 23 would receive a report on a biannual basis with
10:28:46 24 the results of that satisfaction survey.
10:28:51 25 Q. You've given us an example
10:28:53 26 of that in your affidavit. So if we can turn
10:28:56 27 up tab H? It's 72875.
10:29:00 28 And I understand that this was a
10:29:15 29 patient survey done related to nursing provided
10:29:18 30 by Saint Elizabeth for the period of April 1st,
10:29:21 31 2016, through March 31st, 2017?
10:29:23 32 A. Correct.

10:29:23 1 Q. If you scroll down a bit,
10:29:27 2 Laura.
10:29:27 3 Can you tell us what information
10:29:29 4 we can glean from this first page?
10:29:31 5 A. So this report is provided
10:29:36 6 to, as I said, the providers on a semi-annual
10:29:38 7 basis. And this particular page is a series
10:29:42 8 of nine indicators that would specifically
10:29:45 9 relate to Saint Elizabeth services in the
10:29:48 10 southwest.
10:29:50 11 So the first section on the left
10:29:51 12 there the column would indicate their
10:29:54 13 performance in the previous year. The second
10:29:57 14 column, which would be for each of those nine
10:30:01 15 key performance indicators, the performance of
10:30:03 16 Saint Elizabeth during this period. Then the
10:30:06 17 subsequent columns would refer to some key
10:30:10 18 information to allow us to compare how Saint
10:30:12 19 Elizabeth is doing compared to other providers
10:30:16 20 in our area and across the Province.
10:30:18 21 So, as an example, in key
10:30:20 22 performance indicator number 1 it's around
10:30:23 23 overall experience. The first bar would
10:30:25 24 indicate that 96 percent of patients had a
10:30:29 25 positive experience with Saint Elizabeth, that
10:30:33 26 is coming from 106 patients.
10:30:36 27 And then the three additional
10:30:38 28 columns there would refer to benchmarks that we
10:30:41 29 would use. The first one would be the score
10:30:43 30 for all nursing agencies in the southwest
10:30:46 31 region or service providers. The second one
10:30:49 32 would be for all providers across all services

10:30:51 1 in the southwest, and then the third would be
10:30:54 2 the provincial comparison. So outside of the
10:30:58 3 Southwest CCAC what is the satisfaction of
10:31:00 4 organizations in nursing.
10:31:02 5 So in this case Saint Elizabeth
10:31:03 6 would have a higher score on patients' overall
10:31:06 7 experience than our nursing average, or our
10:31:09 8 average across the board in the southwest and
10:31:12 9 that of the Province overall.
10:31:14 10 I will mention that with the
10:31:16 11 surveys some of these items are not always what
10:31:20 12 we'll call "statistically relevant". So on the
10:31:23 13 chart here you will see a couple of areas where
10:31:26 14 there is a very small black arrow beside a
10:31:29 15 particular number.
10:31:29 16 Q. Key performance indicator
10:31:32 17 number 8 looks like it has one in the
10:31:34 18 "Southwest Overall" column?
10:31:34 19 A. Correct. So that would say
10:31:38 20 that in that case where there's a black arrow
10:31:38 21 pointing up would indicate that Saint
10:31:42 22 Elizabeth's current performance in that area is
10:31:43 23 statistically significantly higher than the
10:31:46 24 overall southwest average.
10:31:48 25 So that allows us to ensure that
10:31:50 26 we're using this both for a performance
10:31:53 27 conversation and to help us understand the
10:31:55 28 perspective of the patients and the families.
10:31:58 29 Q. Am I right that the next few
10:32:04 30 pages tell us the specific questions that are
10:32:06 31 being asked to come up with those numbers on
10:32:09 32 the first page?

10:32:10 1 A. Correct.
10:32:10 2 Q. And then if we can turn to
10:32:18 3 page 7? And then scroll down a little bit,
10:32:26 4 Laura?
10:32:30 5 So what does this tell us? This
10:32:34 6 box at the top of the page?
10:32:36 7 A. So this chart -- the purpose
10:32:38 8 of this chart is to really try to understand,
10:32:41 9 of the numerous questions that are being asked
10:32:44 10 to patients which ones are the most important
10:32:46 11 that we should be focusing on to improve the
10:32:49 12 patient experience with our services?
10:32:52 13 So in this survey I believe
10:32:53 14 there are a couple of dozen questions, some of
10:32:56 15 them are more important for a patient than
10:32:58 16 others.
10:32:59 17 So the intent of this box is to
10:33:01 18 say, if you're going to focus on one area for
10:33:04 19 improvement focus on the areas where you have a
10:33:06 20 low performance and is going to have a big
10:33:09 21 impact on a patient's overall satisfaction with
10:33:12 22 their services.
10:33:13 23 So it can get quite technical,
10:33:16 24 but each specific dot in that box would refer
10:33:19 25 to a specific question. And areas in the top,
10:33:23 26 left quadrant of that box would be considered
10:33:26 27 areas where there is low performance from that
10:33:28 28 agency and where that -- a change in that
10:33:32 29 process would have a better impact on a
10:33:34 30 patient's satisfaction.
10:33:35 31 And then each of those four
10:33:37 32 quadrants would be different levels of

10:33:39 1 priorities, as they say.
10:33:40 2 So in this example there is
10:33:42 3 nothing identified in this survey where Saint
10:33:46 4 Elizabeth has low performance, but the number
10:33:48 5 11 there would be an area where they have low
10:33:52 6 performance but it's not directly related to
10:33:56 7 overall satisfaction. So it means if they
10:33:59 8 improve the performance in that area they won't
10:34:01 9 see a huge increase in the sort of more global,
10:34:04 10 overall satisfaction for patient.
10:34:06 11 Q. And if we scroll down just a
10:34:08 12 tiny bit? That's great. Am I right that the
10:34:11 13 numbers corresponding to the dots in that box
10:34:16 14 there's kind of a little legend below it?
10:34:18 15 A. Correct. So in this case
10:34:20 16 things that would be deemed to be important for
10:34:24 17 patient satisfaction would be the items in the
10:34:26 18 top, right-hand box. And then number 11 would
10:34:30 19 be an area where there is a lower performance
10:34:32 20 by that agency but it will not have that
10:34:35 21 intended outcome.
10:34:36 22 So number 11 would be a question
10:34:38 23 asked to the patients around whether they
10:34:41 24 always had the same worker and if care from
10:34:43 25 different workers caused problems. So that
10:34:47 26 would be question number 4.
10:34:48 27 Q. And if we scroll down to the
10:34:52 28 bottom half of that page. What is this chart
10:34:59 29 telling us?
10:35:00 30 A. So it's the information
10:35:04 31 contained in the chart above. So it would,
10:35:06 32 again, in the middle show the current

10:35:08 1 performance of Saint Elizabeth in these areas.
10:35:10 2 And then the box titled "The Correlation
10:35:13 3 Coefficient", the higher that number is the
10:35:16 4 more important it is to an overall patient
10:35:19 5 satisfaction.
10:35:20 6 So in this example if we wanted
10:35:21 7 to significantly improve a patient satisfaction
10:35:24 8 in this organization they should be focused on
10:35:28 9 providing enough notice of when services would
10:35:30 10 end, ensuring the home healthcare workers
10:35:33 11 listen carefully and explained things in a way
10:35:36 12 that was easy to understand, those three green
10:35:39 13 bars.
10:35:39 14 Q. Those are the three that
10:35:40 15 have the most impact on patient satisfaction?
10:35:43 16 A. Correct. Now that would be
10:35:45 17 specifically related to Saint Elizabeth. So
10:35:47 18 these charts would be different for every
10:35:50 19 service provider and every service that we
10:35:51 20 have.
10:35:51 21 Q. Now, I understand that in
10:36:00 22 addition to the key performance indicators, and
10:36:03 23 one of them was patient satisfaction that
10:36:05 24 you've just walked us through, there were also
10:36:10 25 measurements in terms of rate of adverse events
10:36:15 26 and rate of complaints, and things of that
10:36:19 27 nature. Was that something that the service
10:36:21 28 providers factored into the CCACs evaluation of
10:36:26 29 a service provider's performance?
10:36:28 30 A. Yes.
10:36:28 31 Q. And how so?
10:36:30 32 A. We would look at the rate of

10:36:33 1 complaints and adverse events that come through
10:36:35 2 our ETMS system. Within our reporting
10:36:38 3 structure with our service providers they both
10:36:41 4 self-report rates of complaints and adverse
10:36:44 5 events on a quarterly basis through a
10:36:47 6 performance reporting system, and we use the
10:36:50 7 information contained with ETMS.
10:36:53 8 So, on a quarterly basis a
10:36:55 9 service provider would identify the rate of
10:36:59 10 complaints from their end and we would also
10:37:00 11 report on the rate of events from our ETMS
10:37:04 12 system.
10:37:04 13 We primarily use the ETMS system
10:37:06 14 for any performance management conversations or
10:37:09 15 any tracking and trending because it's
10:37:11 16 generally reported from multiple different
10:37:13 17 sources.
10:37:13 18 Q. So, in other words, if the
10:37:15 19 rate of complaints or adverse events is going
10:37:18 20 up that's a trend you're going to look at and
10:37:21 21 have a conversation about?
10:37:22 22 A. Yes.
10:37:23 23 Q. So I want to move on to a
10:37:25 24 different area now and that's the use of
10:37:28 25 subcontractors by service provider
10:37:31 26 organizations.
10:37:32 27 As I read the contract service
10:37:33 28 providers are allowed to engage another agency
10:37:36 29 or a subcontractor to provide some of the
10:37:40 30 services that its providing for the CCAC. So,
10:37:45 31 in other words, Saint Elizabeth, to take an
10:37:47 32 example, could engage another organization to

10:37:49 1 provide some of the nursing services to CCAC
10:37:52 2 patients?
10:37:52 3 A. Correct.
10:37:53 4 Q. Does a service provider need
10:37:55 5 to tell the CCAC if it intends to use a
10:37:58 6 subcontractor?
10:38:00 7 A. So within the Southwest CCAC
10:38:02 8 the service providers are required to obtain
10:38:04 9 the approval of the Southwest CCAC to engage in
10:38:09 10 a subcontracting agreement.
10:38:10 11 Q. And what does the CCAC look
10:38:12 12 at when deciding whether it's going to give
10:38:14 13 that approval?
10:38:14 14 A. So we would look at the past
10:38:17 15 performance of that particular subcontractor,
10:38:20 16 whether or not they have history working in the
10:38:23 17 Home and Community Care sector; we would look
10:38:27 18 at whether there's been any legal claims or
10:38:30 19 concerns related to that particular provider;
10:38:33 20 and specifically how the service provider
10:38:36 21 organization that maintains the contract with
10:38:38 22 us will ensure the performance of their
10:38:40 23 subcontractor.
10:38:41 24 That's important because
10:38:43 25 although an organization is able to retain a
10:38:45 26 subcontractor we still hold the original
10:38:48 27 service provider organization responsible for
10:38:51 28 meeting the contractual terms and reporting and
10:38:54 29 following all the same processes.
10:38:54 30 Q. So, in other words, when a
10:38:57 31 subcontractor is used that subcontractor has to
10:39:00 32 meet all the same standards that are set out in

10:39:03 1 the services agreement?
10:39:04 2 A. Yes, they need to meet the
10:39:08 3 same standards and it maintains the
10:39:11 4 responsibility of the original, contracted SPO
10:39:13 5 to ensure that that occurs.
10:39:15 6 Q. Do subcontractors have any
10:39:17 7 direct contact with the CCAC?
10:39:19 8 A. So on a day-to-day basis it
10:39:23 9 is possible that staff or a scheduler from a
10:39:27 10 subcontracting agency might directly liaise
10:39:30 11 with a care co-ordinator, but as far as any
10:39:33 12 performance conversations or reporting
10:39:35 13 complaints and adverse events that would be,
10:39:38 14 again, directly a conversation between us and
10:39:40 15 the SPO that holds the contract.
10:39:42 16 Q. Do you have or are you given
10:39:46 17 any information about how the service provider
10:39:49 18 is going to ensure they're properly overseeing
10:39:51 19 the subcontractor?
10:39:52 20 A. That information is collected
10:39:54 21 when we approve the subcontractor, so the
10:39:57 22 agency does need to provide details on how they
10:39:59 23 will do that.
10:40:00 24 On an ongoing basis we do
10:40:03 25 sometimes engage with them where we do hear
10:40:07 26 about complaints or issues related to the
10:40:08 27 services provided by the subcontractor, and
10:40:11 28 that would roll into our performance management
10:40:14 29 conversations if necessary.
10:40:15 30 Q. Apart from situations where
10:40:17 31 you're actually hearing complaints, does the
10:40:22 32 CCAC have any more routine process to verify

10:40:25 1 that a service provider is in fact properly
10:40:27 2 monitoring their subcontractor?
10:40:29 3 A. We don't have anything formal
10:40:31 4 to do that, no.
10:40:31 5 Q. So, in other words, the CCAC
10:40:35 6 is putting its trust in the service provider
10:40:37 7 organization to ensure the subcontractor is
10:40:40 8 operating appropriately?
10:40:41 9 A. I'm not sure I would use the
10:40:44 10 term "putting our trust" in there because we
10:40:48 11 still have interactions on a day-to-day basis
10:40:50 12 with that service provider.
10:40:51 13 In a lot of cases service
10:40:53 14 providers use subcontractors to enhance
10:40:56 15 services provided to the patient. So there
10:40:58 16 will still be service providers of our --
10:41:02 17 employed by -- there will be staff employed by
10:41:04 18 the service provider also in that home.
10:41:06 19 So if we become aware of issues
10:41:08 20 we will address them, but there is no formal
10:41:11 21 oversight process of the performance of the
10:41:13 22 subcontractors directly.
10:41:15 23 Q. Right. So unless something
10:41:16 24 is reported to you you're basically not
10:41:21 25 looking at what the service provider
10:41:22 26 organization is doing to oversee that
10:41:27 27 subcontractor?
10:41:27 28 A. No.
10:41:28 29 Q. Do subcontractors have to
10:41:31 30 make any reports to the CCAC?
10:41:32 31 A. So that obligation of reports
10:41:35 32 would be, again, followed by the organization

10:41:37 1 holding the contract.
10:41:38 2 Q. So in terms of reporting
10:41:40 3 complaints and risk events, for example, if a
10:41:44 4 subcontractor learns of a risk event how does
10:41:48 5 that get reported to the CCAC?
10:41:49 6 A. So that issue should be
10:41:51 7 reported to us from the service provider
10:41:55 8 organizations, and we do see that quite a bit.
10:41:56 9 Q. So the subcontractor reports
10:41:59 10 to the service provider, the service provider
10:42:03 11 reports to the CCAC?
10:42:05 12 A. Correct. So the service
10:42:05 13 provider organizations have access to ETMS and
10:42:05 14 the reporting, and they have the relationship
10:42:08 15 on a day-to-day basis with the co-ordinators,
10:42:09 16 where our subcontracting agencies would not
10:42:12 17 have access to ETMS.
10:42:13 18 Q. So earlier when we were
10:42:16 19 talking about how complaints and risk events
10:42:19 20 are dealt with you seemed to say that there was
10:42:20 21 a fair amount of back-and-forth between -- I
10:42:23 22 think you used the term "collaboration" between
10:42:26 23 the SPO and the CCAC. How does that work when
10:42:29 24 it's the subcontractor who is involved in the
10:42:31 25 risk event? How does that collaborative
10:42:36 26 process work?
10:42:37 27 A. So in a lot of cases when
10:42:39 28 there is a subcontractor directly involved in a
10:42:41 29 particular event, whether that's a complaint
10:42:43 30 from a patient or an issue around safety, as I
10:42:46 31 discussed, the service provider personnel will
10:42:50 32 often engage the subcontractor in the response

10:42:52 1 and investigation to that issue.
10:42:54 2 So it's not uncommon for when we
10:42:56 3 are doing a review or a conference related to
10:42:59 4 an issue to have the staff or the leadership of
10:43:01 5 a subcontractor agency on the call for that
10:43:05 6 particular event.
10:43:06 7 Q. You also spoke earlier about
10:43:10 8 service provider organizations -- the
10:43:15 9 requirement that they document in ETMS the
10:43:18 10 action plan, the steps they're going to take
10:43:20 11 to resolve it, and sometimes that CCAC would
10:43:23 12 go back to them and tell them that something
10:43:25 13 more was required. So, again, how does that
10:43:28 14 work with a subcontractor? Is the CCAC
10:43:30 15 speaking to is the service provider or telling
10:43:33 16 the service provider to tell the subcontractor
10:43:35 17 what to do, or...?
10:43:39 18 A. Yes. Again, we maintain our
10:43:41 19 relationship with our service provider
10:43:43 20 organization. I would say it's not sort of
10:43:45 21 that chain you describe of one talking to the
10:43:48 22 other.
10:43:50 23 When a service provider does
10:43:52 24 engage with a subcontractor it's typically to
10:43:54 25 enhance their level of staffing, and it would
10:43:57 26 be a small percentage of the services that they
10:44:00 27 receive.
10:44:01 28 So, for example, within our
10:44:02 29 region now we have very few organizations using
10:44:05 30 subcontractors for nursing, it's primarily for
10:44:08 31 personal support workers and may include things
10:44:11 32 like the service provider subcontracting

