

*The Public Inquiry into the Safety and Security of Residents
in the Long-Term Care Homes System*

**CLOSING SUBMISSIONS to the Public Hearings
on behalf of the MINISTRY OF HEALTH AND LONG-TERM CARE and
the LOCAL HEALTH INTEGRATION NETWORKS**

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PART I – INTRODUCTION

1. The Province offers these submissions on behalf of the Ministry of Health and Long-Term Care (MHLTC) and the Local Health Integration Networks (LHINs) to assist the Commission in making its findings and developing recommendations pursuant to its mandate under the Order in Council establishing this Inquiry.
2. These submissions are intended to place in context the legislative and regulatory framework, the mandate and operations of the MHLTC, Long-Term Care Homes Division and in particular the Long-Term Care Inspections Branch, in relation to long-term care homes, and also the South West LHIN in the provision of home care services. These submissions will also review the evidence of witnesses from both the MHLTC and the South West LHIN during the Inquiry.
3. The long-term care sector in Ontario is governed by the *Long-Term Care Homes Act* and the Regulation made under the Act. Long-term care homes are to be understood fundamentally as the homes of the residents who live there. The Act and Regulation prescribe the standards of care and operational requirements to ensure that residents are safe, secure, and receive the health care services that they need. The legislation places responsibility for compliance with the Act and Regulation on the licensees who operate long-term care homes.
4. The Long-Term Care Inspections Branch of the MHLTC has put in place a robust and comprehensive inspections regime to ensure that homes are in compliance with the Act and Regulation. The Branch undertakes inspections both in response to information received from homes, from residents and families, and from other sources, and also undertakes proactive inspections on an annual basis that are focused on the residents and provides a more objective review of the whole operation of the long-term care homes.

5. Home care services, on the other hand, by their very nature have a different regulatory and oversight structure. These are health care services provided to individuals in their own homes, and home care patients generally manage their own medications and make other decisions regarding their own care as individuals. Service provider organizations are expected to supervise and evaluate the care provided by nurses to home care clients, and the South West LHIN has performance tools to oversee the performance of the service provider organizations and also monitors risk events and adverse events in the home care context.

6. The criminal actions of Elizabeth Wettlaufer did not come to the attention of the MHLTC nor to the South West LHIN during the time that she was working in the long-term care sector. Nobody working with Wettlaufer, neither her colleagues nor supervisors, suspected her of criminal wrongdoing, and there were no suspicions reported either to the LTC Inspections Branch, to the home care agencies where she worked, or to the police. The evidence heard in this Inquiry does not support a need for significant change to the existing legislative regime.

7. The Province in these submissions does not intend to comment on the evidence of other participants to this Inquiry. It recognizes that to best serve the interests of residents in long-term care and clients in home care, and their families and loved ones, all participants must work together in order to ensure their safety, security, and well-being. The Province is committed to working with all partners to ensure quality care in a safe environment for residents and clients in both the long-term care and the home care systems.

8. This Inquiry is borne out of tragic events, and the Province recognizes the tremendous loss of the victims and their families. All participants must work together to strengthen the system to reduce the possibility of similar events ever happening again.

PART II – LONG-TERM CARE HOMES – LEGISLATIVE FRAMEWORK

A. Overview of the *Long-Term Care Homes Act, 2007 (LTCHA)*

9. Since 2010, long-term care homes in Ontario have been governed by the *Long-Term Care Homes Act (LTCHA)* and the regulation made under the Act, O. Reg. 79/10 (Regulation).¹ The LTCHA is administered and enforced by the MHLTC.²

10. The LTCHA governs the licensing, funding, and regulatory oversight of long-term care homes in the province.³ Prior to the LTCHA, long-term care in Ontario was regulated through three separate pieces of legislation: the *Charitable Institutions Act*, the *Homes for the Aged and Rest Homes Act*, and the *Nursing Homes Act*. The LTCHA consolidated these pieces of legislation, renewing focus on resident care and placing greater accountability on licensees for compliance with the same Act.⁴

11. The overarching principle enshrined in the LTCHA, set out as the “fundamental principle” of the Act, is that the long-term care home is primarily the home of the residents who live there and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort.⁵

12. The LTCHA sets out the rights of residents living in long-term care, and allows for the establishment of Residents’ and Family Councils to advise, assist, and support residents.⁶ It establishes the process for admission of residents to long-term care homes and regulates the operation of those homes.⁷ The LTCHA also regulates licensing and funding of long-term care

¹ SO 2007, c. 8; O Reg 79/10

² LTCHA, s 2(1)

³ Affidavit of Karen Simpson, (Exhibit 129), para. 56

⁴ Affidavit of Karen Simpson, (Exhibit 129), para. 56; Affidavit of Karin Fairchild, (Exhibit 154), para. 26

⁵ LTCHA, s 1; Affidavit of Karen Simpson, (Exhibit 129), para. 57

⁶ Part II – Residents: Rights, Care and Services, Part IV – Councils

⁷ Part III – Admission of Residents, Part V – Operation of Homes

homes, and provides for enforcement of the law where compliance with the requirements in the LTCHA and the Regulation has not been achieved by licensees.⁸ The LTCHA places responsibility on the licensee to ensure compliance with the requirements of the legislation.

13. The Regulation, made under the LTCHA, sets out more detailed requirements regarding the provision of long-term care including, among others, requirements regarding medication management, prevention of abuse and neglect, and reporting certain matters to the Director.⁹

B. The LTCHA Places Responsibility for Compliance on Licensees

14. The LTCHA places responsibility on the licensee to ensure compliance with the requirements of the LTCHA and the Regulation. This represents a shift from the predecessor regulatory regime, in which the Administrator or the individual long-term care home bore most of the responsibility for compliance.¹⁰ This change was intended so that the person or entity holding the licence has a positive obligation under the LTCHA to ensure that homes operating under the authority of their licence are compliant with the legislation.¹¹ Where the licensee is a corporation, the LTCHA additionally requires that its directors and officers take such measures as necessary to ensure the licensee complies with the requirements under the Act.¹²

15. For example, the LTCHA and the Regulation require that the licensee shall: protect residents from abuse by anyone, ensure that residents are not neglected by the licensee or staff, and ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents, and that

⁸ Part VI – Funding, Part VII Licensing, Part IX – Compliance and Enforcement

⁹ The Director is an officer created under the Act, appointed by the Minister, and has the powers and obligations assigned to the Director under the Act. For example, the Director is the recipient of mandatory reports and critical incidents under the Act, and must ensure in certain circumstances that an inspection or inquiry is done in relation to information received. LTCHA, ss 24, 25, 170

¹⁰ Affidavit of Karin Fairchild, (Exhibit 154), para. 26

¹¹ Affidavit of Karin Fairchild, (Exhibit 154), para. 26

¹² LTCHA, s 69

that policy is complied with;¹³ ensure that the home is a safe and secure environment for its residents;¹⁴ ensure that the rights of residents set out in the Residents' Bill of Rights are fully respected and promoted;¹⁵ and ensure that every alleged, suspected or witnessed incident of abuse or neglect is immediately investigated and that appropriate action is taken, and report the results of the investigation and the actions taken to the Director.¹⁶

16. As professional health care organizations, the legislation expects licensees to develop appropriate policies and practices in order to meet their legislative obligations and to ensure that residents receive the care they need and live in a safe and secure home.¹⁷

17. For example, the MHLTC does not have a role in direct management of staff in long-term care homes. As the employer and as the entity responsible for legislative compliance, it is the licensee's responsibility to manage staff in the home and to make appropriate staffing decisions such as hiring and discipline of staff.¹⁸

18. The LTCHA requires that the licensee ensure that there are nursing services and personal support services to meet the residents' assessed needs, and that there is a written staffing plan to provide these services. The staffing plan must, among other things, provide for a staffing mix that is consistent with residents' assessed care and safety needs.¹⁹ It further requires that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for

¹³ LTCHA, ss 19-20; O Reg 79/10, ss 96-99

¹⁴ LTCHA, s 5

¹⁵ LTCHA, s 3

¹⁶ LTCHA, s 23; O Reg 79/10, s104

¹⁷ Testimony of Karin Fairchild, August 7, 2018, p. 7508, 1-5; Affidavit of Karen Simpson, (Exhibit 129), para 58

¹⁸ Affidavit of Karin Fairchild, (Exhibit 154), para 29

¹⁹ LTCHA, 8(1); O Reg 79/10, s 31

in the Regulation.²⁰ However, it is the licensee's responsibility to determine what staffing numbers and staffing ratios are required in order to properly meet residents' needs. This model recognizes that licensees are best positioned to determine the appropriate levels of staffing required in their homes based on the individual and changing care and safety needs of all residents at all times.²¹

19. This approach is consistent across the LTCHA and the Regulation: all licensees, regardless of business ownership, are expected to determine how to operate their long-term care homes in such a way as to ensure compliance with legislative requirements and to ensure that residents are receiving appropriate care. One of the expectations in introducing this legislation was that all long-term care homes would be able to implement the standards and requirements it sets out using the resources available to them. Many long-term care homes in the province are successful in running homes that provide good care to their residents.

20. To ensure that licensees comply with legislative and regulatory requirements, MHLTC inspectors regularly inspect long-term care homes. Copies of Inspection Reports must be given to the licensee, and summaries to the Residents' Council, and the Family Council.²² The Administrator will also receive a copy as a courtesy.²³ A public version of all Inspection Reports and orders are also publicly posted online on the Ministry's website.

²⁰ LTCHA, 8(3); O Reg 79/10, s 45

²¹ Testimony of Karin Fairchild, (Exhibit 154), August 7, 2018, p 7476, ll 20-32, p 7477, ll 1-12

²² LTCHA, s 149

²³ Affidavit of Karin Fairchild, (Exhibit 154), para 28

C. Enforcement of the LTCHA: The Role of MHLTC Inspectors

21. MHLTC inspectors are appointed under the LTCHA to perform inspections of long-term care homes and to ensure compliance with the LTCHA.²⁴ Inspectors have the power to perform inspections of long-term care homes. When carrying out these powers, MHLTC inspectors have all the powers set out in sections 146 and 147 of the LTCHA. Among other things, inspectors may: enter any long-term care home at any reasonable time to conduct an inspection;²⁵ inspect or copy a record or any other thing, and demand the production of records or other things the inspector believes are relevant to the inspection;²⁶ and question a person, and may exclude any persons from that questioning.²⁷

22. MHLTC inspectors carry out two types of inspections: comprehensive annual inspections which are conducted in every long-term care home, called Resident Quality Inspections (RQIs); and Critical Incident, Complaint and Follow Up (CCF) inspections, which inspect specific incidents reported to the MHLTC and follow-up on orders previously issued.²⁸

23. Where non-compliance is identified, inspectors must do one of the following: (i) issue a written notification to the licensee; (ii) issue a written request to the licensee to prepare a written plan of correction, to be implemented voluntarily; (iii) make a compliance order or a work or

²⁴ LTCHA, ss 141-142

²⁵ LTCHA, s. 146(1)

²⁶ LTCHA, s. 147(1)(b) and (c)

²⁷ LTCHA, s. 147(1)(d) and 147(4). This subsection is a recent amendment to the LTCHA; during the EW inspections that took place in 2016-17, any person who was questioned was allowed to have other persons, including counsel, present during the interview

²⁸ Affidavit of Karen Simpson, (Exhibit 129), para 15

activity order against the licensee; (iv) issue a written notification to the licensee and refer the matter to the Director for further action.²⁹

24. The Director may also issue a compliance order against a licensee. The Director has further powers to (a) make an order that funding be returned by or withheld from the licensee; (b) issue a mandatory management order, requiring the licensee to retain at their own expense one or more persons acceptable to the Director to manage or assist in managing the long-term care home; or (c) issue an order revoking the licensee's licence and put in place an interim manager to manage the home until the residents can be relocated and the home can be closed.³⁰

25. Where an order is issued by an inspector, a licensee may request that the Director review the order. On review, the Director may rescind, confirm, or alter the order, or substitute their own order for that of the inspector.³¹ A decision made by the Director on review, or an order issued by the Director, may be appealed to the Health Services Appeal and Review Board.³²

26. All of the enforcement actions described above are taken against the licensee. Orders under the LTCHA cannot be issued against individual staff members or other persons involved in the provision of long-term care.³³

²⁹ LTCHA, ss 152-154. In addition to these powers, a recent amendment to the LTCHA, to come in force on January 1, 2019, will allow an inspector or the Director to issue a notice of administrative penalty to the licensee: LTCHA, s 156.1

³⁰ LTCHA, ss 155-157. The Director may also direct a suspension of admissions to the home where the Director believes there is a risk to the health or well-being of residents: LTCHA, s 50

³¹ LTCHA, s 163

³² LTCHA, ss 164-171

³³ Affidavit of Karin Fairchild, (Exhibit 154), para 29

D. Complaints and Reporting

27. The LTCHA requires that licensees have processes in place regarding reporting and addressing complaints, and that certain types of incidents are investigated internally by the licensee and also reported to the Director.

28. Licensees must have written procedures for anyone to make a complaint to the licensee and for how the licensee will deal with such complaints, and they also must forward any such complaints to the Director immediately when they concern the care of a resident or the operation of the long-term care home.³⁴

29. The LTCHA further requires that the licensee immediately investigate every alleged, suspected, or witnessed incident of abuse of a resident by any person, or neglect of a resident by the licensee or staff. They must take appropriate action in response to every such incident, and report to the Director the results of every such investigation and any actions taken.³⁵

30. Additionally, any person who has reasonable grounds to suspect the following has occurred or may occur, is required to immediately report it to the Director: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; abuse of a resident by any person or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident; unlawful conduct that resulted in harm or risk of harm to a resident; misuse or misappropriation of a resident's money; misuse or misappropriation of funding provided to a licensee.³⁶ Where the Director receives a report alleging these and other types of incidents, she must ensure that inquiries are made or an inspection is conducted.³⁷

³⁴ LTCHA, ss 21-22; O Reg 79/10, ss 100-103

³⁵ LTCHA, s 23; O Reg 79/10, s 104

³⁶ LTCHA, s 24

³⁷ LTCHA, s 25; O Reg 79/10, ss 100-106

31. The Regulation also requires licensees to report certain critical incidents to the Director, including but not limited to: an unexpected or sudden death; a missing or unaccounted for controlled substance; an incident that causes an injury to the resident for which the resident is taken to a hospital and which results in a significant change in their health condition; and a medication or adverse drug reaction that results in a resident being taken to hospital.³⁸

32. Any information reported to the Director, including information reported pursuant to these requirements, may result in an inspection of the long-term care home to determine compliance.

33. The LTCHA contains whistle-blowing protections, prohibiting retaliation by anyone against disclosing information to an inspector or the Director, and prohibiting licensees and staff members from discouraging reporting.³⁹

E. Medication Management

34. The LTCHA and the Regulation set out requirements for medication management in long-term care homes. In particular, sections 114-136 of the Regulation identify minimum standards with which licensees are required to comply with respect to storage, administration, and disposal of drugs, and regular evaluation by the licensee of their own medication management systems.⁴⁰

35. Licensees are required to develop an interdisciplinary medication management system to ensure safe and effective medication practices, and to evaluate it quarterly and annually.⁴¹ They must develop a system to track medication incidents and adverse drug reactions and learn from them, and are responsible for documenting, reviewing, analyzing, and taking corrective action

³⁸ O Reg 79/10, s 107

³⁹ LTCHA, s 26

⁴⁰ O Reg. 79/10, ss 114-136

⁴¹ O Reg 79/10, ss 114-116

for all medication incidents and adverse drug reactions, for maintaining records of this information, and for conducting quarterly interdisciplinary reviews of all such incidents.⁴²

36. These minimum requirements are intended to ensure that licensees take responsibility for quality management and improvement of their own programs and organizations in order to minimize the number of medication errors which occur.⁴³

37. The Regulation also contains requirements pertaining to the safe storage, administration, and disposal of drugs and controlled substances.⁴⁴ Many of these requirements are for the licensee to develop written policies and ensure that appropriate systems are in place in order to implement, review and evaluate these policies.

F. Prevention of Abuse and Neglect of Residents

38. The LTCHA requires licensees to protect residents from abuse by anyone, and to ensure that residents are not neglected by the licensee or by staff. It also requires the licensee to ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is complied with.⁴⁵

39. The LTCHA and the Regulation set out in greater detail what the licensee's zero tolerance for abuse and neglect policy must contain, including: measures and strategies to prevent abuse and neglect; training and retraining requirements for staff; and procedures for conducting investigations of alleged abuse and neglect.⁴⁶ The Regulation also requires the licensee to notify police where they believe the alleged abuse or neglect may constitute a criminal offence.⁴⁷

⁴² O Reg 79/10, s 135

⁴³ Affidavit of Karin Fairchild, (Exhibit 154), para 43

⁴⁴ O Reg 79/10, ss 122-137

⁴⁵ LTCHA ss 19-20; O Reg 97/10, ss 96-99

⁴⁶ LTCHA, s 20(2); O Reg 79/10, s 96

⁴⁷ O Reg 79/10, s 98

40. As described above, there is also an obligation to report suspected abuse or neglect to the Director.⁴⁸ Where the Director receives a report alleging abuse or neglect, the Director must ensure that inquiries are made or an inspection is conducted in relation to the report.⁴⁹

PART III – LONG-TERM CARE INSPECTIONS BRANCH

A. Inspection Activities under the LTCHA

41. The Long-Term Care Homes Division (LTCH Division) of the MHLTC ensures compliance with the LTCHA through the use of inspectors appointed under the Act and employed within the Long-Term Care Inspections Branch. The powers of inspectors under the LTCHA are described above at paragraphs 21 to 26.