10:44:16 1 personal support to a retirement home where we
10:44:18 2 have a lot of CCAC patients.
10:44:20 3 So the process of how that
10:44:23 4 happens is not a process where they sort of
10:44:28 5 hand over the care. The service provider is
10:44:30 6 still responsible and is often times still
10:44:33 7 providing care in that home.
10:44:34 8 Q. If the CCAC has concerns
10:44:41 9 about a subcontractor's performance can it
10:44:44 10 require the service provider to stop using
10:44:46 11 that subcontractor for CCAC patients?
10:44:49 12 A. Yes.
10:44:50 13 Q. What -- maybe let's pull it
10:44:55 14 up. Let's go to tab A, page 24. And, Laura,
10:45:02 15 it's 69216, page 24. Excuse me, page 25.
10:45:20 16 So I think subsection 4 there at
10:45:22 17 the top of the page outlines when the CCAC can
10:45:27 18 require a service provider not to use a
10:45:29 19 subcontractor. Are these the requirements that
10:45:31 20 apply?
10:45:31 21 A. Yes.
10:45:32 22 Q. And what are they?
10:45:34 23 A. So the two aspects would be
10:45:39 24 if the subcontractor had committed a serious
10:45:41 25 error, in this case a serious misconduct or has
10:45:45 26 been charged with a crime. And the second
10:45:47 27 would be if the CCAC determines that we're
10:45:50 28 unsatisfied with the performance of a
10:45:52 29 particular subcontractor.
10:45:53 30 Q. So those are similar to the
10:45:55 31 requirements we talked about earlier where the
10:45:59 32 CCAC can require that the service provider not

10:46:03 1 send a particular staff member any more?
10:46:07 2 A. Correct.
10:46:07 3 Q. Has this power ever been
10:46:09 4 used, as far as you're aware?
10:46:10 5 A. It has not occurred in my
10:46:12 6 time with the Southwest CCAC.
10:46:13 7 Q. Now, I want to talk for a
10:46:18 8 minute about your experience with Saint
10:46:20 9 Elizabeth as a service provider. Do you know
10:46:22 10 how long they've been a service provider with
10:46:24 11 the Southwest CCAC?
10:46:24 12 A. So I don't know the specific
10:46:28 13 details of how long they've been a service
10:46:31 14 provider within the Southwest CCAC. We've had
10:46:34 15 the same group of service providers for
10:46:37 16 numerous years so it does predate my time with
10:46:40 17 the Southwest CCAC.
10:46:40 18 Q. And has it been under any
10:46:43 19 formal performance management process?
10:46:46 20 A. So Saint Elizabeth has been
10:46:48 21 under, to my understanding, one formal process
10:46:50 22 and that was related to ordering medical
10:46:53 23 supplies and medical equipment.
10:46:55 24 Q. So not related to nursing
10:46:57 25 services, the provision of nursing services?
10:47:00 26 A. Not the provision of nursing
10:47:03 27 services. This particular issue would have
10:47:05 28 been around ensuring that medication -- or
10:47:07 29 sorry, not medication, but medical supplies and
10:47:10 30 medical equipment was ordered with enough
10:47:12 31 advance notice to allow that to be delivered to
10:47:15 32 a patient's home.

10:47:16 1 Q. And have you had any general
10:47:19 2 concerns about Saint Elizabeth's performance as
10:47:21 3 a service provider organizations?
10:47:23 4 A. So through my work on a
10:47:26 5 day-to-day basis I do have the opportunity to
10:47:29 6 interact with all of our service provider
10:47:33 7 organizations, and while we may address
10:47:34 8 specific areas of concern generally speaking
10:47:37 9 Saint Elizabeth is a well-performing service
10:47:40 10 provider, and I do see lower instances of
10:47:42 11 complaints from patients and families around
10:47:45 12 Saint Elizabeth as opposed to some of the
10:47:46 13 others.
10:47:46 14 Q. The last area I want to talk
10:47:49 15 to you about is the investigation the Southwest
10:47:53 16 CCAC did after Ms. Wettlaufer's confessions
10:47:56 17 came to light, because Donna told us yesterday
10:47:59 18 that you oversaw that process.
10:48:04 19 Based your knowledge when did
10:48:06 20 you become aware of her confessions?
10:48:10 21 A. I became aware I believe it
10:48:13 22 was on October 18th after receiving an e-mail
10:48:16 23 from Donna Ladouceur after she had been made
10:48:19 24 aware from Saint Elizabeth.
10:48:20 25 Q. And that was the e-mail we
10:48:22 26 pulled up yesterday?
10:48:23 27 A. Correct.
10:48:24 28 Q. And in that e-mail I recall
10:48:29 29 that Donna said that your team was going to
10:48:32 30 create an ETMS entry. Was that done?
10:48:35 31 A. That was, yes.
10:48:36 32 Q. And was access to that ETMS

10:48:39 1 entry restricted?
10:48:39 2 A. Yes. Within ETMS there's
10:48:43 3 ability to mark something as "confidential",
10:48:46 4 which restricts the access to that to those who
10:48:48 5 are exclusively involved in the event and
10:48:52 6 members of the quality team.
10:48:53 7 Q. And that was done in this
10:48:55 8 case?
10:48:55 9 A. It was.
10:48:56 10 Q. What was the rationale for
10:48:59 11 restricting access?
10:49:01 12 A. With ETMSs (sic) and our
10:49:04 13 patient records if we feel something is of a
10:49:07 14 sensitive or serious nature we would identify
10:49:09 15 that as confidential and restrict access.
10:49:12 16 Q. I understand from your
10:49:13 17 affidavit that Saint Elizabeth received that
10:49:17 18 e-mail we just spoke about on October 18th, and
10:49:20 19 then on October 21st there was a phone call
10:49:24 20 between CCAC and Saint Elizabeth?
10:49:26 21 A. Correct.
10:49:28 22 Q. Can we pull up tab N of your
10:49:31 23 affidavit? It's 57057.
10:49:48 24 Now this isn't indicated, do you
10:49:50 25 know if these are the notes from that phone
10:49:52 26 call?
10:49:52 27 A. I believe these are the
10:49:55 28 notes from the October 21st phone call, yes.
10:49:57 29 Q. And can you tell us who the
10:50:00 30 participants in that phone call were?
10:50:02 31 A. This was a phone call between
10:50:04 32 two staff members from Saint Elizabeth. So

10:50:07 1 Eileen Cunningham would have been I believe the
10:50:07 2 executive director or the regional director
10:50:10 3 title, I'm not sure, and Tamara Condy, and then
10:50:14 4 two members of the CCAC at the time. So Gwen
10:50:18 5 Vanderheyden was our regional manager of
10:50:22 6 quality with responsibility for overseeing the
10:50:25 7 patient relations process, and Alison Coffey is
10:50:28 8 our patient relations co-ordinator.
10:50:30 9 Q. Were you updated about what
10:50:33 10 was discussed during that call?
10:50:34 11 A. I was, yes.
10:50:35 12 Q. And can you tell us, based on
10:50:37 13 your understanding, what that discussion was?
10:50:40 14 A. So at the time of this call
10:50:42 15 the focus was around the sort of initial
10:50:46 16 understanding that the CCAC and Saint Elizabeth
10:50:50 17 had of the event at that particular time. So
10:50:53 18 it was around -- at that time we were under the
10:50:55 19 impression that this was a harm from one nurse
10:50:59 20 to one CCAC patient with long-term -- impacts
10:51:02 21 in long-term care and private nursing. And
10:51:04 22 then the CCAC and Saint Elizabeth walked
10:51:07 23 through some of the steps that we felt were
10:51:09 24 necessary to do that.
10:51:11 25 So, for instance, we did ask
10:51:11 26 that they review with their staff if there were
10:51:14 27 any issues or check-in any unexpected deaths
10:51:20 28 and kind of walk through those things,
10:51:21 29 including whether not this report was to be
10:51:24 30 provided to the College of Nurses.
10:51:26 31 So the initial call, to my
10:51:28 32 understanding, was t o just try to collect the

10:51:29 1 information that was available and understand
10:51:31 2 the nature of the issue that we were working
10:51:33 3 with.
10:51:33 4 Q. And so if we scroll down the
10:51:36 5 page a little bit there's a highlighted line
10:51:44 6 there that -- well maybe you can explain to me
10:51:48 7 what this is saying?
10:51:49 8 A. Sorry, the highlighted part?
10:51:52 9 Q. Yes.
10:51:53 10 A. So this would have been notes
10:51:55 11 from my staff, which would have indicated that
10:51:58 12 our expectation was Saint Elizabeth was going
10:52:00 13 to check in with the team and the other
10:52:02 14 patients who the nurse provided care to and see
10:52:06 15 if there were any other quality of care issues.
10:52:08 16 So although the initial incident
10:52:11 17 identified harm to one patient we wanted to
10:52:13 18 ensure that there was nothing else to any other
10:52:15 19 patient that were received care. And we
10:52:17 20 thought it would be value for them to talk to
10:52:21 21 not only other nurses providing care but to
10:52:24 22 really review the patients' records for those.
10:52:26 23 Q. So, in other words, CCAC was
10:52:28 24 telling Saint Elizabeth to do two things, to
10:52:31 25 speak to the other nurses who might have
10:52:33 26 worked alongside Ms. Wettlaufer, and to
10:52:36 27 follow-up by either contacting the patients or
10:52:39 28 reviewing the patient files to make sure there
10:52:41 29 weren't any issues with other patients?
10:52:43 30 A. Correct.
10:52:44 31 Q. Now, based on what you were
10:52:48 32 told was a report made by Saint Elizabeth to

10:52:53 1 the College of Nurses?
10:52:53 2 A. So it was my understanding at
10:52:56 3 the time that at that point in time a report
10:52:58 4 had not been made to the College of Nurses of
10:53:00 5 Ontario. The notes aren't fully fleshed out in
10:53:05 6 that respect, but it is my understanding that
10:53:07 7 Tamara was going to check with the College of
10:53:09 8 Nurses and provide a report.
10:53:10 9 Q. If we go to the bottom of the
10:53:15 10 page it says, "Patient's doctor is aware of the
10:53:21 11 situation." What was the conversation around
10:53:24 12 that?
10:53:25 13 A. Because I was not there I'm
10:53:26 14 not too sure on the details of that one.
10:53:28 15 Q. Is your understanding that
10:53:31 16 Ms. Bertram's doctor had been informed or
10:53:34 17 spoken to by someone?
10:53:36 18 A. Reading these notes that
10:53:38 19 would be my understanding, yes.
10:53:39 20 Q. And then just over to the
10:53:41 21 last page the last line there says:
10:53:46 22 "Alison to set up a 15 minute check-in in two
10:53:49 23 weeks."
10:53:50 24 Did that check-in happen?
10:53:52 25 A. So that check-in didn't
10:53:55 26 occur. I think primarily as more information
10:53:58 27 came out, specifically on October 25th, and
10:54:00 28 the scope and nature of the issue was
10:54:03 29 understood more frequent check-ins were
10:54:06 30 occurring between Gwen and members of Saint
10:54:09 31 Elizabeth.
10:54:09 32 Q. So in other words they were

10:54:11 1 touching base before that 2 weeks came up?
10:54:13 2 A. Correct, yes.
10:54:15 3 Q. And if we can pull up tab M
10:54:17 4 to your affidavit? It's 56924. And just
10:54:32 5 scroll down a little bit, Laura.
10:54:34 6 So we just spoke about a phone
10:54:39 7 call between the CCAC and Saint Elizabeth on
10:54:43 8 October 21st. And here under "Background" it
10:54:46 9 refers to a teleconference on October 18th. Do
10:54:49 10 you know if there was a teleconference that
10:54:50 11 day?
10:54:50 12 A. No, so that item should
10:54:53 13 state the conference on October 21st, so
10:54:56 14 there's an error in that note.
10:54:58 15 Q. So that's referring to the
10:55:00 16 phone call we just spoke about?
10:55:01 17 A. Correct.
10:55:01 18 Q. And a minute ago you said
10:55:03 19 there was more information released on October
10:55:05 20 25th. Can you tell us about what information
10:55:09 21 was released and then what CCAC did as a
10:55:12 22 result?
10:55:13 23 A. So on October 25th there was
10:55:15 24 a press conference I believe by the Woodstock
10:55:19 25 police, which detailed the nature of these
10:55:22 26 circumstances and the extent of that. So that
10:55:24 27 would have been the first point, to my
10:55:26 28 understanding, that the CCAC would have been
10:55:28 29 fully aware of the nature and the scope of what
10:55:31 30 had occurred. So in that press conference
10:55:33 31 there was the identity of additional people
10:55:35 32 that were identified.

10:55:37 1 So from that the CCAC would have
10:55:39 2 taken steps to understand had those been CCAC
10:55:44 3 patients? Whether or not receiving home care
10:55:46 4 services? Or whether or not the CCAC at any
10:55:49 5 time had placed those patient into long-term
10:55:52 6 care homes.
10:55:53 7 Q. And what did the CCAC find
10:55:55 8 when it looked into that?
10:55:56 9 A. We did find numerous files
10:55:58 10 for those patients both in at the time our
10:56:02 11 existing health record system and in other
10:56:04 12 health record systems that we had previously
10:56:06 13 used in the past.
10:56:07 14 Just to be sure we did lock down
10:56:09 15 access to those records to ensure that there
10:56:13 16 were no additional people looking into them or
10:56:15 17 accessing those records. And those were locked
10:56:18 18 down to I believe myself, the director who's
10:56:21 19 responsible for the placement process in our
10:56:23 20 organization, Donna Ladouceur and our patients
10:56:28 21 relations co-ordinator, Alison Coffey.
10:56:31 22 Q. So given that we know
10:56:34 23 Ms. Wettlaufer's other victims were in
10:56:37 24 long-term care homes would these have been
10:56:40 25 older CCAC files related to them?
10:56:40 26 A. Yes.
10:56:40 27 Q. Either related to their
10:56:40 28 placement in long-term care homes or related to
10:56:43 29 home care services they perhaps received before
10:56:43 30 they went into long-term care?
10:56:44 31 A. Correct.
10:56:45 32 Q. And I understand that --

10:56:49 1 thank you, we're done with that document,
10:56:52 2 Laura.
10:56:52 3 I understand that the CCAC also
10:56:54 4 e-mailed all its service providers to confirm
10:56:57 5 if Ms. Wettlaufer ever worked for them, is that
10:56:59 6 right?
10:56:59 7 A. Correct, yes.
10:57:03 8 Q. So let's turn up tab O of
10:57:05 9 your affidavit, and the document is 56972. And
10:57:24 10 then just scroll down a little bit.
10:57:25 11 This is an e-mail from Michelle
10:57:27 12 McKellar, who's regional manager of contract
10:57:34 13 management?
10:57:34 14 A. Correct.
10:57:34 15 Q. And was she primarily
10:57:36 16 responsible for the discussions with the
10:57:38 17 service provider organizations?
10:57:39 18 A. Correct.
10:57:40 19 Q. And what's she asking for in
10:57:43 20 this e-mail?
10:57:44 21 A. For this e-mail Michelle is
10:57:47 22 reaching out to all the providers that provide
10:57:49 23 care to the Southwest CCAC providing them with
10:57:53 24 the name of the RN who was arrested and
10:57:56 25 charged, Ms. Wettlaufer, and asking them
10:57:57 26 specifically to check if that person had been
10:58:00 27 employed in their organization in any capacity.
10:58:03 28 So that went out to all of our
10:58:06 29 service provider. And I believe we heard from
10:58:07 30 all service provider within a fairly short
10:58:10 31 order related to this instance.
10:58:12 32 Q. And what was the response