42. One of the key recommendations of a report released in 2004 by Monique Smith, the Parliamentary Assistant to the Minister of Health and Long-Term Care, recommending changes and reform in the delivery of long-term care in the province, was to create an enhanced inspection function to ensure that regulatory standards and requirements are met by long-term care homes.⁵⁰ Ms. Smith perceived a conflict in the role of Compliance Advisors who, under the predecessor legislation, worked with long-term care homes to ensure standards were met, particularly if they were also responsible for the inspection of that home and any subsequent enforcement.⁵¹ Karen Simpson, the then Director of the LTC Inspections Branch (and the Director appointed under s. 175 of the LTCHA⁵²) testified that the Ministry's research at the time of the creation of the LTCHA and the new inspection regime that accompanied it confirmed that

⁴⁸ LTCHA, s 24

⁴⁹ LTCHA, s 25

⁵⁰ Monique Smith, *Commitment to Care: A Plan for Long-Term Care in Ontario*, Spring 2004, Exhibit C to Affidavit of Karin Fairchild (Exhibit 154, LTICI00046531), p 19

⁵¹ *Commitment to Care*, p 19

⁵² Ms Simpson was appointed as Acting Director of the Performance Improvement and Compliance Branch of the MHLTC during periods in 2012 and 2013-14, and was appointed as Director of the LTC Inspections Branch for the purposes of ensuring compliance and enforcement of the LTCHA from November 2015 to June 2018

inspectors needed to ensure they maintained their objectivity, and thus inspectors no longer give advice to homes on how to be compliant, as it is the responsibility of the licensee to determine how to come into compliance.⁵³ Inspectors may now refer homes to other resources, such as professional associations, health regulator colleges, and other organizations and homes that have developed best practice information. The LTC Inspections Branch has also provided long-term care homes with decision trees with additional support in understanding the legislative requirements around zero tolerance of abuse and neglect of residents, explaining the definitions of abuse, when to report, the obligation of a home to investigate, etc.⁵⁴

43. As part of the transformation to the new legislative regime under the LTCHA, the LTCH Division adopted a methodology, developed in the United States, that is now the basis of a robust inspection system used to determine whether long-term care homes are compliant with the LTCHA and Regulation.⁵⁵ This inspection system is resident-focused, and begins with collecting evidence from the residents, staff, and families, and works outward from there.⁵⁶

44. One of the significant innovations in the inspections regime under the LTCHA is the use of Inspection Protocols. Through the inspection methodology, inspectors collect data and information from direct observation, interviews and record review. The Inspection Protocols focus the inspector on the legislative and regulatory requirements for any particular care area that is triggered in the course of their data collection. The Inspection Protocols guide the inspector on

⁵³ Testimony of Karen Simpson, July 30, 2018, p 6079, l 18 – p 6080, l 15; Affidavit of Karen Simpson (Exhibit 129), para 22

⁵⁴ Affidavit of Karen Simpson (Exhibit 129), para 78. Witnesses from long-term care homes also testified about attending “flag” meetings with other administrators and directors of care and would discuss common issues arising out of inspections and would share experiences and learn from each other: Testimony of Melanie Smith, June , p 2502, l 28 – p 2504, l 21

⁵⁵ Testimony of Karen Simpson, July 30, 2018, p 6123, l 31 – p 6125, l 2; Affidavit of Karen Simpson (Exhibit 129), para 51

⁵⁶ The standards of care inspected against in the US model align very closely with the Ontario legislation. The Ministry contracted with the model’s developers to adapt the inspection methodology to the LTCHA and Regulation, and also to provide training to Ontario inspectors on the new methodology. Testimony of Karen Simpson, July 30, 2018, p 6125, l 29 – p 6126, l 6; Affidavit of Karen Simpson (Exhibit 129), para 52

the questions and information that the inspector will need to gather in order to assess a home's compliance, and also direct the inspector to the portions of the LTCHA and Regulation that set out the standards and criteria that a home must meet in order to be compliant.⁵⁷

45. These Inspection Protocols cover many of the standards and criteria contained in the LTCHA and Regulation, including the requirements related to medication management and medication system evaluation, prevention of abuse and neglect, reporting and complaints requirements, resident dignity, choice and privacy, restraints, pain management, responsive behaviours, sufficient staffing, food and nutrition, training and orientation, etc.⁵⁸ Of note, since the LTCHA came into force on July 1, 2010, these Inspection Protocols have been made available to all long-term care homes, and they can be used to assist homes in training their own staff and in understanding the requirements of the inspection program and of the legislation.⁵⁹

B. Critical Incident, Complaint and Follow Up (CCF) Inspections

46. As set out above, the LTCHA requires mandatory reporting to the Director of suspicion of improper or incompetent treatment or care, abuse, neglect, and unlawful conduct, among other things. The LTCHA also contains whistleblower protection for anyone making reports or other disclosure to the Director or to an inspector.⁶⁰ The Regulation requires licensees to report certain critical incidents to the Director as well, including, among others, an unexpected or sudden death, a disease outbreak, a missing or unaccounted for controlled substance, and a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.⁶¹

⁵⁷ Testimony of Karen Simpson, July 30, 2018, p 6126, l 23 – p 6129, l 1; Affidavit of Karen Simpson (Exhibit 129), para 54; Affidavit of Rhonda Kukoly (Exhibit 134), para 34

⁵⁸ The LTC Homes Public Inquiry: Evidence of Karen Simpson, Slide deck at Exhibit B to Affidavit of Karen Simpson (Exhibit 129, LTCI00072869), slide 33

⁵⁹ Testimony of Karen Simpson, July 30, 2018, p 6129, ll 15-20

⁶⁰ LTCHA, ss 24-26

⁶¹ O Reg 79/10, s 107

47. Mandatory reports and critical incident reporting are done through the Inspection Branch's online critical incident reporting system, to which all long-term care homes have access.⁶² Reports can also be made after hours to an emergency contact number provided to homes. In addition to these types of report, any person can make a complaint to the Ministry about a home.

48. All homes are required to provide a package of information to all residents and family members that includes the Ministry's toll-free number for making complaints about homes.⁶³ In addition, this information must be posted in all homes in a conspicuous and easily accessible location.⁶⁴

49. If the Director receives information from any source about conduct that has resulted in harm or risk of harm to a resident or a failure to comply with a requirement under the LTCHA, among other things, the Director must ensure that an inspection or inquiry is done for the purpose of ensuring that the home is compliant with the requirements of the LTCHA.⁶⁵

50. In conducting a critical incident or complaint inspection, the inspector is focused on the issue at hand, and gathers information specific to that issue. These may be understood to be "reactive" inspections that are initiated through the receipt of information in the Inspections Branch from the home, from the resident or their family, or from some other complainant. Inspectors will use the relevant Inspection Protocol(s) to guide their inspection activity. They will gather evidence from the sources available to them: record review, interviews, and observations.⁶⁶

⁶² See, for example, memorandum from Nancy Lytle dated February 12, 2015, Clarification of Mandatory and Critical Incident Reporting Requirements, Exhibit G to Affidavit of Karen Simpson (Exhibit 129, LTCI00055639)

⁶³ LTCHA, s 78; O Reg 79/10, s 224

⁶⁴ LTCHA, s 79; O Reg 79/10, s 225

⁶⁵ LTCHA, s 25

⁶⁶ Affidavit of Rhonda Kukoly (Exhibit 134), para 37. Ms Kukoly describes conducting a CCF inspection like "putting together a puzzle": she is looking to see how everything fits together (e.g., record review, interviews with

C. Resident Quality Inspections

51. Resident Quality Inspections, or RQIs, are comprehensive and proactive inspections, and are meant to be an objective review of the whole operation of the long-term care home. The purpose of an RQI is to look at the home's compliance with the LTCHA and the Regulation from a broader perspective, given that focusing only on specific complaints or critical incidents could lead to missing systemic issues.⁶⁷ Every long-term care home receives an RQI annually.

52. The RQI methodology is a data driven exercise conducted in two stages. Stage 1 of the RQI is resident-focused, and inspectors gather information from a set number of randomly selected residents as well as families and others, including staff. They also draw on RAI-MDS data⁶⁸ for the same set of randomly selected residents, and make observations about the long-term care home and care being provided. In addition, they review documents, including clinical records of residents.⁶⁹ Inspectors will attempt to interview all of the randomly selected residents to obtain information from them, using a specific set of questions and entering the answers into an IT tool developed for this purpose. If a resident is not able to be interviewed, the inspector will conduct observations of that resident and will interview staff about the resident. Inspectors will also interview families for three of the residents who are not able to be interviewed.⁷⁰

53. All of the data collected in Stage 1 of the RQI is entered into the ministry's RQI inspection IT tool that then identifies potential areas of non-compliance in the home based on the

frontline staff and management, observations, etc.), and if there are inconsistencies she will follow up with someone with direct knowledge of the incident or issue to try to get clarification

⁶⁷ Affidavit of Karen Simpson (Exhibit 129), para 103

⁶⁸ RAI-MDS (Resident Assessment Instrument – Minimum Data Set) is an internationally adopted standardized assessment tool used on admission of a resident, and then re-done on at least a quarterly basis, and also when there is a significant change in health status of a resident. Its use is mandated in all long-term care homes in the province. It is a source of detailed and current information regarding the health status of each resident, and the information collected on the assessment contributes to the resident's plan of care required under the LTCHA: LTCHA, s 6

⁶⁹ Affidavit of Karen Simpson (Exhibit 129), para 104; Affidavit of Rhonda Kukoly (Exhibit 134), para 42

⁷⁰ Affidavit of Rhonda Kukoly (Exhibit 134), para 56

information collected. The results of Stage 1 will determine what care areas the team of inspectors will be inspecting further in Stage 2. It will also determine which Inspection Protocols the inspectors will be using to assist in guiding their inspections in Stage 2. In addition to Inspection Protocols for the care areas that are triggered from Stage 1, there are some mandatory tasks that are completed for all RQIs.⁷¹

54. One recent change to the methodology has made certain questions in the Medication Inspection Protocol mandatory in all RQIs – these questions relate to medication incidents and adverse drug reactions and address the requirements of the home for internal reporting of medication incidents and taking corrective action, and also the requirements of the home to conduct quarterly assessments of their medication management system with an interdisciplinary team including the medical director, the Director of Care, the Administrator, and the consulting pharmacist, among others.⁷²

D. Approach to Inspections

55. The LTCHA requires that inspections conducted under the LTCHA are unannounced, whether they are CCF or RQI inspections.⁷³ Inspectors conduct inspections to ensure compliance with the LTCHA and the Regulation. As noted above, inspectors will make observations, review records, and conduct interviews with residents, staff and families in order to determine whether the home is in compliance.⁷⁴

⁷¹ Affidavit of Karen Simpson (Exhibit 129), paras 104-105

⁷² Testimony of Karen Simpson, July 30, 2018, p 6139, ll 2-31; Affidavit of Karen Simpson (Exhibit 129), para 126; Affidavit of Rhonda Kukoly (Exhibit 134), para 62; O. Reg 79/10 ss 131, 135

⁷³ LTCHA, s 144. But note O.Reg 79/10, s 298 which specifies that notice may be given of three types of inspections: (1) inspection of beds in an existing home that are not covered by the home's license; (2) inspection of a home's closure plan; or (3) inspection initiated at the request of the home.

⁷⁴ Rhonda Kukoly testified that as an inspector she feels strongly that an inspector must go into a home looking for evidence of compliance, and not go in randomly looking for non-compliance. This helps her stay focused on the issue or issues on which she is inspecting. If she cannot find evidence of compliance, she will continue to ask questions until she has enough evidence to support a finding of non-compliance: Testimony of Rhonda Kukoly, August 1, 2018, p 6651, ll 1-24; Affidavit of Rhonda Kukoly (Exhibit 134), para 31

56. Inspectors must have evidence to support their findings of non-compliance. They do not view the matter as meeting a “burden of proof”, but instead look for sufficient evidence to support a finding of non-compliance. The amount of evidence required, and whether it comes from all three of observations, record reviews and interviews, will differ depending on the matter being inspected.⁷⁵

57. If the inspector finds that a licensee is not in compliance, the inspector is required under the LTCHA to document any findings of non-compliance in an Inspection Report.⁷⁶ Where there is a finding of non-compliance, an inspector must also determine what action to take, whether issuing a written notification, a written notification accompanied by a voluntary plan of correction, or a compliance order.⁷⁷ A compliance order may require a licensee to do or refrain from doing something to achieve compliance, or it may require the licensee to prepare, submit and implement a plan for achieving compliance.⁷⁸ If a compliance order is issued, it will be accompanied by a compliance date by which the order must be complied with, and an inspector will then conduct a Follow Up inspection to determine whether the home has complied with the order. Homes may contact their local Service Area Office if they need more time to come into compliance.

58. An inspector may also, in appropriate cases, issue a written notification and refer the matter to the Director for further action.⁷⁹ In determining what action to take, inspectors are guided by a judgment matrix to promote consistency in the exercise of their discretion. They must assess the

⁷⁵ Testimony of Rhonda Kukoly, August 1, 2018, p 6662, 19 – p 6663, 19; Affidavit of Rhonda Kukoly (Exhibit 134), para 38. Ms Kukoly testified that she would never issue a finding of non-compliance unless the home was given every opportunity to give her the documentation or confirmation to establish it is in compliance: Testimony of Rhonda Kukoly, August 1, 2018, p 6663, ll 9-15

⁷⁶ LTCHA, s 149(3)

⁷⁷ LTCHA, s 152

⁷⁸ LTCHA, s 153; Affidavit of Karen Simpson (Exhibit 129), para 63

⁷⁹ LTCHA, s 152

scope of non-compliance, the severity, and also the compliance history to determine which action or enforcement mechanism to accompany the finding of non-compliance.⁸⁰ These are the only factors the inspector may consider. Neither due diligence on the part of the licensee nor honest mistake may be considered when an inspector or the Director makes an order.⁸¹

59. The finding of non-compliance is always directed to the licensee, who has the obligation to ensure compliance with the LTCHA and Regulation.⁸² An inspector will not direct a finding of non-compliance toward a staff member, including registered staff, nor to a Director of Care or an Administrator. As an example, if evidence shows that a staff member has failed to follow a required policy or procedure, and the inspector determines that the LTCHA requires that a policy is developed, the finding of non-compliance is directed to the licensee for failing to ensure that the staff member complied with the policy. In this case, an inspector may issue an order to the licensee to ensure that staff are trained on and have knowledge of the policy.⁸³

60. Similarly, it is not the job of an inspector to determine whether a staff member is at fault for an incident, nor whether the actions of a staff member are reckless, negligent, or otherwise worthy of discipline. It is not the job of an inspector to determine whether or not any disciplinary actions of an employer were required or sufficient. It is the obligation of a licensee to manage and operate the home, including hiring, training, supervising, and disciplining staff, up to and including termination. The focus of an inspection is always to determine whether there is

⁸⁰ O Reg 79/10, s 299

⁸¹ LTCHA, s 159

⁸² Written notifications and requests, compliance orders, work and activity orders, funding orders, mandatory management orders, and licence revocations can only be made against licensees: LTCHA, ss 152-158. The Act also contains a number of offence provisions; most of these offences are for non-compliance with the aforementioned orders, meaning only a licensee can commit these types of offences: LTCHA, s 162.2. However, the Act also contains a limited number of other offences which could be committed by additional persons other than the licensee. For example, section 24 requires a person who suspects certain activity to report it to the Director, and it is an offence for licensees, directors and officers, staff members, and other enumerated classes of persons to fail to do so: LTCHA, s 24(5).

⁸³ The licensee is also deemed to be vicariously liable where a staff member has not complied with the mandatory reporting requirement under s 24 or has retaliated against a whistle-blower under s 26; LTCHA, s 152(2)

evidence to support that the licensee has responded with appropriate action to ensure the safety and well-being of residents. For example, in an instance of an allegation of abuse or neglect of a resident by a staff member, the obligation on the licensee is to ensure that it protects all residents from abuse and neglect by staff and in doing so that it has in place a policy to promote zero tolerance of abuse and neglect and that the policy is complied with, and also to immediately investigate all allegations of abuse and neglect, report the abuse or neglect to the Director, and to ensure appropriate action is taken.⁸⁴ The focus of an inspection in this matter will always be whether the licensee is in compliance with these legislative obligations.