10:58:13 1 from the service providers?
10:58:15 2 A. At that time nobody
10:58:17 3 identified that that nurse had been employed by
10:58:19 4 them.
10:58:19 5 Later on that day we did receive
10:58:22 6 a couple of pieces of information that led us
10:58:26 7 to do a further check in with our providers.
10:58:28 8 One would have been we found out
10:58:32 9 Ms. Wettlaufer's maiden name so we would have
10:58:34 10 reached out and asked them to check whether or
10:58:37 11 not anybody employed under that name.
10:58:38 12 And then we also understood, I
10:58:39 13 believe through an article in the London Free
10:58:42 14 Press, that Ms. Wettlaufer had been an employee
10:58:44 15 of Lifeguard, which was a subcontractor agency
10:58:47 16 of two of our service provider organizations.
10:58:48 17 Q. And in terms of the -- let's
10:58:53 18 talk about the maiden name issue first. I
10:58:58 19 understand Michelle e-mailed all service
10:59:00 20 providers with that updated information. What
10:59:01 21 was the response from service providers to
10:59:03 22 that new information?
10:59:05 23 A. To my recollection there
10:59:07 24 was -- nobody identified that person under
10:59:09 25 their maiden name as well.
10:59:10 26 Q. And you said that -- you
10:59:13 27 identified that she had worked for Lifeguard,
10:59:17 28 which was a subcontractor of two service
10:59:19 29 providers. To be clear we heard some testimony
10:59:23 30 from Heidi Wilmot-Smith who worked for an
10:59:27 31 agency called Lifeguard during the facilities
10:59:32 32 phase of these hearings, is that the same

10:59:35 1 agency you're talking about?
10:59:35 2 A. I believe it would be, yes.
10:59:36 3 Q. And the two service providers
10:59:39 4 that Lifeguard subcontracted for were ParaMed
10:59:39 5 and Care Partners, is that right?
10:59:40 6 A. Yes.
10:59:41 7 Q. Can we turn up tab P to your
10:59:47 8 affidavit? And this is 56974. And then scroll
10:59:54 9 down to the bottom of the page once you get
10:59:57 10 there. Sorry, 56947.
11:00:29 11 So this appears to be an e-mail
11:00:31 12 from Michelle McKellar to Steven Brown and
11:00:35 13 Helen Lyons. I understand they work for
11:00:40 14 ParaMed?
11:00:40 15 A. Yes, that would be the
11:00:41 16 leadership of ParaMed.
11:00:43 17 Q. So the last line of that
11:00:45 18 e-mail seems to say:
11:00:47 19 "I know your contract in that
11:00:48 20 area is for PSW services but I
11:00:51 21 just want to be 100% confident."
11:00:55 22 So she's indicating that
11:00:57 23 Ms. Wettlaufer worked for Lifeguard. What
11:00:59 24 contract is she talking about that related to
11:01:01 25 PSW services?
11:01:02 26 A. I'm sorry, can you rephrase
11:01:05 27 the question?
11:01:05 28 Q. I'm wondering if you can
11:01:07 29 explain the last sentence of her e-mail there.
11:01:11 30 She says:
11:01:12 31 "I know your contract in that
11:01:13 32 area is for PSW services[...]"

11:01:18 1 Do you know if she's talking
11:01:19 2 about the subcontract with Lifeguard or
11:01:20 3 ParaMed's contract with the CCAC?
11:01:20 4 A. I believe in that sentence
11:01:23 5 she's referring to that in that particular
11:01:24 6 area ParaMed does not have a contract to
11:01:27 7 provide nursing, nursing services.
11:01:29 8 Q. Okay.
11:01:29 9 A. So, yeah. So she would be
11:01:32 10 referring to the fact that wanting to ensure
11:01:36 11 that through the subcontractor we are checking
11:01:39 12 not only nursing but PSW services as well.
11:01:42 13 Q. And do you know what the
11:01:44 14 response from ParaMed was in terms of whether
11:01:47 15 Ms. Wettlaufer had in fact provided services to
11:01:51 16 CCAC clients?
11:01:53 17 A. Yes, the response was that
11:01:55 18 she had, yes.
11:01:55 19 Q. And how many?
11:01:57 20 A. I believe it was one
11:01:59 21 patient -- or seven patients, I'm sorry.
11:02:01 22 Q. So seven patients. And I
11:02:03 23 take it that that would have been as a PSW?
11:02:06 24 A. Correct.
11:02:06 25 Q. Was ParaMed asked to do
11:02:09 26 anything to verify if those patients had been
11:02:13 27 harmed or if there were any quality of care
11:02:17 28 issues related to their care?
11:02:18 29 A. Yes, I believe in this e-mail
11:02:20 30 thread it does specifically ask to do a check
11:02:22 31 to ensure there were no issues or unexpected
11:02:25 32 deaths.

11:02:25 1 Q. So if we can pull up 56977
11:02:25 2 and go to page 2?
11:02:25 3 THE COURT REPORTER: Counsel, if
11:02:25 4 we can have a moment to switch
11:02:25 5 the audio?
11:02:34 6 MS. KINKARTZ: Certainly.
11:02:34 7 -- RECESSED AT 11:02 A.M.
11:02:50 8 -- RESUMED AT 11:02 A.M.
11:02:50 9 BY MS. KINKARTZ:
11:02:51 10 Q. And so at the top of that
11:02:53 11 page appears to be an e-mail from Michelle back
11:03:00 12 to ParaMed?
11:03:01 13 A. Um-hmm.
11:03:01 14 Q. And she says:
11:03:03 15 "We'll await the notes from your
11:03:03 16 investigation, and if there's
11:03:05 17 anything further in the
11:03:05 18 meantime, I'll reach out."
11:03:07 19 So is that investigation she's
11:03:10 20 talking about what you just described to us?
11:03:12 21 A. Correct.
11:03:17 22 Q. And if we go up to the first
11:03:20 23 page of that document, scroll down a little
11:03:27 24 bit, this is the response from ParaMed, and
11:03:30 25 what are they indicating about whether there
11:03:33 26 were issues with those patients?
11:03:34 27 A. I believe at the time of this
11:03:36 28 issue, they're indicating that through the
11:03:38 29 reports that had been publicly available that
11:03:41 30 there were no other issues that had been
11:03:44 31 identified by the police.
11:03:45 32 We still did ask ParaMed to do

11:03:47 1 an investigation on their end to determine if
11:03:50 2 anything additional had occurred.
11:03:52 3 Q. And based on what ParaMed
11:03:54 4 reported back, were there any additional
11:03:57 5 issues?
11:03:57 6 A. I don't believe so, no.
11:03:58 7 Q. And if we turn to tab Q of
11:04:01 8 your affidavit, this is 56946, and if we scroll
11:04:13 9 down to the bottom of the first page of this as
11:04:16 10 well?
11:04:16 11 So this, I take it, is the
11:04:18 12 e-mail from Michelle to CarePartners, the other
11:04:23 13 service provider that subcontracted with
11:04:25 14 Lifeguard?
11:04:25 15 A. Correct.
11:04:25 16 Q. And she's making the same
11:04:28 17 request of them that she made of ParaMed to
11:04:30 18 check if Ms. Wettlaufer had provided services
11:04:34 19 to any CCAC clients?
11:04:36 20 A. Correct.
11:04:36 21 Q. If we scroll to the top of
11:04:39 22 the page, can you tell us what CarePartners'
11:04:42 23 response was?
11:04:43 24 A. Care Partners did indicate
11:04:45 25 that this individual did complete one shift for
11:04:48 26 them as a subcontractor through Lifeguard.
11:04:51 27 Q. And what kind of shift was
11:04:54 28 that?
11:04:54 29 A. So I believe at that time,
11:04:56 30 that that would have been an e-shift, so they
11:04:59 31 would have been operating as a PSW.
11:05:01 32 Q. What is an e-shift?

11:05:04 1 A. So in the Southwest CCAC, we
11:05:05 2 have a program for patients where a PSW, called
11:05:10 3 a tech -- a technician in this case would be
11:05:12 4 the one in the home, and through a smartphone
11:05:18 5 application would be receiving direction and
11:05:20 6 communicating with a nurse. So one nurse
11:05:23 7 remotely would be supporting multiple PSWs.
11:05:26 8 Q. Did the CCAC ask CarePartners
11:05:32 9 to do an investigation?
11:05:33 10 A. Correct.
11:05:34 11 Q. And what was the result of
11:05:36 12 that investigation?
11:05:37 13 A. I believe that no issues were
11:05:40 14 identified.
11:05:41 15 THE COMMISSIONER: No what was
11:05:44 16 identified?
11:05:44 17 THE WITNESS: No issues were
11:05:46 18 identified, excuse me.
11:05:48 19 THE COMMISSIONER: Okay.
11:05:48 20 BY MS. KINKARTZ:
11:05:49 21 Q. We're done with that
11:05:50 22 document, thank you.
11:05:51 23 In your affidavit, you say that
11:05:53 24 Michelle McKellar also contacted the Hamilton
11:05:59 25 Niagara Haldimand Brant CCAC. Why did she do
11:06:02 26 that?
11:06:06 27 A. So Michelle would have been
11:06:07 28 aware, I believe, that Lifeguard was providing
11:06:12 29 services in that area and wanted to ensure that
11:06:14 30 the CCAC was aware of that and could take any
11:06:17 31 appropriate action that was necessary.
11:06:18 32 Q. And do you know what the

11:06:21 1 HNHB CCAC did in terms of investigation?
11:06:23 2 A. So at the time, I was not
11:06:25 3 directly aware of what their investigation was,
11:06:28 4 but since then, I have spoken to them, and they
11:06:31 5 did complete an independent investigation of
11:06:33 6 any patients receiving care, but I do not know
11:06:37 7 the outcome of that investigation.
11:06:38 8 Q. Do you know when the
11:06:42 9 HNHB CCAC looked into this Lifeguard was
11:06:45 10 providing services as an a subcontractor to --
11:06:47 11 how many SPOs in the HNHB region was Lifeguard
11:06:54 12 subcontracted to?
11:06:55 13 A. I'm not sure of that
11:06:57 14 information.
11:06:57 15 Q. Now, can we turn up
11:07:00 16 paragraph 89 of your affidavit? So it's the
11:07:07 17 bottom of 32, top of 33.
11:07:23 18 So if we look at the last
11:07:25 19 sentence on bottom of page 32, it seems to say
11:07:30 20 that once the HNHB CCAC became aware that
11:07:35 21 Ms. Wettlaufer worked for Lifeguard, they sent
11:07:37 22 a follow-up message to their SPOs who had
11:07:40 23 subcontracts with Lifeguard, and then it lists
11:07:41 24 ParaMed, Victorian Order of Nurses, and
11:07:46 25 CarePartners.
11:07:47 26 So I take it from that, there
11:07:49 27 were three service providers in the HNHB region
11:07:52 28 that Lifeguard had subcontracts with?
11:07:55 29 A. So I think it's important
11:07:58 30 to -- I believe that those are the service
11:08:01 31 provider organizations that they would have
11:08:02 32 sent a note to, but I'm not specifically sure

11:08:07 1 if all those would have received Lifeguard
11:08:07 2 services.
11:08:07 3 Q. Okay.
11:08:08 4 A. So this was a conversation
11:08:08 5 that I had with the HNHB CCAC, so that
11:08:18 6 distinction I'm unsure of.
11:08:20 7 Q. Okay. Well, if we go to the
11:08:22 8 top of 33, it looks like what was reported to
11:08:25 9 you was that all three service provider
11:08:28 10 organizations provided a list of patients to
11:08:31 11 whom Ms. Wettlaufer had provided services while
11:08:32 12 employed by Lifeguard; is that right?
11:08:34 13 A. Correct. So, sorry, that
11:08:35 14 would have been my mistake, so thank you.
11:08:38 15 Q. Okay. So Lifeguard would
11:08:40 16 have subcontracts with all three, and it sounds
11:08:43 17 like Ms. Wettlaufer provided services to CCAC
11:08:47 18 patients through all three?
11:08:47 19 A. Correct.
11:08:48 20 Q. And then the last sentence of
11:08:50 21 the affidavit -- of that paragraph, excuse me,
11:08:51 22 what does that indicate about the outcome of
11:08:54 23 their investigation there?
11:08:55 24 A. I am aware that they
11:08:57 25 indicated that were no unexpected deaths
11:09:01 26 involving those patients. I think I'm
11:09:02 27 specifically referring to I'm not sure how
11:09:04 28 their investigation was conducted or how they
11:09:09 29 used, so I'm aware of sort of the outcome, I
11:09:13 30 guess I should say.
11:09:13 31 Q. Okay, fair enough. So let's
11:09:15 32 talk about the investigation that was done at

11:09:18 1 the Southwest CCAC. I understand from your
11:09:20 2 affidavit that your quality team did an audit
11:09:22 3 of all the CCAC patients that Ms. Wettlaufer
11:09:24 4 had seen?
11:09:25 5 A. Correct.
11:09:26 6 Q. So can you tell us what was
11:09:28 7 involved in that audit?
11:09:30 8 A. So that audit was led by
11:09:38 9 Gwen Vanderheyden who was our regional manager
11:09:38 10 of quality at the time, who's a registered
11:09:38 11 nurse.
11:09:38 12 So in addition to the
11:09:39 13 investigation being done by Saint Elizabeth, we
11:09:42 14 wanted to ensure that we were checking the
11:09:46 15 information that the CCAC would have received
11:09:48 16 for every patient that received care from
11:09:52 17 Ms. Wettlaufer from Saint Elizabeth, from
11:09:56 18 ParaMed, and from CarePartners, and to
11:10:01 19 understand had there been any specific
11:10:04 20 complaints, talking specifically around when
11:10:04 21 those patients received CCAC services, what
11:10:07 22 services were necessary, and all those types of
11:10:09 23 things.
11:10:09 24 So that audit was for each one
11:10:11 25 of those patient files on our end as a CCAC.
11:10:14 26 Q. And what was the outcome of
11:10:15 27 that audit?
11:10:17 28 A. So the outcome of that audit
11:10:20 29 is that there were no additional issues
11:10:23 30 identified other than the issue with
11:10:25 31 Ms. Bertram.
11:10:26 32 Q. Did Ms. Vanderheyden record

11:10:31 1 any information that she was gathering from
11:10:33 2 those patient files?
11:10:35 3 A. Sorry, can you be more
11:10:36 4 specific?
11:10:37 5 Q. What things was she looking
11:10:40 6 for in those patient files?
11:10:42 7 A. So there is a table that --
11:10:43 8 in the exhibit that might be helpful if we
11:10:47 9 can...
11:10:47 10 MS. KINKARTZ: Okay. So this is
11:10:50 11 tab T to your affidavit, but,
11:10:52 12 Commissioner, we've got that
11:10:55 13 table in a -- well, I would say
11:10:57 14 more legible form in that it
11:11:00 15 fits on one page, but it's quite
11:11:03 16 tiny. I believe Madam Clerk has
11:11:05 17 a copy.
11:11:06 18 THE COMMISSIONER: Thank you.
11:11:14 19 BY MS. KINKARTZ:
11:11:16 20 Q. Steven, is this the table you
11:11:18 21 were talking about?
11:11:19 22 A. Yes.
11:11:19 23 Q. And is that the same table
11:11:20 24 that's produced in a slightly different format
11:11:21 25 at tab T of your affidavit?
11:11:22 26 A. Yes.
11:11:23 27 MS. KINKARTZ: Can we mark this
11:11:25 28 as the next exhibit,
11:11:27 29 Commissioner?
11:11:29 30 THE COMMISSIONER: Yes, we can.
11:11:30 31 Madam Clerk, exhibit what?
11:11:32 32 THE COURT CLERK: 162.