61. The licensee is required to post the public summary version of the Inspection Report and any Orders issued in the home from the past two years.⁸⁵ The public version of all Inspection Reports and Orders are posted online on the Ministry's webpage.⁸⁶ In addition, as of April 2018 the home's ranking pursuant to the LQIP Performance Assessment⁸⁷ is also posted on the Ministry's webpage.⁸⁸

E. Inspection Issues regarding Elizabeth Wettlaufer (EW)

62. As explained above, inspectors do not conduct their inspection so as to come to a conclusion or finding as to whether actions of an individual staff member, including registered staff, are

⁸⁴ LTCHA, ss 19, 20, 23, 24

⁸⁵ LTCHA, s 79; the summary is edited to remove all personal information and personal health information: O Reg 79/10, s 301

⁸⁶ LTCHA, s 173

⁸⁷ The Long-Term Care Home Quality Inspection Program (LQIP) Performance Assessment, or LPA, is a tool developed by the LTC Inspections Branch to assist the Branch in assessing risk in long-term care homes, and is now used to determine whether a home will receive an Intensive Risk-Focused Resident Quality Inspection annually. See Affidavit of Philip Moorman (Exhibit 148), paras 6, 36. Homes ranked as "substantially compliant" will undergo a Risk-Focused RQI annually, with an Intensive Risk-Focused RQI every three years. Testimony of Karen Simpson, July 30, 2018, p 6221, l 13 – p 6222, l 12

These changes to the RQI methodology were in response to a recommendation from the Auditor General in 2015 to consider whether a full RQI needed to be conducted in every home, including those performing well, every year: Testimony of Karen Simpson, July 30, 2018, p 6205, l 22 – p 6206, l 25; Affidavit of Karen Simpson (Exhibit 129), paras 110-115

⁸⁸ Testimony of Karen Simpson, July 30, 2018, p 6216, ll 6-17; Affidavit of Karen Simpson (Exhibit 129), paras 134-135

careless, negligent, reckless, or done with intent to harm or injure a resident. Any investigation into a staff member's conduct, whether it relates to a medication incident or an allegation of abuse or neglect of a resident, is the obligation of the employer and the licensee. Allegations of criminal conduct are the purview of the police, and where there are suspicions of criminal conduct, an inspector will look for evidence that a licensee has immediately conducted its own investigation and that the licensee has contacted police if appropriate.

63. The actions of EW while working in long-term care came to the attention of the LTC Inspections Branch only in a few instances. Many of the instances involving EW that were examined in the evidence at this Inquiry, including most incidents involving her work performance, were not reportable to the Director. In some cases, an incident was reportable to the Director but the licensee failed to make a mandatory report. Some of these incidents were inspected upon retrospectively in inspections conducted by the Inspections Branch in 2016-2017. It must be noted here that the Director did not receive any reports of a suspicion that EW was intentionally harming residents, for the reason that the people working with EW, including her colleagues and supervisors from the period of 2007 to 2016, did not suspect her of such activity.

Non-reportable incidents involving EW

64. This Inquiry heard testimony during the Facilities phase of evidence regarding many incidents involving EW's actions, including medication errors she committed, and interactions with residents and staff that invited comment, criticism and discipline. Many of these incidents were not reportable to the Director, either under the LTCHA or its predecessor legislation.

65. For example, while working at Caressant Care – Woodstock, there were a series of incidents starting as early as 2007 where EW made errors involving the dispensing of medications. Some examples of medication errors that occurred while EW worked at Caressant Care – Woodstock

include: failure to give a resident's medications;⁸⁹ charting that medication had been given when it had not been;⁹⁰ putting eye drops in without waiting to administer the second drops;⁹¹ giving Maureen Pickering a medication outside the allowable time frame;⁹² and placing the wrong insulin in insulin pen (an error not discovered until March 24, 2014).⁹³

66. None of these medication incidents were required to be reported to the Director, as they did not result in a resident's transfer to hospital. They were required to be reported internally within the home, including to the Director of Nursing, the prescriber and the pharmacist, and follow up action by the home was required in respect of the medication incidents, but there was no obligation at the time, nor would there be under the current LTCHA and Regulation, to report such medication incidents to the Director.⁹⁴

Reportable incidents involving EW that were not reported

67. Some incidents involving EW were not reported to the Director, even though they were reportable incidents. Some examples of these incidents include:

- (a) August 12, 2007: After EW administered a lethal dose of insulin to James Silcox, she completed the Institutional Patient Death Record and faxed it to the Office of the Chief Coroner. She checked off on the form that this was an "accidental death" and that the death was "sudden and unexpected".⁹⁵ This should have been the subject of an unusual occurrence report to the Ministry but there was no evidence it was reported.

⁸⁹ Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, paras 9-10; Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, para 14 (EW was suspected to be involved in this error: Testimony of Helen Crombez, June 8, 2018, p 769, 1 21 – p 770, 1 7); Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, paras 16, 19; Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, paras 18, 20; Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, para 23

⁹⁰ Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, paras 101-03

⁹¹ Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, paras 117-19

⁹² Affidavit of Helen Crombez (Exhibit 16), para 214

⁹³ Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5, paras 134-39

⁹⁴ O. Reg. 79/10, s 135

⁹⁵ Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5(iii), para 46; Inspection Report dated January 24, August 15, 2017 re Inspection No 2016_229213_0035 (Exhibit 56, LTCI00043372), pp 2-3

(b) October 6-7, 2007: An Internal Resident Incident Report was completed regarding an apparent medication error in relation to Clotilde Adriano, whose blood sugar was bottoming out overnight and she was admitted to hospital next day.⁹⁶ This should have been the subject of an unusual occurrence report as it concerned a medication incident leading to the hospitalization of a resident, but there was no evidence it was reported.

68. Both of these should have been reported to the Director under the Ministry's Program Standards Manual at the time, and were connected with EW's criminal offences. No conclusion can be made, however, as to what actions the LTC Inspections Branch might have taken had those incidents been reported.

69. There were further examples of non-reporting to the Director in respect of incidents involving EW at Meadow Park. These were all incidents in which EW had documented in progress notes allegations of suspected abuse. In each of the three incidents documented by EW, she indicated that management was aware of the incident. In one of these incidents, EW documented that she found Arpad Horvath tied to the bed rail by his jogging pant string, and that she had told the home's manager on call about the incident. The Director of Care acknowledged being aware of one of these incidents and believed a Critical Incident Report had been filed. The Administrator and Director of Care either could not recall or had no knowledge of the other two incidents and there were no records in relation to them other than EW's notes. In each of these three incidents, the suspicion of abuse of a resident should have been the subject of a mandatory report to the Director.⁹⁷

⁹⁶ Overview Report: The Facilities and Agencies (Exhibit 6), Volume 5(i), paras 44-47; Inspection Report dated January 24, August 15, 2017 re Inspection No 2016_229213_0035 (Exhibit 56, LTCI00043372), pp 3-4

⁹⁷ Affidavit of Natalie Moroney (Exhibit 142), para 31(b)

Incidents that were reported to the Director

70. One incident at Caressant Care – Woodstock that was reported to the Director involved an allegation by a resident (CH) that EW slapped her as the resident was attempting to leave the building late at night. The home investigated the incident. A few days later, the resident recanted this allegation, but after that she then phoned the Inspections Branch and reported that EW had slapped her. It was not until after this complaint, and a call from an inspector to the home, that the home completed a Critical Incident Report with the details of this incident.⁹⁸

71. The police were called about the incident and investigated. The last information provided to the Inspections Branch in the amended Critical Incident Report indicated that a meeting was held with the resident, her Power of Attorney and other family, EW, the Director of Nursing and the Administrator, and goals were set for the resident with her input. The resident then asked that the Ministry be asked not to conduct an inspection. Ultimately, the inspectors determined not to complete an inspection into this matter.⁹⁹ Ms. Simpson testified that, given the entire context of the situation and the information provided to the Inspections Branch in the Critical Incident Report, as it was amended, she understood the decision that was made not to conduct an inspection into this matter, but that each case has to be dealt with in its own unique circumstances.¹⁰⁰

72. Some incidents were reported to the Director, but reported incorrectly, or without complete information. One such report involved an alleged incident of resident to staff abuse, as reported by the home. The substance of the Critical Incident report was that a resident did not want EW to

⁹⁸ Critical Incident Report dated January 30, 2012, amended February 24, 2012, Overview Report: Ministry of Health and Long-Term Care (Exhibit 9, LTCI00059485)

⁹⁹ Inquiry/Intake Report dated January 24, 2012, amended March 1, 2012, Overview Report: Ministry of Health and Long-Term Care (Exhibit 9, LTCI00059320)

¹⁰⁰ Testimony of Karen Simpson, July 30, 2018, p 6146, 16 – p 6148, 122

be giving him medications, and he verbally threatened EW. The police were called and talked to the resident, the physician was also called, and the home investigated the incident.¹⁰¹

73. Because of the information contained in the Critical Incident report, this incident was reviewed by a triage inspector but not sent on for further inspection. Resident-to-staff abuse is not reportable under the LTCHA or Regulation, and there was no risk to residents identified in the report. The Critical Incident report contained information indicating that the home had taken steps to work with the resident to support him with his responsive behaviours.¹⁰²

74. Upon further review of EW's employment file during the inspections following EW's confession, Rhonda Kukoly, an inspector with the LTC Inspections Branch, later determined that there were two written complaints submitted by other staff members that indicated that EW addressed the resident in an inappropriate manner. The Director of Nursing was aware of the written complaints, and acknowledged that the way EW spoke to the resident was not acceptable. The home had reasonable grounds to suspect verbal abuse by EW, and failed to investigate this or take appropriate actions.¹⁰³ Had this information been included in the Critical Incident report that was submitted, the triage inspector may likely have made a different conclusion regarding the risk to the resident involved and would have sent this on for further inspection.

75. Another incident that was reported to the Director, but without complete information, involved the fall of a resident who was transferred to hospital. This was correctly reported as an

¹⁰¹ Critical Incident Report dated April 1, 2013, Exhibit C to Affidavit of Aislinn McNally (Exhibit 147, LTCI00043113)

¹⁰² Affidavit of Aislinn McNally (Exhibit 147), paras 55-56; Testimony of Karen Simpson, July 30, 2018, p 6150, 1 31 – p 6151, 1 25

¹⁰³ Inspection Report dated January 24, August 15, 2017 re Inspection No 2016_229213_0035 (Exhibit 56, LTCI00043372), pp 20-21

injury sustained by a resident for which the resident was taken to hospital.¹⁰⁴ What was missing from the Critical Incident Report was further contextual information contained in a complaint regarding the incident: another staff member reported to the home that EW had independently transferred that resident onto the bed after the fall, and then had lanced a hematoma on the resident using a pair of non-sterile scissors. The home undertook an internal investigation of the incident and gave a written warning to EW. The Director of Nursing acknowledged to Ministry inspectors that EW had not followed the home's policy and procedure after a fall, and had acted outside the scope of her practice as a registered nurse in lancing the hematoma. This was an incident of improper or incompetent care on the part of EW that should have been reported to the Director.¹⁰⁵

76. Two incidents connected to EW involving missing narcotics were correctly reported to the Director. The first was an incident of a missing 10 mg capsule of Kadian SR at Caressant Care – Woodstock, discovered to be missing during the narcotics count between shifts. This was reported to the Director, noting that EW believed she had given an extra dose to a resident in error. The Critical Incident Report indicated that the police were notified, the resident was not affected by the error, and the home sent a memo to all staff with corrective action. EW received a one-day suspension for the error.¹⁰⁶

77. This incident was not sent for inspection. Ms. Simpson testified that based on the information in the Critical Incident Report showing that that the resident was assessed and there was no adverse impact, that the home did an investigation and called the police, and also took

¹⁰⁴ Critical Incident Report dated January 13, 2012, Overview Report: Ministry of Health and Long-Term Care (Exhibit 9, LTCI00043110); O Reg 79/10, s 107(3)

¹⁰⁵ Inspection Report dated January 24, August 15, 2017 re Inspection No 2016_229213_0035 (Exhibit 56, LTCI00043372), pp 23-24

¹⁰⁶ Critical Incident Report dated March 14, 2013, Overview Report: Ministry of Health and Long-Term Care (Exhibit 9, LTCI00058984)

action to mitigate the risk going forward, she understood why the incident was not sent for inspection. In her view, the home had acted appropriately in response to this incident.¹⁰⁷

78. A final incident that was correctly reported to the Director involved an incident of a missing 1 mg card of Hydromorphone at Meadow Park.¹⁰⁸ A critical incident inspection was completed into this incident. During the inspection, the Director of Care and Administrator advised the inspector that they suspected EW had taken the missing narcotics. The Director of Care and Administrator also advised the inspector that EW had revealed she had overdosed on drugs after the narcotics went missing.¹⁰⁹

79. Ms. Kukoly conducted this inspection. She reviewed the home's policies related to ordering, receiving and storing controlled substances. She reviewed the relevant narcotics counts to determine whether they were being completed in accordance with the applicable policy. She ensured that the home had taken steps to confirm that the resident had not missed any medications and that the resident's pain was being addressed. She also noted that the home had contacted the police and the police had undertaken an investigation into the incident.¹¹⁰

80. The inspector made no findings of non-compliance on this inspection. The focus of the inspection was not to determine whether EW had committed the offence and had stolen the narcotics. Her focus was to determine whether the home's conduct surrounding the circumstances of the theft, the storage and counting of narcotics, and their response to the incident, were in compliance with the requirements of the LTCHA and Regulation. Her inspection provided her with evidence to confirm that the home's actions were in compliance.

¹⁰⁷ Testimony of Karen Simpson, July 30, 2018, p 6166, l 1 – p 6167, l 2; see also Affidavit of Aislinn McNally (Exhibit 147), paras 51-52. Note as well that EW

¹⁰⁸ A licensee shall ensure that the Director is informed of a missing or unaccounted for controlled substance: O Reg 79/10, s 107(3)

¹⁰⁹ Medication Inspection Protocol, Inspection No: 2014_229213_0072 (Exhibit 63), pp 3-5

¹¹⁰ Affidavit of Rhonda Kukoly (Exhibit 134), para 79

81. Prior to the home becoming aware that the Hydromorphone was missing, EW resigned from her position at Meadow Park, stating that she was unable to work as a registered nurse during or following treatment for an illness. Regarding the issue of acquiring information during an inspection that a registered nurse employed by a home may have addiction issues, or may have left their employment because of addiction issues, Ms. Kukoly testified that it is her normal practice to ask the home if they have advised the College of Nurses of this situation. This is not documented in her notes, so she assumes that she did not ask the home whether they had reported to the College in this instance.¹¹¹

Inspections following EW's confessions

82. After EW's confessions became known to the LTC Inspections Branch on October 5, 2016, the Director, Karen Simpson, directed that inspections be initiated immediately at Caressant Care – Woodstock, Meadow Park and Telfer Place.¹¹² Once the initial criminal charges against EW were publicly announced, on October 25, 2016, the inspectors could move ahead with their on-site inspections and interviews of home staff. They continued to coordinate with the police throughout the inspections so that they did nothing to jeopardize the police investigation and criminal prosecution.¹¹³

83. The EW inspections were different from the usual critical incident or complaint inspection. They lasted much longer than the normal inspection; inspectors were on-site at Caressant Care – Woodstock, for example, for six months. The focus was much broader than in a typical CCF inspection which is focused on the narrow issue that bring the inspectors into the home. In the

¹¹¹ Testimony of Rhonda Kukoly, August 1, 2018, p 6738, 130 – p 6739, 19. Note that there is no obligation to report the possible incapacity of a registered nurse to the College on anyone other than the facility operator. An employer has an additional obligation to report to the College the termination or intention to terminate the employment of a nurse for reasons of professional misconduct, incompetence or incapacity. See Mandatory Reporting: A process guide for employers, facility operators and nurses (Exhibit 25)

¹¹² Affidavit of Karen Simpson (Exhibit 129), para 139

¹¹³ Affidavit of Karen Simpson (Exhibit 129), paras 142-45

EW inspection, the inspectors were not just looking at the records involving EW but were also looking at the home's systems to determine if there were any current risks to residents. To that end, they reviewed medication systems, reporting and complaints, training and orientation, critical incident response and staffing issues.¹¹⁴

84. While the EW inspections at both Caressant Care – Woodstock and Meadow Park made several findings of non-compliance, the Compliance Orders issuing from these inspections were in respect of current significant deficiencies in each of the home's medication management systems. At Caressant Care – Woodstock, the inspectors issued two immediate Compliance Orders on January 24, 2017. These were issued in relation to the current large number of documented medication errors and medication management problems identified in the home.¹¹⁵ The home was eventually able to bring these Orders into compliance in late November 2017, after admissions were suspended and a mandatory management order was issued by the Director requiring the licensee to retain a management company to manage Caressant Care – Woodstock.¹¹⁶

85. At Meadow Park, the inspectors issued an immediate Compliance Order on February 6, 2017 based on current observations of multiple problems with the home's medication management system.¹¹⁷ Given the wide breadth of the deficiencies in the medication management system identified at Meadow Park (deficiencies in medication management policies and protocols, storage of drugs and control substances, security of the drug supply, proper administration of drugs), it was determined to issue one broad Order so that the licensee

¹¹⁴ Affidavit of Rhonda Kukoly (Exhibit 134), para 94

¹¹⁵ Affidavit of Rhonda Kukoly (Exhibit 134), para 110; Orders of the Inspector dated January 24, 2017, Overview Report: Ministry of Health and Long-Term Care (Exhibit 9, LTCI00043511)

¹¹⁶ Affidavit of Rhonda Kukoly (Exhibit 134), para 120; Suspension of Admissions to Caressant Care Woodstock Nursing Home dated January 25, 2017 (Exhibit 88); Order of the Director dated September 1, 2017 (Exhibit 87)

¹¹⁷ Affidavit of Natalie Moroney (Exhibit 142), para 31(h); Order of the Inspector dated February 6, 2017, Overview Report: Ministry of Health and Long-Term Care (Exhibit 9, LTCI00040984)

understood they would have to look to improve their entire medication management system to come into compliance.¹¹⁸

F. Conclusions regarding the Role of the Long-Term Care Inspections Branch

86. The LTCHA and the Regulation create a strong regulatory framework in which long-term care homes must operate to ensure the safety, security and quality care of residents. Long-term care homes have a responsibility to the residents in their care.