11:11:35 1 THE COMMISSIONER: Exhibit 162,
11:11:37 2 then, and it's the CCAC audit,
11:11:41 3 Document 72895.
11:11:42 4 EXHIBIT NO. 162: Document
11:11:44 5 72895, CCAC Audit.
11:11:44 6 BY MS. KINKARTZ:
11:11:45 7 Q. Can you walk us through what
11:11:48 8 information Ms. Vanderheyden was looking for
11:11:52 9 and why?
11:11:55 10 A. So within each of these
11:11:58 11 columns specifically relates to a piece of
11:12:01 12 information that at the time we felt was
11:12:03 13 necessary to collect.
11:12:04 14 So specific information on the
11:12:07 15 blacked-out column, which would have been the
11:12:11 16 billing reference number, so it's a unique
11:12:13 17 identifier of each patient, the initials of the
11:12:14 18 patients, their age, what type of services and
11:12:21 19 who the provider was, and then certain columns
11:12:23 20 on whether they were an active CCAC patient at
11:12:29 21 the time or -- and if they had an active
11:12:31 22 nursing file at the time.
11:12:32 23 In addition, there would be
11:12:34 24 fields around when they were active with the
11:12:36 25 CCAC, when they were discharged both from
11:12:39 26 receiving nursing services but also from
11:12:42 27 receiving CCAC services in general.
11:12:45 28 And then there are specific
11:12:48 29 fields that Gwen -- I believe Gwen found
11:12:48 30 important around there which was what was the
11:12:56 31 service plan, what was the diagnosis of the
11:12:58 32 patient, was the patient diabetic or were they

11:13:01 1 receiving -- on insulin, and did the patient
11:13:03 2 have an IV.
11:13:06 3 In addition, we also checked for
11:13:08 4 each one of these patients whether or not there
11:13:10 5 were risk events or complaints that had been
11:13:12 6 received by the CCAC for these patients, and
11:13:16 7 whether or not there was explicit patient
11:13:19 8 contact necessary by the CCAC, which would have
11:13:22 9 been separate and distinct from the contact
11:13:25 10 that Saint Elizabeth would have to make with
11:13:27 11 each of these patients.
11:13:28 12 And then there would be a few
11:13:30 13 issues whether there would be some follow-up
11:13:31 14 required directly with the patient or maybe
11:13:33 15 with a care co-ordinator, and then any
11:13:36 16 comments.
11:13:38 17 So this specifically would be
11:13:42 18 for all patients, as I said, of ParaMed,
11:13:42 19 CarePartners, and Saint Elizabeth, and any
11:13:45 20 patients that we would have placed in long-term
11:13:49 21 care that would have been identified to us.
11:13:50 22 Q. There's a column here that
11:13:51 23 says further investigation necessary. How did
11:13:56 24 Ms. Vanderheyden or how did your team decide
11:13:58 25 whether further investigation was necessary for
11:14:00 26 a particular patient or not?
11:14:02 27 A. So it's my understanding that
11:14:04 28 she would use the information around whether
11:14:07 29 there was events or complaints that had
11:14:10 30 happened or concerns after reviewing the chart
11:14:13 31 or any records that would have been included in
11:14:14 32 that, but I can't speak to specifically how she

11:14:19 1 would have made that determination.
11:14:20 2 Q. Okay. Did she review any
11:14:22 3 other records related to or authored by
11:14:25 4 Ms. Wettlaufer?
11:14:25 5 A. Yes. So in addition to going
11:14:29 6 through in detail the entire patient record for
11:14:30 7 these patients to understand, there are
11:14:32 8 documents that we would have received that
11:14:34 9 would have been authored by Ms. Wettlaufer,
11:14:36 10 which were our APRs or Automated Provider
11:14:36 11 Reports, so she would have reviewed all of
11:14:44 12 those and filed those for our records.
11:14:44 13 Q. And would that have been for
11:14:47 14 these particular patients or for the same
11:14:50 15 patients in this list?
11:14:52 16 A. So one of the key parts of
11:14:53 17 that review is not only to understand what was
11:14:57 18 the content of that but to ensure that as we
11:14:59 19 look through all those documents authored by
11:14:59 20 that nurse that there were no patients that had
11:15:02 21 not been previously identified.
11:15:05 22 So through this review, in
11:15:07 23 reviewing the Automated Provider Reports, no
11:15:08 24 additional patients were identified.
11:15:10 25 Q. In other words, all of the
11:15:11 26 CCAC patients that Ms. Wettlaufer had served
11:15:13 27 were already captured by the audit that
11:15:20 28 Ms. Vanderheyden had done?
11:15:21 29 A. Correct.
11:15:22 30 Q. And were there any issues
11:15:23 31 that came up in those APR reports?
11:15:26 32 A. Not to my knowledge, no.

11:15:28 1 Q. Did the CCAC follow up with
11:15:30 2 Ms. Bertram to determine if she needed any
11:15:33 3 additional support?
11:15:34 4 A. So it's my understanding that
11:15:35 5 the care co-ordinator would have followed up
11:15:38 6 with Ms. Bertram directly.
11:15:41 7 Q. And that was Karen Mitchell?
11:15:43 8 A. Correct.
11:15:44 9 Q. Now, I want to turn now to
11:15:45 10 the parent whose home Ms. Wettlaufer entered
11:15:48 11 unannounced in order to steal the insulin that
11:15:50 12 she used in her offense against Ms. Bertram.
11:15:54 13 Was that a CCAC patient?
11:15:56 14 A. Yes.
11:15:56 15 Q. And we heard from Donna
11:16:01 16 yesterday when she heard about this incident,
11:16:05 17 and I believe she indicated that she heard
11:16:08 18 about it from you. So can you tell us when you
11:16:11 19 learned about it?
11:16:12 20 A. So through the preparations
11:16:14 21 for this process or this Inquiry is when we put
11:16:17 22 all the pieces together of who that patient was
11:16:21 23 and found out that that event had not been
11:16:22 24 previously reported to us.
11:16:24 25 Q. And so how recently was that?
11:16:26 26 A. Over the last couple weeks.
11:16:28 27 Q. Okay. So since
11:16:30 28 Saint Elizabeth testified in June during these
11:16:34 29 hearings?
11:16:35 30 A. Correct.
11:16:36 31 Q. So I take it that given that
11:16:44 32 you've just learned about this, that means

11:16:46 1 Saint Elizabeth did not report either that
11:16:48 2 Ms. Wettlaufer had entered a home unannounced
11:16:50 3 or that she had stolen insulin from that
11:16:55 4 patient?
11:16:57 5 A. Correct.
11:16:57 6 Q. Are those things that should
11:16:59 7 have been reported?
11:17:00 8 A. Yes.
11:17:00 9 Q. Have you had conversations
11:17:02 10 with Saint Elizabeth since learning about this?
11:17:04 11 A. Yes. So I've had some
11:17:07 12 initial follow-up conversation with the
11:17:07 13 leadership at Saint Elizabeth to first indicate
11:17:09 14 that that would have been an event at the time
11:17:11 15 with the information that was available that we
11:17:16 16 would have expected to be a reportable event to
11:17:19 17 the CCAC.
11:17:20 18 We've also committed with
11:17:21 19 Saint Elizabeth to do a review around that
11:17:23 20 nature and address any issues as to why that
11:17:25 21 event was not reported to the CCAC.
11:17:26 22 Q. Are you doing any other work
11:17:30 23 besides those conversations with
11:17:31 24 Saint Elizabeth to follow up or address this
11:17:33 25 incident?
11:17:34 26 A. I believe a lot more work
11:17:36 27 will be required with Saint Elizabeth to
11:17:37 28 address specific areas, and I would imagine
11:17:40 29 with other service providers as well to
11:17:43 30 understand practices and learn that, but we're
11:17:47 31 just in the initial stages of that work right
11:17:49 32 now.

11:17:49 1 Q. Do you have a sense of what
11:17:52 2 kind of work is being contemplated either with
11:17:53 3 Saint Elizabeth or with the other service
11:17:54 4 providers?
11:17:54 5 A. So from my perspective, from
11:17:56 6 a quality and risk perspective, ensuring that
11:17:58 7 things that are reportable or we consider
11:18:03 8 reportable are very clear and understood not
11:18:03 9 only by the leadership of our service provider
11:18:07 10 organizations but from the staff, and that
11:18:09 11 there's a lot of clarity as it relates to those
11:18:13 12 things.
11:18:13 13 So this specific incident, there
11:18:15 14 is no distinct category in our event system
11:18:18 15 that refers to an unauthorized entry.
11:18:21 16 So I believe that we're going to
11:18:23 17 have to continue to do some work to create that
11:18:26 18 clarity and ensure that is reported. I do
11:18:28 19 believe that this is an event that should be
11:18:32 20 reported, and regardless of what was known at
11:18:35 21 the time, should have been reported to the
11:18:38 22 CCAC.
11:18:38 23 Q. Now, given that, from what
11:18:39 24 you've said, the CCAC relies on service
11:18:48 25 providers to report issues so they can be
11:18:49 26 addressed, is this an area where you think that
11:18:52 27 one potential solution or one potential way
11:18:55 28 to approach it could be having more additional
11:19:00 29 phone calls with patients to see if there are
11:19:00 30 things that they report that the service
11:19:02 31 provider perhaps can't -- or has not. Excuse
11:19:03 32 me.

11:19:03 1 A. So I think in my role in
11:19:08 2 quality and risk, this is something that, you
11:19:10 3 know, we do spend a lot of time ensuring proper
11:19:14 4 reporting. So the mechanisms of how that --
11:19:16 5 there's a lot of different ways that we could
11:19:18 6 do that.
11:19:19 7 I think it's important that
11:19:20 8 right at the beginning that we have the proper
11:19:23 9 processes in places so that people know their
11:19:26 10 reporting obligations and understand how to
11:19:28 11 make those reports, and that can include the
11:19:32 12 patient and the service provider staff.
11:19:34 13 In this case, this event was
11:19:36 14 reported from the frontline nurse to the
11:19:36 15 supervisor of the service provider
11:19:40 16 organization, so that adds an additional layer.
11:19:42 17 The question of whether or not
11:19:44 18 there should be spot checks or how to do those
11:19:47 19 conversations directly, I think we will need to
11:19:50 20 explore, but it is -- sort of, there are a lot
11:19:52 21 of important contexts in terms of how that
11:19:54 22 would happen, the work load associated with
11:19:57 23 that, how we can ensure that that happens.
11:20:00 24 But I think it is an important
11:20:01 25 conversation that I'd like to dig deep in with
11:20:03 26 our providers.
11:20:04 27 Q. In light of what you've just
11:20:07 28 said about the importance of ensuring clarity
11:20:10 29 and the importance of proper reporting, do you
11:20:14 30 see any areas where changes could be made to
11:20:19 31 improve patient safety or to ensure that
11:20:22 32 problems are caught sooner?

11:20:25 1 A. So it's a good question. I
11:20:28 2 think in my role, in quality improvement and my
11:20:31 3 team's role, that is the function that we
11:20:34 4 provide is to try to learn from these examples
11:20:36 5 and put pieces into place.
11:20:39 6 It's not lost on me the
11:20:41 7 challenges that exist in home and community
11:20:43 8 care of care being delivered in multiple
11:20:46 9 different homes, oftentimes, you know, by
11:20:48 10 individuals and the uncontrolled nature
11:20:50 11 sometimes of those things. So, you know, that
11:20:52 12 is a part of our conversations, our efforts on
11:20:53 13 an ongoing basis.
11:20:54 14 Q. Are there specific things,
11:20:56 15 though, in light of this that you think should
11:20:59 16 be considered or that might be helpful?
11:21:01 17 A. Nothing specific I can think
11:21:04 18 of at this time, no.
11:21:06 19 Q. Since Ms. Wettlaufer's
11:21:08 20 offenses came to light, have there been any
11:21:12 21 changes to how subcontractors are overseen?
11:21:16 22 A. No.
11:21:16 23 Q. And right now, based on what
11:21:18 24 you've told us, it sounds like the CCAC doesn't
11:21:22 25 get that much information about a subcontractor
11:21:27 26 or certainly about their staff.
11:21:30 27 Do you see any changes that
11:21:31 28 might be useful there in order to ensure
11:21:31 29 problems are caught or to ensure that patients
11:21:33 30 are safe?
11:21:34 31 A. So I think for our
11:21:37 32 organization, the subcontractor is not

11:21:41 1 something that our preference would be to use.
11:21:44 2 We prefer to have a direct relationship with
11:21:46 3 our service provider organizations.
11:21:48 4 So we've been trying as an
11:21:50 5 organization in consultation with our
11:21:52 6 certifiers to minimize the use of
11:21:54 7 subcontractors.
11:21:55 8 It is something that is an
11:21:58 9 unfortunate part of our industry as, you know,
11:22:00 10 the needs for services up and down, and, you
11:22:03 11 know, regional differences that use the
11:22:04 12 subcontractors. But I do believe there is
11:22:08 13 additional work that could be done to really
11:22:11 14 improve in that area.
11:22:13 15 Q. So you say you don't want to
11:22:14 16 use subcontractors or your preference is to
11:22:17 17 deal directly with the service providers, so
11:22:18 18 what factors are there that contribute to the
11:22:20 19 use of subcontractors?
11:22:22 20 A. So there's a couple factors,
11:22:24 21 one including -- you know, in some cases,
11:22:27 22 subcontractors are retirement homes, so it
11:22:30 23 might make a lot of sense from a patient's
11:22:33 24 perspective to have one organization providing
11:22:34 25 their care in a home. So a retirement home
11:22:36 26 would be a natural place for a subcontractor.
11:22:41 27 In other instances, the
11:22:41 28 subcontractor is used to meet the demand for
11:22:42 29 services that are out there, so where an
11:22:43 30 organization simply can't provide all the care
11:22:47 31 that's required in the community. So, yeah.
11:22:53 32 MS. KINKARTZ: Okay, that's

11:22:54 1 helpful. Those are all my
11:22:56 2 questions, Commissioner.
11:22:57 3 I'm not sure if you'd prefer to
11:23:00 4 have the Ministry do its
11:23:02 5 examination or take the morning
11:23:04 6 break now?
11:23:05 7 THE COMMISSIONER: I think
11:23:05 8 probably, it would be a good
11:23:06 9 time to take our morning break
11:23:09 10 and then come back for the
11:23:11 11 Ministry questions. Thank you.
11:23:32 12 -- RECESSED AT 11:23 A.M.
11:38:04 13 -- RESUMED AT 11:38 A.M.
11:38:23 14 THE COMMISSIONER: Good morning.
11:38:23 15 EXAMINATION BY MS. PARKER:
11:38:23 16 Q. Good morning, Steven. My
11:38:23 17 name is Judith Parker. I'm here on behalf of
11:38:32 18 Ontario and the LHINs. And I just have a few
11:38:34 19 questions I wanted to ask you to clarify a few
11:38:37 20 points you made this morning and yesterday.
11:38:39 21 During your testimony yesterday,
11:38:44 22 Lara asked you some questions about reporting
11:38:47 23 and complaints, and I think I remember that you
11:38:49 24 had said that about 50 percent of complaints
11:38:51 25 come from patients and their caregivers; do you
11:38:54 26 recall giving that testimony?
11:38:55 27 A. Correct. So complaints and
11:38:57 28 risk events.
11:38:59 29 Q. Complaints and risk events,
11:39:01 30 okay. What's a caregiver?
11:39:03 31 A. So when I refer to a
11:39:06 32 "caregiver," we refer to a patient's informal

11:39:11 1 caregiver, oftentimes a member of their family.
11:39:14 2 Q. So that wouldn't be a SPO
11:39:17 3 staff member providing care?
11:39:17 4 A. No.
11:39:18 5 Q. And do you know what
11:39:20 6 percentage of your risk events and complaints
11:39:27 7 come from the SPOs?
11:39:28 8 A. About 25 percent.
11:39:28 9 Q. And what's the other 25
11:39:28 10 percent, then?
11:39:29 11 A. So it would be CCAC or LHIN
11:39:29 12 staff or other sources such as MPP offices, the
11:39:35 13 long-term care action line, physicians, and
11:39:38 14 other groups.
11:39:40 15 Q. Thank you. I understand that
11:39:42 16 you were here during Donna Ladouceur's
11:39:46 17 testimony, and I think towards the end of her
11:39:49 18 testimony, she mentioned "clinical auditors."
11:39:53 19 Can you tell me what a clinical auditor is?
11:39:56 20 A. So as the CCAC and now the
11:39:59 21 LHIN have seen the complexity in the services
11:40:03 22 change, there's been conversations within our
11:40:06 23 organization and within the sector about the
11:40:10 24 potential role of a clinical auditor in the
11:40:12 25 home care space, which would be an employee of
11:40:16 26 the Southwest CCAC who would maybe take on more
11:40:20 27 of a proactive role in auditing patient files
11:40:23 28 and really closely working with the leadership
11:40:25 29 and the educators in a service provider
11:40:27 30 organization to improve practice.
11:40:28 31 Q. And do you have any clinical
11:40:31 32 auditors working for you now?

11:40:34 1 A. So we don't have any clinical
11:40:36 2 auditors in the general sense. We do have one
11:40:40 3 program within the Southwest CCAC, which is our
11:40:40 4 regional wound care program where they would
11:40:41 5 audit patient records to determine improvement
11:40:44 6 on it, but it's a very small percentage of our
11:40:48 7 business.
11:40:48 8 Q. And are you intending on
11:40:51 9 expanding the clinical audit program?
11:40:53 10 A. So I think it's been a
11:40:56 11 conversation within our organization for a long
11:40:56 12 time, one that we think would add value to the
11:40:57 13 organization, but I'm not sure what the
11:40:58 14 immediate plans are for that. But it's
11:41:01 15 something that we -- I think we all believe
11:41:03 16 would be a valuable addition to the home care
11:41:07 17 space.
11:41:07 18 Q. Lastly, in this your
11:41:09 19 conversation with Lara, you explained about the
11:41:12 20 use of subcontractors, and you talked a little
11:41:18 21 bit about retirement home. When you say
11:41:20 22 "retirement home," are you speaking about a
11:41:23 23 long-term care home?
11:41:24 24 A. In that instance, no. I was
11:41:24 25 referring to a private pay retirement home. So
11:41:29 26 within the home care sector, a patient that
11:41:30 27 resides in a retirement home, that is
11:41:33 28 considered their residence, and the CCAC
11:41:34 29 sometimes would continue to provide services.
11:41:37 30 It does cause difficulty as it
11:41:40 31 introduces multiple different organizations
11:41:42 32 into the care being provided to the patients.