87. The LTC Inspections Branch has developed a comprehensive inspections regime to ensure compliance with the LTCHA and the Regulation. Inspectors attend at homes on an unannounced basis to conduct both reactive (CCF) and proactive (RQI) inspections. These inspections are guided by robust inspection tools such as Inspection Protocols that map the focus areas of the inspection to the requirements in the LTCHA and Regulation. The resident quality inspections are resident-focused, rely in Stage 1 on resident interviews and observations, along with other information collected by the inspectors, and are grounded in current and reliable health data through the RAI-MDS to identify relevant areas for inspection.

88. Despite these robust tools and the comprehensive nature of the inspections regime, the offences of EW did not come to light through ministry inspections over the years that she worked in long-term care. EW's colleagues, co-workers, and managers – those who worked closely with her on a daily basis – did not suspect she was committing the offences that are the subject of this Inquiry. The focus of the inspections regime is, under the LTCHA in particular, to ensure that the licensee is compliant with the standards of care and other requirements in the LTCHA and Regulation. The LTC Inspections Branch is focused on ensuring that the licensee operates the long-term care home to provide quality care in a safe environment for residents.

¹¹⁸ Affidavit of Karen Simpson (Exhibit 129), para 150; Affidavit of Natalie Moroney (Exhibit 142), para 31(h)

89. The detection of criminal actors in the system is best left to other bodies more suited to that role: the police (for criminal activity), the coroners (for investigation of causes of death), and the College of Nurses (for detecting registered nurses performing below the standards of their profession).

90. The LTC Inspections Branch can best work collaboratively with each of these partners, recognizing that its expertise is in ensuring that homes provide quality care in a safe environment for all residents in long-term care in accordance with the requirements in the legislation.

PART IV – HOME CARE

A. Publicly Funded Home Care in Ontario

91. Home care services are available both privately and publicly. Available publicly funded home care services are set out in the *Home Care and Community Services Act, 1994* and include nursing services and personal support services.¹¹⁹

92. Publicly funded home care is delivered by or on behalf of Local Health Integration Networks (LHINs), who took over this role in 2017 when the responsibilities of Community Care Access Centres (CCACs) were transferred to the LHINs. The CCACs, and now the LHINs, determine eligibility for publicly funded home care. Where a patient is eligible for one or more services that a LHIN is approved to provide, the LHIN develops a plan of care for the patient based on a clinical needs assessment. Other community support service agencies also receive funds from the government to provide the community services they are approved to provide under the *Home Care and Community Services Act, 1994*, but home care services are those suite of services that the LHINs are approved to provide.

¹¹⁹ For a full description of publicly funded home care services, see the Affidavit of Donna Ladouceur, paras. 11-12.

93. Generally, patients receive home care services in their homes, where they live independently or with the assistance of caregivers.¹²⁰ Clinical needs vary widely. Publicly funded home care patients include those who are “short-stay” and will likely be discharged within a few months of being referred for services. There is also a group of “chronic” patients who have stable conditions that require longer term services. These could be patients with multiple co-morbidities, which require care over several years. There are also “complex” patients, whose conditions are less stable, such as palliative care patients, or patients who are dependent on a ventilator.

94. The majority of patients are short-stay: approximately 60% of patients in the South West LHIN are discharged within three months.¹²¹ Of the long-stay patients, however, the complexity of need is increasing. Of the adult long-stay population in Ontario, the percent of patients with high care needs has gone from approximately 35% in 2007/08 to 74% in 2015/16.¹²² This can include patients who have high nursing care needs, high PSW care needs, or both.¹²³ According to Donna Ladouceur, there is an increase in the number of patients with dementia who are staying in their homes, who then receive home care services, e.g. a patient with dementia has a hip replacement, and requires nursing for wound care upon discharge to her home.

95. Most referrals received by CCACs/LHINs come from hospitals – in the South West LHIN that is an estimated 35% - 40%. The majority of home care services provided are personal support services by personal support workers (PSWs). The nursing services provided generally fall into two categories: visiting nursing and shift nursing. Visiting nurses are usually in a

¹²⁰ In these submissions, “caregiver” is used in the same manner as it is defined in the Services Schedule to the contracts with SPOs, to mean “any individual who is responsible for the care of a Patient and who provides care to the Patient without remuneration, and includes the Patient’s substitute decision-maker as defined the *Home Care and Community Services Act*.”

¹²¹ Testimony of Donna Ladouceur, August 8, 2018, p 7649, ll 23-29

¹²² Exhibit G to the Affidavit of Donna Ladouceur (Exhibit 160, LTCI00072876-3)

¹²³ Testimony of Donna Ladouceur, August 8, 2018, p 7655, ll 1-20

patient's home for a short period, averaging about an hour, during which time the nurse completes specific clinical tasks pursuant to the care plan. More complex patients may require shift nursing, where a nurse is in the home for four or eight hours, and may involve monitoring pain control and symptom management in addition to specific clinical tasks. The chart below from Health Shared Services Ontario¹²⁴ provides statistics for all publicly funded home care services provided by CCACs/LHINs in Ontario, measured in either hours of service or visits made:

Number of publicly funded services

Service	Quantity (Visits / Hours) FY 2015-2016	Quantity (Visits / Hours) FY 2016-2017
Personal Support - Hours	28,694,262	29,688,288
Nursing - Visits	6,964,017	7,276,301
Nursing Shift - Hours	2,102,683	2,191,723
Physiotherapy - Visits	850,000	760,570
Occupational Therapy - Visits	575,852	608,132
Speech Language Therapy - Visits	267,231	284,940

96. Home care patients generally manage their own medications. This means that the patient is responsible for obtaining, storing, and disposing of their own medications. An individual patient chooses the pharmacy they use, decides where in their own home they will store their own medications, and determines how and where they will dispose of medications. Generally, they also self-administer medication, as autonomous individuals.

97. Only a minority of patients receiving nursing services would have a nursing service provider who administers the patient's medication, and these would be commonly intravenous (IV) antibiotics and injectable pain medication for palliative patients. In most cases, the nurse would be instructing the patient or caregiver on how to administer the IV or injectable medication, so

¹²⁴ Exhibit G to the Affidavit of Donna Ladouceur (Exhibit 160, LTCI00072876-2)

they could take over medication management. With respect to insulin, home care patients are generally responsible for administering their own insulin. Nurses may teach the patient, or may support teaching that started in a diabetic clinic at the hospital, with the goal of returning the patient to independent medication delivery.¹²⁵

B. Delivery of Publicly Funded Home Care in Ontario

98. As noted above, publicly funded home care in Ontario is delivered by or on behalf of LHINs. LHINs are Crown agencies that plan, integrate, and fund health services at a regional level. This can include acute care at hospitals, long-term care at long-term care homes, home care, and community care. There are 14 LHINs in Ontario, and each is governed independently by its own board of directors. LHINs are funded by the MHLTC, and each LHIN has a Memorandum of Understanding (MOU) and an Accountability Agreement (MLAA) with the MHLTC. The MLAA sets out performance goals and objectives for the LHIN and the local health care system, including performance standards and reporting requirements. LHINs share information and coordinate work provincially through meetings of senior leadership and with the MHLTC on a regular basis.

99. LHINs use funding provided by the MHLTC to provide or arrange for the provision of home care services through contracted service provider organizations (SPOs). A patient's plan of care is determined, as set out above, according to a clinical needs assessment, completed by CCAC, now LHIN, care coordinators, who are generally registered health professionals. The plan of care is then carried out by staff of the SPO who are contracted to provide the service. The LHINs use a template Services Agreement with their SPOs. Each LHIN modifies the template specific to the SPO and the LHIN's special conditions.

¹²⁵ Transcript of the examination of Donna Ladouceur, August 8, 2018, pp 7691-7694

100. The Service Agreements between the LHINs and SPOs contain specific requirements and obligations that SPOs must fulfill. For example, with respect to nursing services, SPOs must: provide qualified nurses registered with the College of Nurses of Ontario;¹²⁶ ensure nursing staff are screened, including requiring a police records check;¹²⁷ ensure nurses are provided with required orientation, education, and training;¹²⁸ ensure their nursing staff have the clinical expertise and resources available to provide a broad range of general nursing clinical treatments, including managing hyperglycemia and hypoglycemia, monitoring blood glucose levels, and administering a range of medications, including medications administered by injection or IV.¹²⁹

101. SPOs must also retain supervisors for nursing and other staff, as well as perform regular evaluations of the performance and competency of staff.¹³⁰ Donna Ladouceur, Vice President of Home and Community Care of the South West LHIN, testified that SPO nursing supervisors in the South West area use visits, ride-alongs, and preceptors to fulfill these requirements.¹³¹

102. In addition to required reports on the services provided to individual patients, SPOs must report risk events as defined in the agreement¹³², and according to the LHIN's policy and procedures. SPOs must also have a Patient Satisfaction Monitoring System, an internal Risk Management Program, and a Quality Management Program.¹³³

103. In terms of reporting events, in the South West LHIN, SPOs are required to enter risk events and adverse events into the LHIN's Event Tracking Management System (ETMS). This system