11:41:43 1 So in these cases, both to
11:41:46 2 improve the patient satisfaction and outcomes
11:41:49 3 and to deal with capacity issues, we have our
11:41:55 4 service providers subcontract back to the
11:41:57 5 retirement homes. So they are providing care
11:42:01 6 with the staff that they would normally,
11:42:02 7 typically provide care, and that's primarily or
11:42:08 8 exclusively for PSW services.
11:42:11 9 Q. So in this care, if I were a
11:42:12 10 resident of a retirement home, I'm not in a
11:42:13 11 long-term care home; I'm in a retirement
11:42:13 12 residence for older Ontarians?
11:42:15 13 A. Correct, yes.
11:42:16 14 Q. And in your example of using
11:42:18 15 subcontractors there is that the employees of
11:42:20 16 the retirement home would be considered
11:42:24 17 subcontractors in that case?
11:42:25 18 A. Correct.
11:42:28 19 MS. PARKER: Those are all my
11:42:29 20 questions for this witness,
11:42:31 21 thank you.
11:42:35 22 THE COMMISSIONER: Thank you,
11:42:35 23 Ms. Parker. All right. Sorry,
11:42:37 24 can I just -- I just want to
11:42:39 25 make sure that I actually fully
11:42:41 26 understand that last line of
11:42:44 27 questioning. Sorry, Mr. Scott.
11:42:44 28 MR. SCOTT: It was going to be
11:42:44 29 the first set of questions I was
11:42:47 30 going to ask.
11:42:47 31 THE COMMISSIONER: Okay, sorry.
11:42:48 32 So I understand that the

11:42:50 1 concern, what you're talking
11:42:51 2 about is that the retirement
11:42:52 3 home -- I understand what that
11:42:54 4 is -- and you're worried about
11:42:55 5 continuity of care and not
11:42:56 6 introducing too many service
11:43:01 7 providers for an individual
11:43:03 8 within that because we know
11:43:04 9 that's not good.
11:43:06 10 So if they're eligible for a
11:43:07 11 CCAC service, the CCAC tells the
11:43:10 12 service provider organization to
11:43:11 13 go back to the home and have
11:43:14 14 their people provide the
11:43:18 15 service. Is that what you're
11:43:20 16 saying?
11:43:20 17 THE WITNESS: So we don't
11:43:21 18 dictate that they should do
11:43:23 19 that --
11:43:24 20 THE COMMISSIONER: Right.
11:43:25 21 THE WITNESS: -- but it is one
11:43:26 22 of the strategies our
11:43:28 23 organization uses to try to
11:43:30 24 address issues where there is
11:43:33 25 capacity.
11:43:34 26 THE COMMISSIONER: So
11:43:34 27 effectively, it's just, if I
11:43:34 28 can, a money change? They would
11:43:36 29 get those services anyway from
11:43:38 30 the retirement home, but because
11:43:40 31 they're eligible for it through
11:43:41 32 the CCAC, the CCAC then ensures

11:43:43 1 that they get the services
11:43:44 2 they're eligible for, but
11:43:47 3 effectively from the same
11:43:48 4 service provider that they would
11:43:49 5 have otherwise gotten it from?
11:43:52 6 THE WITNESS: So I'm not an
11:43:54 7 expert in terms of the planning
11:43:55 8 for patients in a retirement
11:43:57 9 home, but it's my understanding
11:43:58 10 that when a patient or their
11:44:00 11 family comes into an agreement
11:44:02 12 with a retirement home that they
11:44:05 13 would, by all extents, select
11:44:07 14 what services they would
11:44:08 15 receive --
11:44:08 16 THE COMMISSIONER: Oh, I see.
11:44:08 17 THE WITNESS: -- and that does
11:44:10 18 create a challenge with the
11:44:11 19 services that are available
11:44:11 20 within the publicly funded
11:44:14 21 system.
11:44:15 22 THE COMMISSIONER: I understand
11:44:16 23 better. Thank you, Ms. Parker,
24 for raising that issue, and
25 thank you for your help. And
26 I'm sorry, I interrupted you
27 there, Mr. Scott, but I just
28 wanted to make sure I understood
11:44:25 29 that.
11:44:25 30 MR. SCOTT: Not at all,
11:44:26 31 Your Honour. It comes out of
11:44:27 32 your time, not mine.

11:44:28 1 THE COMMISSIONER: Of course, of
11:44:29 2 course. We know that.
11:44:34 3 CROSS-EXAMINATION BY MR. SCOTT:
11:44:37 4 Q. Good morning, Steven. My
11:44:39 5 name's Paul Scott, and I represent one of the
11:44:43 6 Family Groups and Beverly Bertram.
11:44:46 7 And I do have a few questions
11:44:49 8 for you today, and not to belabour the whole
11:44:52 9 subcontractor issue, but I do want to be clear
11:44:55 10 because there are people at home watching.
11:44:58 11 The distinction between an SPO
11:45:00 12 and a subcontractor -- and there is a
11:45:03 13 distinction, correct?
11:45:04 14 A. Correct.
11:45:04 15 Q. And a subcontractor would be
11:45:06 16 hired by an SPO, correct?
11:45:08 17 A. Correct.
11:45:08 18 Q. And in our situation, was
11:45:14 19 Lifeguard an SPO or a subcontractor?
11:45:17 20 A. In our circumstance,
11:45:19 21 Lifeguard would have been a subcontractor.
11:45:21 22 Q. And who subcontracted
11:45:24 23 Lifeguard?
11:45:24 24 A. In this instance, it would
11:45:27 25 have been ParaMed and CarePartners.
11:45:30 26 Q. Okay, thank you. If we could
11:45:34 27 go to tab I of your affidavit, which is
11:45:39 28 Document 70432, and page 6?
11:45:43 29 I really want to just get you to
11:45:52 30 expand on something you spoke about yesterday,
11:45:55 31 and that's this definition of root causing. Do
11:46:00 32 you recall talking about that briefly?

11:46:02 1 A. A root cause analysis, yes.
11:46:03 2 Q. Yes. And what is a "root
11:46:06 3 cause analysis"?
11:46:08 4 A. So a root cause analysis
11:46:11 5 would be an activity that we would undertake to
11:46:16 6 try to understand the cause or the factors that
11:46:20 7 contributed to a particular event.
11:46:21 8 So depending on the nature of
11:46:24 9 the event that we are using, a root cause
11:46:27 10 analysis can be focused on reviewing one
11:46:30 11 particular incident and trying to understand
11:46:30 12 why that one particular incident occurred, or
11:46:33 13 we would use that on a more broad basis to
11:46:36 14 understand why a series of events had occurred.
11:46:39 15 So we would use that in multiple contexts.
11:46:42 16 Q. Okay. Can I ask you to tell
11:46:45 17 me what you're doing, though? I mean, what do
11:46:47 18 you look at? Is it just documents? Can you
11:46:49 19 give us some idea of what evidence you use to
11:46:54 20 get to this root cause?
11:46:56 21 A. So it's a good question, and
11:46:57 22 it does vary quite significantly depending on
11:47:02 23 the nature of the event, but within the quality
11:47:05 24 improvement or risk management, it really is
11:47:05 25 focusing on -- a lot of things around the
11:47:09 26 process of what has occurred and what's causing
11:47:10 27 it to occur and the people involved in those
11:47:12 28 processes.
11:47:13 29 So an example I think I used
11:47:15 30 either earlier today or yesterday was around
11:47:17 31 this notion of a failure modes and effects
11:47:17 32 analysis, so that might be -- that's an example

11:47:24 1 of a tool that we would use for root cause
11:47:25 2 analysis.
11:47:25 3 Q. I'm going to stop you there
11:47:27 4 because I suspect you may be one of one person
11:47:30 5 in this room who knows what that is.
11:47:32 6 A. Yes. But I'd like to go
11:47:32 7 through it, if that's okay.
11:47:33 8 Q. And I don't want to limit you
11:47:35 9 too much, but if you could perhaps give it to
11:47:38 10 us in layman's terms?
11:47:41 11 A. Of course, yes. So a
11:47:42 12 failure -- in this case, the point of the
11:47:45 13 activity is to go through each specific step in
11:47:48 14 a process and try to understand all the failure
11:47:51 15 points.
11:47:52 16 So when I say a "failure point,"
11:47:54 17 I refer to how are all the different ways that
11:47:58 18 this could go wrong? So that might involve
11:48:01 19 ensuring that, you know, people have the
11:48:03 20 necessary information to carry out a task, or
11:48:06 21 it might be that they have the appropriate
11:48:07 22 skills and knowledge to things as simple as how
11:48:10 23 do we know that the nurse is going to arrive at
11:48:12 24 that particular time due to issues of weather.
11:48:12 25 So by flipping an issue on its
11:48:16 26 head and trying to find all the ways it could
11:48:19 27 go wrong, you then will then translate that
11:48:22 28 into, okay, but how do we ensure that that
11:48:25 29 actually goes as planned.
11:48:26 30 Q. Can I stop you there for a
11:48:28 31 second?
11:48:28 32 A. Of course, yeah.

11:48:29 1 Q. Is that a purely academic
11:48:32 2 endeavour at that point?
11:48:32 3 A. No, I would not say that. I
11:48:32 4 would say that's very much, in improvement, a
11:48:36 5 really important understanding. From my
11:48:38 6 experience, a lot of time when people are
11:48:40 7 focused on improvement, they are focused only
11:48:45 8 on one particular area of an issue and not more
11:48:46 9 broadly an entire issue.
11:48:46 10 So these in-depth reviews really
11:48:48 11 allow us to look at all the factors that will
11:48:50 12 come into play and why there are challenges
11:48:53 13 that relate to a specific area.
11:48:55 14 Q. And if I could, do you speak
11:48:59 15 to staff? Do you speak to nurses? How do you
11:49:02 16 gather this information I guess is what I'm
11:49:04 17 trying to get at?
11:49:05 18 A. Yeah. So it's very much our
11:49:07 19 practice to involve as much people as we can
11:49:10 20 and those involved in it.
11:49:10 21 It's fair to say that those
11:49:10 22 directly involved with the process know how
11:49:15 23 that process actually works rather than people
11:49:16 24 in my position or other leadership positions
11:49:18 25 who will go off a policy or a procedure.
11:49:22 26 So working closely with
11:49:25 27 frontline staff, leaders in the organization to
11:49:28 28 understand the processes and where the failure
11:49:30 29 points are is a critical part of that activity.
11:49:33 30 Q. Okay, that's helpful. Is
11:49:35 31 there anything else important about that system
11:49:38 32 or that process, this root causing that you

11:49:39 1 think the Commissioner should know?
11:49:41 2 A. No.
11:49:41 3 Q. Okay. And, you know, I've
11:49:44 4 listened to what you had to say and the other
11:49:48 5 witnesses, so is it fair to say that the CCAC
11:49:51 6 and now the LHINs is spending a great deal of
11:49:55 7 time in developing systems and learning from
11:49:58 8 complaints and that sort of thing in order to
11:50:02 9 improve?
11:50:02 10 A. Yes.
11:50:02 11 Q. And that seems to be a real
11:50:05 12 focus right now for both you and the LHINs?
11:50:08 13 A. Yes. So a significant part
11:50:11 14 of my role is to work through issues and then
11:50:17 15 translate those to improvements. That's part
11:50:22 16 of my role within the organization.
11:50:23 17 Q. Yes, I appreciate that. And
11:50:24 18 what I'd like to know now is what active steps
11:50:29 19 are you and the LHINs in general taking in
11:50:31 20 those areas to improve?
11:50:32 21 A. Can you be more specific when
11:50:36 22 you say "in those areas"?
11:50:37 23 Q. Well, I wish I could, but you
11:50:41 24 know your area, and so I think if you are
11:50:46 25 actively involved in change or you're actively
11:50:48 26 involved in a new process that you're putting
11:50:50 27 in place, that that's what I'd like to know
11:50:52 28 about.
11:50:52 29 A. Sure. So perhaps I can
11:50:55 30 provide an example because there are a lot of
11:50:58 31 people within my team and the organization
11:51:01 32 taking on different projects around

11:51:05 1 improvement, but the one that is very recent in
11:51:09 2 my mind and still ongoing work for us right now
11:51:12 3 is through the last year and a bit, we've been
11:51:14 4 receiving more complaints directly from
11:51:17 5 patients, families, and primarily physicians
11:51:20 6 relating to the quality of palliative care that
11:51:24 7 we provide in the community.
11:51:25 8 So as I believe Donna alluded
11:51:28 9 to, we are providing a lot more complex nursing
11:51:31 10 and palliative care in the community.
11:51:33 11 So when I talk about
11:51:36 12 improvement, some of the specific activities
11:51:37 13 that we've undertaken to address some of those
11:51:40 14 issues would be doing a root cause analysis, as
11:51:42 15 I've talked about, of why the errors are
11:51:45 16 occurring and what's happening, and concrete
11:51:47 17 steps such as: Last year, the CCAC or the LHIN
11:51:51 18 at the time funded specific education for the
11:51:55 19 nurses related to best practices and palliative
11:51:58 20 care.
11:51:58 21 We also did some work related to
11:52:01 22 ensuring that communication channels were
11:52:03 23 appropriately defined for all the people
11:52:06 24 involved. So how do we ensure that when
11:52:09 25 something occurs the nurse knows that they need
11:52:09 26 to speak to the physician about a particular
11:52:13 27 issue and how does that work.
11:52:14 28 So it's very specific on
11:52:15 29 improving those types of areas. So lots of
11:52:19 30 examples around an issue occurs and my team in
11:52:19 31 consultation with other leaders would take
11:52:24 32 steps to try to improve.

11:52:25 1 Q. Okay, and that's helpful. Is
11:52:27 2 it fair to say that that program is reactive?
11:52:31 3 It's reacting to something, some increasing
11:52:36 4 complaints from the outside?
11:52:37 5 A. In that instance, yes, I
11:52:40 6 think it's reactive.
11:52:41 7 Q. Is there anything going on
11:52:43 8 that isn't reactive, that's proactive that the
11:52:48 9 LHINs has actually taken the initiative on
11:52:51 10 first?
11:52:51 11 A. Yeah. So I think that
11:52:51 12 primarily would come through when the LHIN is
11:52:53 13 introducing new services or new pieces into it
11:52:57 14 or a new structure within the organization, and
11:52:59 15 part of my role would be to try to embed those
11:53:05 16 principles right up at the start before
11:53:08 17 something comes into fruition.
11:53:10 18 Q. Okay. I'd like to take you
11:53:13 19 to tab N of your affidavit, and that's
11:53:20 20 Document 57057, and I think you looked at this
11:53:22 21 one earlier. And this is the ETMS document you
11:53:31 22 looked at earlier, correct?
11:53:32 23 A. Correct.
11:53:32 24 Q. And I think we've established
11:53:34 25 there's no -- well, we haven't established, but
11:53:36 26 there's no date on this document, is there?
11:53:39 27 A. No, there is not.
11:53:40 28 Q. Is there a date on any of the
11:53:42 29 ETMS reports?
11:53:43 30 A. So -- yes. So each ETMS that
11:53:45 31 comes in would be dated at various steps. This
11:53:49 32 document here is actually verbal notes that

11:53:52 1 were taken during that call. So this is not
11:53:55 2 the ETMS record itself; it's just the notes
11:53:58 3 from that particular call.
11:53:59 4 Q. And is there a reason why
11:54:01 5 there's no spot on it to put a date to indicate
11:54:04 6 the notes taken on this particular date?
11:54:07 7 A. So this was just a -- there's
11:54:07 8 no template or anything for these notes to be
11:54:10 9 taken. There should be a date on that, but
11:54:12 10 that was not done in this case.
11:54:14 11 Q. Okay. And can you tell when
11:54:16 12 this was created, exactly?
11:54:19 13 A. So this was created out of
11:54:21 14 the conversation that I know occurred on the
11:54:24 15 21st, and the reason I know that occurred is in
11:54:26 16 the process when this date was not identified,
11:54:29 17 I did go back and review scheduled calendar
11:54:33 18 invites. In addition, I was provided with a
11:54:36 19 verbal update after this call had occurred from
11:54:39 20 the members of my team.
11:54:40 21 Q. And was that verbal update
11:54:42 22 done right away or a couple days later or...?
11:54:44 23 A. I don't believe it was a
11:54:45 24 couple days later, but I don't recall the exact
11:54:50 25 instance.
11:54:51 26 Q. Okay. And do we know who
11:54:51 27 took these notes?
11:54:51 28 A. I believe they would have
11:54:55 29 been taken by Gwen Vanderheyden and Alison.
11:54:56 30 I'm not sure who had the pen on that one.
11:54:58 31 Q. Well, and these are printed.
11:54:59 32 Would they have entered them into the system

11:55:01 1 right then and there?
11:55:02 2 A. Are you referring to entering
11:55:05 3 them into ETMS?
11:55:05 4 Q. Well, I am because as I
11:55:07 5 understand it, providers can have access to
11:55:10 6 that system and enter the notes directly into
11:55:14 7 it, correct?
11:55:15 8 A. Correct, yes.
11:55:16 9 Q. And were these entered
11:55:18 10 directly into the system?
11:55:19 11 A. I'm not sure.
11:55:20 12 Q. Is it possible that there
11:55:22 13 were handwritten notes made and then it was
11:55:24 14 entered into the system?
11:55:25 15 A. It's possible, yes.
11:55:26 16 Q. But we don't have those
11:55:28 17 handwritten notes, as best you know?
11:55:30 18 A. No. And I would add that,
11:55:32 19 you know, typically within our organization, we
11:55:33 20 are a very electronic-based organization. A
11:55:38 21 fairly paper-based organization is -- my
11:55:39 22 experience, we don't typically take handwritten
11:55:41 23 notes.
11:55:41 24 Q. And as a result of these
11:55:44 25 notes that were taken, to the best of your
11:55:47 26 knowledge, the College of Nurses was not
11:55:49 27 contacted at this time, correct?
11:55:51 28 A. So I am not sure of what
11:55:53 29 steps Tamara would have taken directly after
11:55:57 30 this incident, no.
11:55:58 31 Q. No, I appreciate that, but I
11:56:01 32 mean, CCAC or LHINs, they didn't contact the

11:56:03 1 College of Nurses?
11:56:04 2 A. No, it would be our practice
11:56:06 3 that, as the employer, Saint Elizabeth should
11:56:08 4 be referring to the College of Nurses.
11:56:08 5 Q. Do you believe that you have
11:56:09 6 the right to contact the College of Nurses,
11:56:10 7 though?
11:56:10 8 A. Yes, I believe we have the
11:56:15 9 right to contact, yeah.
11:56:16 10 Q. And do you think here today
11:56:19 11 that might be a good idea to contact the
11:56:21 12 College of Nurses in a situation like this?
11:56:21 13 A. So our practice would be to
11:56:23 14 encourage that the employer be the one to make
11:56:27 15 that report to the College, but I would say if
11:56:28 16 we are feeling like the organization is
11:56:30 17 unwilling to do that or has not done that, we
11:56:34 18 would take on that role and have done that in
11:56:35 19 the past.
11:56:35 20 Q. Is there a reason why you --
11:56:37 21 I say you; I mean the CCAC or the LHINs -- is
11:56:40 22 there a reason why you'd be reticent to call
11:56:43 23 the College about something as serious as this?
11:56:46 24 A. So I don't believe I would
11:56:47 25 use the term "reticent" to call the College. I
11:56:52 26 believe that we would consider this to be the
11:56:53 27 role and the responsibility of the College.
11:56:56 28 At this particular time in our
11:56:57 29 investigation, we were really just trying to
11:57:00 30 understand the details and the nature of this
11:57:01 31 incident. We wanted to ensure that
11:57:01 32 Saint Elizabeth had done their due diligence

11:57:04 1 and contacted the College.
11:57:06 2 It would be our practice that in
11:57:09 3 subsequent reviews of that, we would follow up
11:57:13 4 on that, whether they had done that, and in
11:57:15 5 that case, make that determination.
11:57:16 6 Given in this situation the
11:57:16 7 information that we got a few days later around
11:57:19 8 the nature of the event and the public nature
11:57:21 9 of that, that changed the conversation as it
11:57:24 10 relates to this.
11:57:25 11 Q. Yes, I appreciate your
11:57:27 12 position on due diligence, but don't you think
11:57:32 13 it would be diligent on the part of the LHINs
11:57:33 14 or CCAC to also contact the College?
11:57:34 15 What harm could come of two
11:57:37 16 agencies contacting them?
11:57:39 17 A. It's a -- I don't disagree
11:57:41 18 that there's -- there could be no harm in two
11:57:43 19 agencies bringing it forward.
11:57:45 20 I think the reason which I think
11:57:49 21 we'll want to review the nature of this is to
11:57:51 22 ensure that that report is happening, whether
11:57:54 23 or not it's from our organization or the
11:57:55 24 service provider.
11:57:56 25 Q. Is it possible that -- and I
11:57:58 26 used the word "reticent," and I think you
11:58:01 27 disagreed with that word, but I'm going to use
11:58:03 28 it again. Is it possible that the reticence
11:58:06 29 comes from the fact that you have a contract
11:58:09 30 with Saint Elizabeth, and you feel that it's
11:58:11 31 their obligation and not necessarily yours?
11:58:15 32 A. So I'll disagree with you

11:58:17 1 again in a different -- is the reticence, I
11:58:17 2 don't believe --
11:58:17 3 Q. It won't be the first.
11:58:20 4 A. Okay. The reticence is not
11:58:22 5 that we have a contract. Our position at this
11:58:25 6 time has been that that is the role of the
11:58:27 7 employer and that the CCAC is not the employer
11:58:30 8 of those particular employees.
11:58:31 9 Q. But you'll agree with me that
11:58:33 10 the people involved here, the clients, the
11:58:35 11 patients, they're your responsibility as well?
11:58:39 12 A. Yes.
11:58:39 13 Q. And I'd like to take you to
11:58:45 14 tab R of your affidavit. That's
11:58:48 15 Document 56932, and this is the e-mail of
11:59:03 16 Tuesday, October 25th?
11:59:03 17 A. Correct.
11:59:04 18 Q. And if we look below, it
11:59:07 19 looks like it's comes from Sandra Coleman, and
11:59:11 20 at the second-last line of that, she says,
11:59:14 21 "Steven is our lead on this." And is she
11:59:19 22 referring to you?
11:59:20 23 A. Yes.
11:59:20 24 Q. And what does she mean you're
11:59:23 25 the lead?
11:59:24 26 A. So within my role,
11:59:26 27 specifically related to instances like this, my
11:59:26 28 role as the lead would be to ensure that we're
11:59:26 29 taking the appropriate steps and engaging with
11:59:32 30 all the people in the organization that would
11:59:33 31 be required to respond to issues such as this.
11:59:35 32 Q. Okay. So were you the lead

11:59:38 1 investigator on this?
11:59:39 2 A. No, I wouldn't say I'm the
11:59:42 3 lead investigator. Through the investigation
11:59:47 4 that we conducted, that role was conducted by
11:59:50 5 Gwen Vanderheyden who's a registered nurse,
11:59:50 6 which we thought was an important factor in
11:59:50 7 this review.
11:59:54 8 My role would have been to
11:59:55 9 oversee that the activities that I felt were
11:59:58 10 necessary to respond were completed.
12:00:01 11 Q. So were you the directing
12:00:03 12 mind of the investigation?
12:00:04 13 A. Yeah.
12:00:05 14 Q. And do you know, did Gwen or
12:00:09 15 you or anybody else speak to staff directly at
12:00:12 16 Saint Elizabeth?
12:00:12 17 A. We did not, no.
12:00:14 18 Q. And is there a reason why you
12:00:20 19 or Gwen or somebody from your organization did
12:00:21 20 not speak directly to -- I'll limit it to --
12:00:24 21 the nurses at Saint Elizabeth?
12:00:25 22 A. So through the conversations,
12:00:27 23 that would have been the expectation that we
12:00:31 24 had of the leadership of Saint Elizabeth to
12:00:31 25 speak to their staff.
12:00:33 26 Q. So again, it's the
12:00:34 27 expectation that the SPO is going to do that
12:00:38 28 and then deliver that information to you,
12:00:40 29 correct?
12:00:40 30 A. Correct, yes.
12:00:42 31 Q. And we've learned that -- in
12:00:46 32 fairness to you, you didn't know it until very

12:00:52 1 recently, but you've learned that, in fact,
12:00:54 2 Saint Elizabeth was aware that Elizabeth
12:00:56 3 Wettlaufer had entered a patient's home the day
12:00:59 4 before she attempted to kill Bev Bertram and
12:01:07 5 stole medication and insulin, correct?
12:01:09 6 A. Correct.
12:01:10 7 Q. But you weren't aware that
12:01:13 8 she'd entered a patient's home without their
12:01:14 9 permission or knowledge, correct?
12:01:16 10 A. No.
12:01:16 11 Q. And do you think that if
12:01:18 12 somebody from your organization had spoken to
12:01:18 13 at least two nurses at Saint Elizabeth's, they
12:01:21 14 would have found out back in October of 2016
12:01:24 15 that, in fact, that took place?
12:01:26 16 A. Yes.
12:01:26 17 Q. And so sitting here today,
12:01:29 18 and I understand it's retrospect, do you think
12:01:32 19 it might not be a bad idea to actually speak to
12:01:35 20 the staff of your SPOs?
12:01:38 21 A. So naturally, I've spent a
12:01:41 22 lot of time thinking about this, and I do
12:01:44 23 believe that, you know, our approach at this
12:01:45 24 particular time was really focused on, you
12:01:47 25 know, the response in terms of the patients and
12:01:48 26 doing our due diligence on this, but I do
12:01:51 27 believe that there would be value in us
12:01:54 28 speaking directly to staff in instances like
12:01:58 29 this.
12:01:59 30 I will say that one of the
12:02:00 31 challenges faces -- our organization does not
12:02:04 32 have people in the role of investigators.

12:02:08 1 That's not typically how we would approach
12:02:09 2 these situations.
12:02:09 3 We would typically approach
12:02:10 4 these situations from, as I've used in the
12:02:13 5 past, more of a partnership or a collaborative
12:02:16 6 approach with the service providers, but issues
12:02:18 7 like this obviously do make us review or think
12:02:20 8 about how to do that in the future.
12:02:21 9 Q. And you believe you're
12:02:31 10 allowed to speak to the staff of your SPOs,
12:02:35 11 though, correct?
12:02:35 12 A. Correct, yeah.
12:02:36 13 Q. You have the authority?
12:02:38 14 A. Um-hmm.
12:02:38 15 Q. And I believe that's even in
12:02:40 16 the contract, you can -- you're allowed to
12:02:41 17 speak to them?
12:02:41 18 A. Yes.
12:02:42 19 Q. Okay. So is it a policy of
12:02:44 20 CCAC not to do that?
12:02:45 21 A. No, there's no policy.
12:02:48 22 Q. Okay.
12:02:48 23 A. And I should just add to that
12:02:52 24 that there are cases where we would speak
12:02:54 25 directly to the staff. I can think of one
12:02:57 26 particular incident where there was concerns
12:03:00 27 around an inappropriate relationship with --
12:03:02 28 where we did speak directly to staff.
12:03:05 29 So that is something in our
12:03:07 30 reviews of events that we have done in the
12:03:09 31 past.
12:03:09 32 Q. So why in that particular

12:03:11 1 case did you take the step of speaking directly
12:03:13 2 with the staff versus going through the SPO?
12:03:16 3 A. So there's multiple different
12:03:19 4 factors in terms of where we would want to do
12:03:22 5 that. Typically, we'll want to understand the
12:03:24 6 perspective of a particular employee related to
12:03:25 7 an incident. So, you know, that could be, you
12:03:29 8 know, tell us what happened when you entered
12:03:31 9 the home that day or those types of situations.
12:03:35 10 We don't -- we haven't in the
12:03:37 11 past done a lot of formal investigations where
12:03:41 12 we've sat down with SPO staff and conducted
12:03:44 13 this type of investigation, but there is no
12:03:47 14 policy that would prevent us or cause us not to
12:03:49 15 do that.
12:03:49 16 Q. But as a general rule, it's
12:03:52 17 just not something the CCAC does?
12:03:54 18 A. Correct.
12:03:54 19 Q. And do you think now that
12:03:55 20 it's something that the organization is going
12:03:58 21 to look towards doing more often, actually
12:04:01 22 going out into the world and speaking to staff?
12:04:06 23 A. I think as I've been
12:04:08 24 reflecting on this, the important part is for
12:04:10 25 us to understand what the roles and
12:04:13 26 responsibilities should be as it relates to
12:04:15 27 that and be very clear about what our
12:04:18 28 expectations are and ensure that we do that and
12:04:22 29 what that would look like with our service
12:04:24 30 provider organizations.
12:04:25 31 At this particular point, we
12:04:26 32 would not have the capacity or the skill set to

12:04:29 1 do those types of investigations, but I do see
12:04:33 2 how working collaboratively with our providers
12:04:40 3 that could be of value.
12:04:41 4 Q. Well, I just want to stop you
12:04:43 5 there for a second. In terms of skill set,
12:04:47 6 does it take that big a skill set to actually
12:04:50 7 go speak to the nurses?
12:04:52 8 A. No. I think when I'm
12:04:53 9 speaking of skill set, I'm more referring to
12:04:54 10 sort of a broader role in investigation
12:04:56 11 where -- when we're doing these things, we're
12:04:57 12 trying to understand -- do a review, but we're
12:05:01 13 not conducting formal investigations.
12:05:03 14 Q. Okay. And now this has come
12:05:05 15 to light, is there a punishment mechanism in
12:05:08 16 the contract with respect to what can be done
12:05:16 17 to Saint Elizabeth as a result of the failure
12:05:16 18 to disclose this?
12:05:18 19 A. So we have mechanisms in our
12:05:20 20 contract in terms of removing market share or
12:05:23 21 starting a formal performance improvement
12:05:27 22 process. At the particular time, I'm unsure of
12:05:27 23 what we're going to do with the next steps of
12:05:31 24 this, as we're still early on in that process
12:05:34 25 and just understanding all the issues as
12:05:36 26 they've presented themselves now.
12:05:36 27 Q. And to be clear, those are
12:05:37 28 the items you talked about earlier today,
12:05:39 29 correct?
12:05:40 30 A. Correct.
12:05:40 31 Q. There isn't anything else in
12:05:43 32 terms of sanctions?

12:05:44 1 A. No.
12:05:45 2 Q. Okay. I'm just going to move
12:05:47 3 on. My understanding is that there is a
12:05:49 4 Bill of Rights for the patient in the Home Care
12:05:53 5 and Community Services Act; are you familiar
12:05:55 6 with that?
12:05:56 7 A. Correct, yeah.
12:05:57 8 Q. And so they have these
12:05:59 9 rights. Are you aware of any, again, any sort
12:06:01 10 of punishment provisions within the act if
12:06:06 11 those rights are violated?
12:06:08 12 A. No, I'm not aware.
12:06:09 13 Q. I'd like to go to tab A of
12:06:12 14 your affidavit, which is Document 69216, and
12:06:32 15 page 25. And if we just scroll down, it should
12:06:45 16 say "Staffing service provider personnel."
12:06:50 17 Yes.
12:06:51 18 So again, I won't take you
12:06:59 19 through it in great detail, but it does say in
12:07:02 20 the contract that:
12:07:03 21 "The service provider..."
12:07:04 22 in this case, would be Saint
12:07:04 23 Elizabeth,
12:07:07 24 "...shall provide service
12:07:09 25 provider personnel that possess
12:07:09 26 the training and qualifications
12:07:12 27 set out in the special
12:07:12 28 conditions and are competent and
12:07:16 29 capable of carrying out the
12:07:17 30 services in accordance with the
12:07:21 31 agreement."
12:07:22 32 So that's their contractual

12:07:24 1 obligation, correct?
12:07:25 2 A. Yes.
12:07:25 3 Q. And did you hear any of the
12:07:27 4 testimony of Tamara Condy here?
12:07:29 5 A. I did, yes.
12:07:32 6 Q. Okay. And I asked her some
12:07:34 7 questions about the training that she gave to
12:07:37 8 Elizabeth Wettlaufer around the PICC line
12:07:41 9 maintenance; do you recall that?
12:07:43 10 A. I do, yes.
12:07:43 11 Q. And, in a nutshell, what she
12:07:46 12 said was that she watched her do it and she
12:07:50 13 helped her do it, and that at the end of it,
12:07:53 14 she certified Elizabeth Wettlaufer in doing the
12:07:56 15 PICC line maintenance; do you recall that?
12:08:00 16 A. I do, yes.
12:08:01 17 Q. And I had said to her that I
12:08:01 18 believe their own policy was that the person
12:08:04 19 had to do it twice in a row properly, and
12:08:07 20 really, she hadn't that, and she agreed with
12:08:10 21 me; do you recall that?
12:08:11 22 A. I do, yes.
12:08:12 23 Q. Okay. And I already know the
12:08:16 24 answer to my question, but does the CCAC ever
12:08:19 25 check to make sure that the SPO is making sure
12:08:22 26 that the nurses are, in fact, competent to do
12:08:26 27 these procedures?
12:08:26 28 A. No.
12:08:28 29 Q. And is that because you rely
12:08:30 30 on the SPO to tell you when things are not
12:08:34 31 right?
12:08:34 32 A. I would agree that, yes,

12:08:38 1 we -- it is the obligation of the SPO to inform
12:08:42 2 us of things. The one piece I would say is
12:08:45 3 that the CCAC does have processes in place
12:08:51 4 where we work with the service providers to
12:08:54 5 ensure that they do have the proper
12:08:57 6 qualifications. An example, as I had talked
12:08:59 7 about, would be around qualifications to
12:09:01 8 provide palliative care.
12:09:03 9 So as a part of our improvement
12:09:05 10 work that I spoke about earlier, we did do a
12:09:09 11 survey of our service provider personnel to
12:09:11 12 understand which staff and how many had the
12:09:13 13 qualifications in those particular areas.
12:09:17 14 Excuse me, I'll correct myself: How many, not
12:09:20 15 which staff.
12:09:21 16 Q. But you don't actually go out
12:09:22 17 and check?
12:09:23 18 A. We do not, no.
12:09:27 19 Q. And again, is that something
12:09:28 20 you think that the organization, your
12:09:30 21 organization might start to look at doing in
12:09:31 22 the future based on what you're hearing here?
12:09:33 23 A. It's difficult for me to
12:09:37 24 answer because it's the role of overseeing the
12:09:40 25 nurses, and it falls to the nursing supervisor,
12:09:44 26 and that's not the role that the CCAC currently
12:09:49 27 undertakes.
12:09:50 28 Q. But you'll agree with me, you
12:09:54 29 have nurses on staff, correct?
12:09:56 30 A. We have nurses on staff
12:09:57 31 working in roles of care co-ordination.
12:09:57 32 Q. And is it not possible for

12:10:00 1 one of those care co-ordinators to go and watch
12:10:01 2 a nurse who's part of the SPO engaging in some
12:10:05 3 of these processes?
12:10:06 4 A. I'm not sure, not -- as I'm
12:10:10 5 not a registered health care professional, I'm
12:10:15 6 in a good position to answer that question.
12:10:15 7 Q. Are you in a position to
12:10:17 8 direct one of them to do it?
12:10:18 9 A. No.
12:10:18 10 Q. Okay. Who could be in a
12:10:21 11 position to do that?
12:10:21 12 A. We don't have any mechanisms
12:10:23 13 in place in our organization now to do that.
12:10:26 14 Q. Okay. So I just want to take
12:10:33 15 you quickly to page 58 of that same tab. And I
12:10:48 16 asked you earlier, if we could just go down
12:10:55 17 to -- sorry, I didn't give you the document
12:10:59 18 number, did I? 69216. You're already there.
12:11:04 19 Page 58, if we could just go down to 14.3,
12:11:10 20 "independent contractor." That's perfect.
12:11:12 21 Thanks very much.
12:11:13 22 And I think you've already told
12:11:15 23 me that the CCAC and the LHINs are spending a
12:11:18 24 lot of time on collaborations with your
12:11:21 25 partners, correct?
12:11:25 26 A. Correct.
12:11:25 27 Q. This section in the contract
12:11:27 28 says:
12:11:28 29 "The service provider is acting
12:11:29 30 as an independent contractor."
12:11:30 31 We've established that already.
12:11:33 32 "Nothing contained in this

12:11:34 1 agreement shall be deemed to
12:11:36 2 create a partnership,
12:11:37 3 association, joint venture, or
12:11:39 4 agency relationship between the
12:11:41 5 parties. Service provider
12:11:44 6 personnel supplied by the
12:11:45 7 service provider under this
12:11:46 8 agreement are not the CCAC's
12:11:48 9 employees, personnel, or
12:11:53 10 agents."
12:11:53 11 Do you see that?
12:11:54 12 A. Yes.
12:11:54 13 Q. It doesn't sound very
12:11:58 14 collaborative. It sounds like there's a very
12:12:01 15 bright-line distinction between the CCAC and
12:12:06 16 your SPOs.
12:12:08 17 A. So from a contractual
12:12:08 18 perspective, I can understand the language
12:12:10 19 that's set out there. In a practical
12:12:11 20 perspective on a day-to-day basis, we do create
12:12:14 21 partnerships with our SPOs to try to ensure
12:12:17 22 that we're delivering the appropriate care.
12:12:21 23 So I'm speaking more to that
12:12:24 24 perspective that we have as an organization
12:12:26 25 that that's necessary to improve as an
12:12:27 26 organization and to really understand the
12:12:28 27 nature of what's being provided in the
12:12:31 28 community.
12:12:31 29 Q. I guess the point I'm getting
12:12:37 30 at is I appreciate what you're saying, but the
12:12:43 31 contractual side of it really keeps the two of
12:12:45 32 you very separate, doesn't it? And isn't it a

12:12:50 1 fact that that's why you were waiting for the
12:12:51 2 SPO to contact the College?
12:12:53 3 A. So I can say in my decision
12:12:55 4 or any decisions that we make, it wouldn't be
12:12:58 5 specifically related to this contractual
12:13:00 6 provision. So, you know, on a practical
12:13:02 7 perspective, the SPO staff are employees of the
12:13:10 8 SPO, and we rely on them to manage those
12:13:12 9 employees.
12:13:13 10 When I speak to the partnership,
12:13:14 11 it's that both the CCAC and the service
12:13:18 12 provider personnel are providing care to
12:13:20 13 patients. So the partnership that I'm speaking
12:13:21 14 about is important to that delivery of care,
12:13:23 15 but I would not say that this contractual
12:13:26 16 clause is the reason behind the decision to do
12:13:29 17 that.
12:13:29 18 Q. And it may be a bit of -- too
12:13:31 19 much of a legal question, but do you consider
12:13:35 20 the SPOs or the nurses that work for the agents
12:13:38 21 of the CCAC?
12:13:38 22 A. I do not use that term, no.
12:13:39 23 Q. And my final question for
12:13:43 24 you, and I've asked this of a number of people
12:13:46 25 is what's your feeling around having spot
12:13:49 26 checks on SPO nurses delivering services?
12:13:54 27 A. So it's always a very
12:13:57 28 difficult question as it relates to the home
12:14:00 29 care environment. We've spoken a lot about the
12:14:04 30 care in different areas of the home and those
12:14:04 31 types of things.
12:14:05 32 You know, when I spoke earlier

12:14:06 1 about the notion of clinical auditors, that
12:14:11 2 role really, to me, is the role that would
12:14:11 3 address the question I believe that you're
12:14:13 4 asking around, you know, our due diligence to
12:14:15 5 review in a proactive manner the care being
12:14:18 6 provided to the patient.
12:14:20 7 Whether that refers to doing
12:14:22 8 checks of the patient's chart or contacting the
12:14:25 9 patient or actually be present in the service
12:14:30 10 delivery location, I think those are important
12:14:32 11 questions.
12:14:33 12 I think our focus is on ensuring
12:14:35 13 that do we know without reactive, based on
12:14:40 14 complaints, can we understand the care being
12:14:43 15 provided not only by the SPOs but by our own
12:14:45 16 staff as care co-ordinators or rapid response
12:14:46 17 nurses or nurse practitioners.
12:14:52 18 MR. SCOTT: Okay, thank you.
12:14:53 19 Those are my questions.
12:14:54 20 THE COMMISSIONER: Thank you,
12:14:55 21 Mr. Scott.
12:14:57 22 MS. KINKARTZ: CNO? Oh, sorry.
12:15:02 23 Mr. Golden.
12:15:05 24 CROSS-EXAMINATION BY MR. GOLDEN:
12:15:15 25 Q. Steven, good afternoon. My
12:15:16 26 name's David Golden, and I am counsel to
12:15:20 27 Caressant Care.
12:15:22 28 A couple of questions for you,
12:15:25 29 if you can turn up Exhibit G, which is 56810,
12:15:30 30 you were asked some questions about it this
12:15:33 31 morning, and if we can go to page 4, I noted
12:15:54 32 that there's a specific area of complaint at

12:15:58 1 the bottom -- scroll right to the bottom.
12:16:01 2 Thank you -- called "Failed Admission" and
12:16:05 3 "Failed to Follow LTC Legislation." You see
12:16:09 4 that?
12:16:10 5 And I gather that this has to do
12:16:11 6 with complaints from a long-term care home when
12:16:14 7 they accept a resident for placement and then
12:16:19 8 there's a complaint that the assessment that
12:16:22 9 has been done of the needs of that resident was
12:16:28 10 deficient, and that would have been done at the
12:16:30 11 CCAC level; is that basically what these are
12:16:34 12 about?
12:16:34 13 A. So I'm not intimately
12:16:36 14 familiar with the placement processes within
12:16:38 15 our organization, but that, I believe, would be
12:16:41 16 one of the issues that could be captured under
12:16:43 17 these categories.
12:16:44 18 Q. All right. Well, the
12:16:44 19 specific wording that's used says, under
12:16:45 20 "Failed Admission":
12:16:47 21 "Long-Term Care Home unable or
12:16:49 22 unprepared to meet client care
12:16:51 23 needs safely and/or
12:16:54 24 appropriately due to
12:16:57 25 incomplete/undisclosed
12:16:58 26 information and/or missing
12:17:00 27 documents."
12:17:00 28 And then the next one says:
12:17:02 29 "SW LHIN [...] or other third
12:17:05 30 party fails to follow required
12:17:05 31 steps or provide accurate
12:17:05 32 information/communication

12:17:05 1 regarding placement."
12:17:09 2 So I take it this is an issue
12:17:11 3 that comes up?
12:17:12 4 A. Yes.
12:17:12 5 Q. And I take it that you would
12:17:15 6 agree that it's the CCAC or now the LHIN that's
12:17:19 7 responsible for actually doing the assessment
12:17:21 8 of prospective residents for long-term care,
12:17:26 9 and then they get sent to long-term care; is
12:17:29 10 that right?
12:17:29 11 A. Correct.
12:17:29 12 Q. All right. And are you aware
12:17:30 13 of anything in the legislation that governs you
12:17:33 14 or in the contract that assigns consequences to
12:17:39 15 the CCAC for improperly or doing an incomplete
12:17:47 16 assessment that leads to a resident being
12:17:51 17 admitted into long-term care when the complaint
12:17:53 18 from the long-term care side is that their care
12:17:58 19 needs were underestimated?
12:18:00 20 A. So, I'm -- as I said, I'm not
12:18:03 21 an expert in the process, and I'm not aware of
12:18:05 22 any legislation.
12:18:05 23 Q. Now, if we turn up Exhibit M
12:18:14 24 again, that's 56924, that would be a document
12:18:18 25 that we've looked at multiple times.
12:18:20 26 And if we just scroll down a
12:18:39 27 little bit, it looks like, really, the heart of
12:18:42 28 how this investigation got going is the fifth
12:18:44 29 and sixth bullet points, and that's where it
12:18:48 30 says that:
12:18:48 31 "CCAC set the expectation that
12:18:48 32 Saint Elizabeth would complete

12:18:52 1 one-by-one follow up on all the
12:18:54 2 patients who had care provided."
12:18:55 3 And then the next bullet point
12:18:57 4 was that:
12:18:58 5 "CCAC set the expectation that
12:18:59 6 Saint Elizabeth would complete a
12:19:01 7 review of all of the nurses'
12:19:05 8 teammates..."
12:19:06 9 And so on, and you've talked
12:19:09 10 about that. And I want to know, was there any
12:19:13 11 input from the Ministry on how to set up this
12:19:17 12 investigation that you're aware of?
12:19:18 13 A. No, I'm not aware of any.
12:19:21 14 Q. And do you know whether after
12:19:23 15 the process that the LHIN used to conduct this
12:19:27 16 investigation, was there any feedback from the
12:19:30 17 Ministry on the process that was used?
12:19:32 18 A. I'm not aware, no.
12:19:33 19 Q. All right. And you're going
12:19:36 20 to have to take my word for it, but we've heard
12:19:39 21 a lot of evidence so far at the Inquiry about a
12:19:44 22 very different kind of approach to
12:19:46 23 investigating the Wettlaufer crimes that
12:19:50 24 happened in long-term care as compared to the
12:19:53 25 approach taken here.
12:19:53 26 And I'm wondering if you've been
12:19:56 27 privy to any policy discussions regarding the
12:20:02 28 differences between how the investigation of
12:20:06 29 Wettlaufer crimes occurred or unfolded in
12:20:09 30 long-term care versus in the home care context?
12:20:13 31 A. I've not been privy, no.
12:20:16 32 Q. And if we turn to your

12:20:21 1 affidavit, paragraph 82, and I think you've
12:20:33 2 been asked about this paragraph already.
12:20:41 3 From what I'm understanding,
12:20:43 4 Steven, from your affidavit and from your
12:20:46 5 evidence earlier today that the Southwest CCAC
12:20:50 6 found out about the full nature and scope of
12:20:54 7 the Wettlaufer alleged crimes from this press
12:20:58 8 conference; is that right?
12:20:58 9 A. Yes.
12:20:59 10 Q. And so had there not be any
12:21:03 11 prior consultation or information provided to
12:21:04 12 you from the Ministry about their knowledge of
12:21:06 13 the confession and what was going to unfold?
12:21:10 14 A. So I didn't receive anything
12:21:14 15 directly, and I'm not sure if the organization
12:21:16 16 had, but not to my knowledge, no.
12:21:18 17 Q. Meadow Park and Caressant
12:21:25 18 Care Woodstock, are they under the
12:21:28 19 responsibility of your LHIN?
12:21:29 20 A. I believe that they're in --
12:21:30 21 yes. They would be, yeah.
12:21:31 22 Q. All right. Now, do you know
12:21:33 23 whether the LHIN was consulted on the
12:21:37 24 development of the inspection plan for
12:21:39 25 Meadow Park or Caressant Care Woodstock?
12:21:40 26 A. I don't work in that part of
12:21:43 27 the LHIN, so I don't have any details on that,
12:21:46 28 no.
12:21:46 29 Q. Okay. Do you know whether --
12:21:48 30 because you mentioned before that, really, the
12:21:50 31 LHIN or the CCAC doesn't have particular
12:21:54 32 expertise per se in doing investigations.

12:21:59 1 Do you know whether any such
12:22:02 2 assistance in investigations -- in particular,
12:22:06 3 in relation to Wettlaufer -- was offered by the
12:22:09 4 Ministry?
12:22:10 5 A. I'm not aware, no.
12:22:11 6 Q. In terms of your role as
12:22:18 7 director of quality, would you also be looking
12:22:23 8 at -- would you also have knowledge of, for
12:22:30 9 example, the amounts of additional funding that
12:22:35 10 come from municipal taxpayers to help fund
12:22:40 11 long-term care homes that are municipal homes
12:22:42 12 in the jurisdictions that the Southwest LHIN is
12:22:47 13 responsible for?
12:22:49 14 A. I would have no involvement
12:22:50 15 in that, no.
12:22:52 16 MR. GOLDEN: I have nothing
12:22:54 17 further. Thank you.
12:22:55 18 THE COMMISSIONER: Thank you,
12:22:55 19 Mr. Golden.
12:23:04 20 CROSS-EXAMINATION BY MS. MEADUS:
12:23:11 21 Q. Good afternoon. My name is
12:23:14 22 Jane Meadus, and I'm counsel for the Ontario
12:23:14 23 Association of Residents' Councils. That's an
12:23:14 24 umbrella organization for the Residents'
12:23:24 25 Councils in Long-Term Care Homes in Ontario.
12:23:25 26 And all of these residents, of
12:23:29 27 course, would have had some contact with CCAC
12:23:32 28 on their admission, and many of them would have
12:23:35 29 had services while they were in the community
12:23:38 30 through CCACs, so that's where I will be coming
12:23:41 31 from.
12:23:42 32 And I just wanted to follow up a

12:23:43 1 little bit on the retirement home issue that we
12:23:45 2 were speaking about before. Were you
12:23:47 3 indicating that the CCAC sometimes advised
12:23:51 4 clients to purchase the services from the
12:23:54 5 retirement home; is that what I understood,
12:23:56 6 or...?
12:23:56 7 A. No, that wasn't what I was
12:23:58 8 referring to.
12:23:59 9 Q. Okay. So perhaps I
12:24:01 10 misunderstood what you were saying there.
12:24:01 11 Okay. So that's okay. I just wanted to know
12:24:02 12 that because I was a little bit unclear as to
12:24:04 13 what you were talking about. Okay.
12:24:06 14 So I wanted to ask you a few
12:24:08 15 questions around the Bill of Rights contained
12:24:11 16 in the Home Care and Community Services Act.
12:24:14 17 So I understand that there's a Bill of Rights;
12:24:17 18 is that correct?
12:24:17 19 A. Yes.
12:24:17 20 Q. Yes. And are you familiar
12:24:19 21 with that Bill of Rights?
12:24:19 22 A. I am familiar, yes.
12:24:23 23 Q. Okay. And so my
12:24:24 24 understanding is that under Section 31 of the
12:24:26 25 act, the service provider, which I would
12:24:28 26 understand would be the SPOs, have to post that
12:24:32 27 Bill of Rights on their business premises; are
12:24:35 28 you aware of that?
12:24:35 29 A. I'm aware of that, yes.
12:24:37 30 Q. Okay. And you'll agree with
12:24:39 31 me that the service recipients, the clients,
12:24:41 32 they don't generally go to their service

12:24:44 1 providers' offices; would you agree with that?
12:24:46 2 A. Yes.
12:24:46 3 Q. Okay. And so under the
12:24:49 4 Long-Term Care Homes Act, there's a requirement
12:24:52 5 that the residents all receive a copy of the
12:24:55 6 Bill of Rights in that sector and information
12:24:56 7 about how to give complaint -- how to make a
12:25:01 8 compliant.
12:25:02 9 Is there a requirement that you
12:25:04 10 provide a copy of the Bill of Rights for that
12:25:06 11 act to all your clients?
12:25:08 12 A. Sorry, can you repeat the
12:25:11 13 question? Sorry.
12:25:11 14 Q. Is there a requirement that
12:25:13 15 the CCAC or the service provider provide a copy
12:25:18 16 of the Bill of Rights to your clients?
12:25:19 17 A. So there's no policy or --
12:25:21 18 that would specifically address that. I am
12:25:23 19 aware that the CCAC provides a brochure to
12:25:30 20 patients that includes that information, but
12:25:32 21 I'm not certain about how that is being done
12:25:35 22 with the service provider organizations.
12:25:36 23 Q. Okay. So you have a
12:25:37 24 brochure; that's correct? But the CCAC itself
12:25:41 25 doesn't provide that; is that correct?
12:25:44 26 A. Well, that brochure is
12:25:45 27 provided to patients when they start receiving
12:25:49 28 CCAC services.
12:25:49 29 Q. From the service provider or
12:25:51 30 from the CCAC?
12:25:52 31 A. From the CCAC.
12:25:52 32 Q. Okay. And does that

12:25:54 1 information include information about how to
12:25:56 2 make a complaint?
12:25:57 3 A. It does, yes.
12:25:58 4 Q. Okay. And does it include
12:26:00 5 information about how to make an appeal?
12:26:03 6 A. I'm sorry. I don't recall
12:26:05 7 specifically, but I believe it does.
12:26:07 8 Q. Okay, thank you. One of the
12:26:10 9 questions that often comes up with respect to
12:26:14 10 service providers is whether or not a client
12:26:17 11 can request that a certain caregiver not be
12:26:22 12 assigned to them. Is that something that
12:26:26 13 someone can do?
12:26:28 14 So if they're unhappy with a
12:26:30 15 specific PSW or nurse, can they request that
12:26:32 16 that person not be assigned?
12:26:34 17 A. Yes.
12:26:34 18 Q. And is that usually followed?
12:26:37 19 A. So that request would go
12:26:37 20 directly to the service provider organization,
12:26:37 21 so I can't speak to how that practice is
12:26:37 22 followed.
12:26:41 23 I do know we sometimes deal with
12:26:44 24 concerns or issues from families that point to
12:26:47 25 their asking a significant number of service
12:26:52 26 provider staff, which generally creates
12:26:56 27 challenges with continuity of care for those
12:26:58 28 patients, but I'm not sure directly how that
12:27:00 29 would be handled by the service provider
12:27:02 30 organization.
12:27:02 31 Q. But that's something that you
12:27:02 32 do get complaints about, specific service

12:27:03 1 providers and perhaps not having them assigned
12:27:05 2 to that person's home?
12:27:06 3 A. Yes. I would say, typically,
12:27:08 4 though, in my role where I would see that
12:27:12 5 escalate to me would be when there are so many
12:27:16 6 people on these lists that it's compromising
12:27:19 7 the care provided to the patient or where
12:27:22 8 there's been -- there's reasons to suspect that
12:27:24 9 those requests are being made on discriminatory
12:27:27 10 grounds.
12:27:27 11 Q. So I understand -- I'm going
12:27:30 12 to go to medication and ask you some questions
12:27:32 13 about medication issues.
12:27:35 14 I understand that you said
12:27:36 15 earlier -- there was some questions about the
12:27:37 16 number of complaints around or issues around
12:27:40 17 this provision of medication in the home and
12:27:43 18 that it seemed to be less than what we would
12:27:45 19 see in long-term care.
12:27:47 20 Do you remember being asked
12:27:48 21 those questions?
12:27:49 22 A. I remember being asked that
12:27:51 23 question. I don't believe I made that direct
12:27:54 24 comparison.
12:27:55 25 Q. Okay. And do you think that
12:27:56 26 perhaps the reason is -- I think you talked
12:27:58 27 about how the clients are generally in charge
12:28:03 28 of their own medication provision in the home;
12:28:04 29 is that correct?
12:28:05 30 A. I believe that was Donna who
12:28:07 31 spoke specifically to that.
12:28:07 32 Q. Oh, was that Donna spoke

12:28:07 1 about it? I apologize.
12:28:08 2 A. Related to how medications
12:28:09 3 are handled or the roles and responsibilities,
12:28:11 4 I don't believe I'm the best person to speak to
12:28:14 5 that.
12:28:15 6 Q. Okay, thank you. All right.
12:28:21 7 Okay. Can we bring up tab G, which is 56810,
12:28:28 8 and page 2 of that?
12:28:29 9 And there was a discussion -- so
12:28:45 10 it says "medication errors," and I just wanted
12:28:48 11 to clarify from what you were speaking about.
12:28:51 12 Is this specifically regarding
12:28:53 13 only the CCAC nurses that are going in, or does
12:28:57 14 it include any nurses that going in, whether
12:28:59 15 they're from a service provider?
12:28:59 16 A. So the data that's provided
12:29:02 17 here is specifically only related to service
12:29:05 18 provider staff. So the numbers that you see
12:29:08 19 here were -- would be where the event has been
12:29:11 20 deemed to be regarding the service provider
12:29:13 21 staff, so there would be more data or
12:29:15 22 information for the CCAC's own nursing staff.
12:29:19 23 Q. Okay, thank you. And can we
12:29:21 24 go to page 4 of that document? So just at the
12:29:27 25 top, we see:
12:29:28 26 "Claim/Legal Proceeding/Police
12:29:31 27 Investigation Involving
12:29:34 28 Client/Caregiver,"
12:29:34 29 and a bunch of question marks
12:29:37 30 there, and there's no data there. And
12:29:39 31 obviously, we know there were police involved
12:29:41 32 in the Wettlaufer matter, and I'm sure that

12:29:41 1 there are police involved in other matters
12:29:45 2 regarding thefts in long-term care -- or,
12:29:45 3 sorry, in home care.
12:29:47 4 Can you just explain why there's
12:29:49 5 question marks and no data there?
12:29:51 6 A. Yes. So in the process of
12:29:53 7 preparing for this Inquiry, there was questions
12:29:56 8 around what data we would provide specifically
12:29:59 9 related to an SPO or all data and how that was
12:30:02 10 to be captured.
12:30:03 11 It's my understanding that we
12:30:05 12 chose not to include that data, but we would
12:30:07 13 have issues contained in there, and I can say
12:30:10 14 that I do know there are events that relate to
12:30:15 15 those types of things.
12:30:18 16 It is possible, though, that
12:30:20 17 issues that arise that are claims or legal
12:30:20 18 proceedings or police investigations are not
12:30:23 19 always captured under this category because
12:30:25 20 they might be captured under another, more
12:30:28 21 appropriate category such as an abuse of a
12:30:31 22 patient or other items that may lead to that.
12:30:32 23 So this category is not the catch-all for
12:30:34 24 everything.
12:30:35 25 Q. Okay, thank you. And I just
12:30:36 26 have a couple of questions about the
12:30:39 27 investigation. Were you contacted directly by
12:30:41 28 the police about this matter?
12:30:43 29 A. We were not, no.
12:30:45 30 Q. Okay. And did you try to
12:30:46 31 reach out to them given your involvement in the
12:30:49 32 service provider -- you know, contracting with

12:30:52 1 the service provider?
12:30:53 2 A. We did not reach out
12:30:55 3 directly, but it's my understanding through my
12:30:58 4 conversations with my team that there was
12:31:00 5 either a direction or a conversation to inform
12:31:02 6 the police that these were CCAC patients.
12:31:05 7 But no direct contact from our
12:31:08 8 organization to the police.
12:31:09 9 Q. Thank you. And you obviously
12:31:12 10 relied very heavily on your service providers
12:31:14 11 to do this investigation.
12:31:15 12 And when you asked the question
12:31:19 13 about whether or not they had employed
12:31:24 14 Ms. Wettlaufer, did you presume that they would
12:31:26 15 look at the subcontractors as well?
12:31:29 16 A. I think at that point, I
12:31:33 17 don't think we had made that specific thought,
12:31:36 18 and I can't speak to Michelle's thinking of
12:31:41 19 that, so I can't directly answer that question.
12:31:43 20 Q. Okay. And you also indicated
12:31:47 21 that you found out from the media that
12:31:51 22 Lifeguard was involved; is that correct?
12:31:53 23 A. Correct, yeah.
12:31:55 24 Q. Did Saint Elizabeth not
12:31:57 25 consider that issue at all at the time?
12:32:00 26 A. So at that time,
12:32:02 27 Saint Elizabeth did not have a subcontract
12:32:04 28 agreement with Lifeguard.
12:32:06 29 Q. Okay.
12:32:06 30 A. Yes.
12:32:06 31 Q. And you'd indicated that
12:32:09 32 you'd a number of meetings since October 2016,

12:32:13 1 is that correct, with Saint Elizabeth?
12:32:16 2 A. Sorry --
12:32:18 3 Q. So you had a number of
12:32:20 4 meetings to discuss the Wettlaufer matter
12:32:22 5 starting in October 2016; is that correct?
12:32:24 6 A. Yeah, yeah.
12:32:26 7 Q. And at no time did they
12:32:29 8 indicate anything about the unauthorized entry;
12:32:32 9 is that correct?
12:32:32 10 A. No.
12:32:33 11 Q. Okay. And they didn't report
12:32:34 12 to the College of Nurses about this, about
12:32:36 13 Ms. Wettlaufer; is that correct?
12:32:39 14 A. Are you referring to --
12:32:42 15 specifically related to that issue or --
12:32:42 16 Q. Yes.
12:32:44 17 A. -- in a general sense?
12:32:45 18 Q. In a general sense.
12:32:47 19 A. So I'm not sure how they
12:32:50 20 reported that to the College.
12:32:50 21 Q. Okay. And you also
12:32:52 22 indicated, I believe, that there were other
12:32:52 23 occasions where CCACs had not reported issues
12:32:56 24 to the College of Nurses where the CCAC, in
12:33:00 25 fact, had -- so the service provider had not
12:33:02 26 reported, and the CCAC had then reported to the
12:33:06 27 College of Nurses; is that correct?
12:33:07 28 A. Yes.
12:33:08 29 Q. And what kind of consequences
12:33:09 30 are there on the service providers if they're
12:33:12 31 not fulfilling that duty from the CCAC
12:33:15 32 perspective?

12:33:15 1 A. So I can't speak to any
12:33:20 2 direct consequences for that, but we would
12:33:27 3 consider that to be their role and
12:33:27 4 responsibility in overseeing their staff, and
12:33:29 5 if they're not fulfilling that obligation, that
12:33:32 6 would be part of our performance conversations.
12:33:34 7 But I can't specifically think
12:33:36 8 of one instance where we've undertaken that
12:33:40 9 work.
12:33:40 10 Q. And finally, when the
12:33:42 11 investigations happened, was this a paper
12:33:45 12 review by yourselves or the service providers,
12:33:48 13 or did you actually go out and speak to people
12:33:49 14 who had had services from Ms. Wettlaufer?
12:33:51 15 A. So the review that was
12:33:52 16 conducted by our organization, all of our
12:33:56 17 records, our electronic records, so we would
12:33:59 18 have done that type of review.
12:34:01 19 We did not speak directly to
12:34:04 20 the patients as it relates to the
12:34:04 21 investigation. I'm not sure how Saint
12:34:05 22 Elizabeth contacted their patients, so I do
12:34:08 23 know that some of those conversations happened
12:34:11 24 by phone, but the extent of that, I'm not sure.
12:34:14 25 MS. MEADUS: Okay, thank you.
12:34:16 26 Those are my questions.
12:34:17 27 THE COMMISSIONER: Thank you,
12:34:20 28 Ms. Meadus.
12:34:25 29 MS. KINKARTZ: RPNAO, any
12:34:28 30 questions? HMQ?
12:34:32 31 Commissioner, there's no further
12:34:34 32 questions.

12:34:36 1 THE COMMISSIONER: All right.
12:34:36 2 Thank you so much for your
12:34:37 3 assistance to the Inquiry. It's
12:34:40 4 much appreciated.
12:34:41 5 You are free to go. I always
12:34:43 6 have to say those words.
12:34:45 7 THE WITNESS: Thank you.
12:34:47 8 THE COMMISSIONER: So that
12:34:53 9 concludes all the witnesses the
12:34:56 10 Commission had intended to call
12:34:58 11 during this phase of the
12:34:59 12 proceedings, and I don't think
12:35:01 13 anyone else here has some
12:35:02 14 witnesses waiting around to take
12:35:04 15 the stand unless someone has a
12:35:06 16 last-minute surprise for us.
12:35:08 17 THE COMMISSIONER: All right.
12:35:08 18 Well, that's good news.
12:35:10 19 So thank you again to the team
12:35:12 20 who's led us the last two weeks.
12:35:18 21 And as always, my continuing
12:35:19 22 gratitude and thanks to all the
12:35:20 23 Participants. Your involvement
12:35:21 24 really does make the evidence
12:35:24 25 much more important, not just
12:35:26 26 for us but for the public.
12:35:28 27 So I believe that means that we
12:35:30 28 will be leaving this room now,
12:35:32 29 and the next time I will see you
12:35:34 30 is if you are attending the
12:35:37 31 expert and technical evidence
12:35:39 32 week in September, and then of

12:35:40 1 course, we have the last week
12:35:42 2 back here in September for
12:35:43 3 closing submissions.
12:35:44 4 So with that, I hope you have
12:35:46 5 some summer holiday -- probably
12:35:49 6 a vain hope for us all -- and of
12:35:52 7 course, all documents and
12:35:54 8 everything else will have to be
12:35:56 9 removed today. There's no
12:35:58 10 guarantee they will even be here
12:36:01 11 tomorrow if we don't do that.
12:36:24 12 So thank you very much.
12:36:28 13

14 -- Adjourned at 12:36 P.M.

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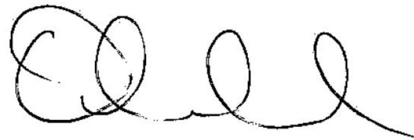
1 REPORTER'S CERTIFICATE
2
3 We, HELEN MARTINEAU, CSR, Certified
4 Shorthand Reporter, and OLIVIA ARNAUD, CSR,
5 Certified Shorthand Reporter, do certify:
6 That the foregoing proceedings were
7 taken before us at the time and place therein
8 set forth;
9 That the testimony of the witness and
10 all objections made at the time of the
11 examination were recorded stenographically by
12 us and were thereafter transcribed;
13 That the foregoing is a true and
14 correct transcript of our shorthand notes so
15 taken.
16
17
18
19 Dated this 9th day of August, 2018.
20
21

22
23

24
25 ______________________________
26 NEESON COURT REPORTING INC.
27 PER: HELEN MARTINEAU, CSR
28 & OLIVIA ARNAUD, CSR
29
30
31
32

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