¹²⁶ General Conditions, s 3.3(1) (Exhibit A to the Affidavit of Donna Ladouceur, Exhibit 160, LTCI 00069216-25) and Special Conditions (Exhibit B to the Affidavit of Donna Ladouceur, LTCI 00069220-11)

¹²⁷ Nurses Services Schedule s 7.4(1) (Exhibit A to the Affidavit of Donna Ladouceur, LTCI 00069216-157, -158)

¹²⁸ Nurses Services Schedule s 7.4(1) (Exhibit A to the Affidavit of Donna Ladouceur, LTCI 00069216-157, -158)

¹²⁹ Nurses Services Schedule s 3.3.1 (Exhibit A to the Affidavit of Donna Ladouceur, LTCI 00069216-133 - 139)

¹³⁰ Nurses Services Schedule s 3.2.2 and 7.4 (Exhibit A to the Affidavit of Donna Ladouceur, LTCI 00069216-133 and -157-158); Special Conditions (Exhibit B to the Affidavit of Donna Ladouceur, LTCI 00069220-13)

¹³¹ Testimony of Donna Ladouceur, August 8, 2018, pp 7695-7696 and 7700-7701

¹³² Nurses Services Schedule s 5.5 (Exhibit A to the Affidavit of Donna Ladouceur, LTCI 00069216-149 - 151)

¹³³ Nurses Services Schedule ss 7.1-7.3 (Exhibit A to the Affidavit of Donna Ladouceur, LTCI 00069216-153 - 157)

is also used internally by the LHIN to track complaints and events it becomes aware of. The LHIN staff track and trend the complaints and incidents recorded in the ETMS to identify issues that require response by the LHIN or SPOs. As set out in the affidavit of Steven Carswell, Director of Quality for the South West LHIN, complaints from patients about home care services can be made by the patient or the caregiver to the SPO, or to the LHIN. Within the LHIN, the patient's main point of contact is the care coordinator, but patients can also seek assistance through the Long-Term Care Action Line, the Provincial Patient Ombudsman, or through the LHIN's patient relations advisors. It is common for care coordinators to resolve minor issues directly, and more serious complaints are escalated within the LHIN to be addressed. In some cases, the LHIN may conduct a root cause analysis to identify the underlying cause and appropriate solutions to an issue that arises in the delivery of care.

104. LHINs monitor and manage the performance of SPOs using a variety of tools. SPOs report on a number of performance indicators and provide other reports on issues related to performance, such as rates of adverse events, the number and types of client and caregiver complaints, and the results of the patient satisfaction surveys completed by the LHINs. The LHINs carry out quarterly performance reviews with all SPOs to review these performance indicators and identify emerging issues.¹³⁴ At the quarterly meetings, the LHIN staff will include a discussion of the LHIN's internal information on risk events and adverse events reported to the LHIN about the SPO's services, as well as its own patient satisfaction information. As raised during the public hearings, the South West LHIN is already exploring ways to formalize its use of auditing powers in the SPO contracts.

¹³⁴ Affidavit of Steven Carswell, Exhibit 161, paras 56-60

105. Where issues arise with SPO performance, the LHINs have informal and formal means to address the issues, from meeting with the SPO to discuss the problem, to issuing Quality Improvement Notices, to reducing market share and terminating service agreements.¹³⁵ The LHIN also has the ability to require an SPO to stop an individual SPO staff person from providing services where there is reasonable cause to be dissatisfied with her or his performance. Likewise, while an SPO may subcontract the provision of services, the LHIN can refuse to permit a particular subcontractor where there are grounds to do so.¹³⁶

106. In the case of EW, she was an employee of an SPO, St. Elizabeth Health Care. During the short period she worked for St. Elizabeth providing nursing services, no complaints were received about her from patients, their caregivers, or any other person. Her attempted murder of one South West LHIN client only came to light through her confession. The South West LHIN, upon learning of the confession from St. Elizabeth, did a thorough review of the files of all patients who had received service from her, and found no record of any complaints or concerns about the care provided. During the course of the public inquiry, the South West LHIN became aware that EW had made an unauthorized entry into the home of another patient, and as a result the South West LHIN is making inquiries with St. Elizabeth as to how this incident was not reported to the South West LHIN as it should have been.

C. Conclusions and Key Considerations for Policy Phase of the Public Inquiry

107. The Commission heard evidence from two witnesses from the South West LHIN, including suggestions for areas to explore for potential recommendations, such as reviewing contract and performance management practices. However, while the 14 LHINs shares a common model for

¹³⁵ Affidavit of Steven Carswell, Exhibit 161, paras 61-74.

¹³⁶ General conditions, ss. 3.2 and 3.3, LTCI00069216-24 through -26

home care and use the same template agreements, each LHIN serves a different community and may have different practices. In addition, the overall policy for publicly funded home care is set by the Home Care Division at the MHLTC. As a result, to develop useful and responsive recommendations, the experiences of each of these participants in the publicly funded home care system need to be gathered and considered. In lieu of specific recommendations, the MHLTC and LHINs have provided the factors regarding home care as set out in paragraphs 107 to 112 above that will be valuable in moving forward with the remaining steps of the public inquiry.

108. Home care is, as the name suggests, provided in individual patient homes. This has several implications. First, the fact that home care is provided for specific services in a patient's home means that, unlike in an institutional setting, the patient is responsible and accountable for the management of the environment in which they live, rather than the service provider. In an institutional setting, such as long-term care homes or hospitals, the patient total care needs are taken over by the facility, and the facility's staff provides for virtually all of the patient's needs 24 hours per day. By contrast, home care service providers are present in the home for only a short period, perhaps up to four hours a day at maximum, usually providing a specific service such as wound care. As explained by Donna Ladouceur,

When you go into a hospital you or you go into a long-term care home you're handing over your meal delivery, your medication delivery, your physio, all of your social activities are handed over to someone else to manage. Where in as a home you remain very much in control or your family along with supporting you. You remain very much in control of your circumstances.¹³⁷

109. Second, delivering health care in individual patient homes means that SPO staff members are generally working independently and at a distance from other health workers. While a

¹³⁷ Testimony of Donna Ladouceur, August 8, 2018, p 7644, ll 18-26

complex home care patient may have multiple members of a health care team visiting the home at different times, generally each health care professional is delivering care alone. The South West LHIN has pioneered the use of technology to provide remote supervision and back-up, but the SPO workers are still in a patient's home without other SPO workers present. At the same time, professional services, including nursing services, are provided by regulated health professionals who are governed by their respective health professional colleges.

110. Third, institutional settings are small in number. For example, there are approximately 630 long-term care homes in Ontario where care is delivered to residents. By contrast, in the South West LHIN alone, there could be 20,000 individual patients being served in their individual homes on a daily basis, in every corner of the catchment area from the shores of Lake Erie in the south to the top of the Bruce Peninsula. The geography of northern LHIN service areas present additional realities that must be considered.

111. Home care is also provided to individuals who are capable of remaining in their homes, either independently or with the assistance of caregivers. As set out above, the majority of home care patients are short-stay patients, and likely receive a discrete service related to a particular medical issue, such as wound care arising out of a surgery. Among the long-stay population, patients are still, by definition, sufficiently resourced to be able to remain in their homes. By contrast, residents of long-term care homes are less able to address their health needs and/or do not have caregivers to assist them.

112. It is notable that 50 percent of complaints and risk events reported to the South West LHIN related to home care come from patients and their caregivers. Only 25 percent come from the

SPOs.¹³⁸ Other sources of complaints related to home care, include family, friends, and other members of the health system such as physicians or hospital staff, By contrast, in long-term care homes, the number of complaints from all sources made to the MHLTC inspections branch is dwarfed by the number of critical incidents reported by the homes themselves.¹³⁹ This difference may be, in part, a reflection of the fact that home care patients and their caregivers are generally in a better position to advocate for themselves than residents in long-term care homes.

113. Finally, as noted above, home care can be provided privately, through insurance benefits, or purchased directly by patients and their caregivers. Outside of the schemes for regulating health professionals such as nurses, private home care is not subject to regulatory oversight. In addition, privately funded home care is not delivered by or on behalf of LHINs and is not subject to oversight by the LHINs.

114. With these factors in mind, the MHLTC, which sets policy for publicly funded home care, and the LHINs, which implement the policy and integrate local health services generally, welcome the opportunity during the policy consultations of this inquiry to explore mechanisms to improve quality of care and oversight of SPO care delivery in patients' homes across the province.

¹³⁸ Testimony of Steven Carswell, pp 7899-7900

¹³⁹ See Graphs 6 and 14, MHLTC Overview Report Volume 6A. Graph 6 indicates that the maximum number of Critical Incidents received in a full calendar year ranged from a low of about 13,000 in 2014 to a high of was just below 18,000 in 2012. Graph 14 indicates that the maximum number of complaints from all sources received in a full calendar year ranged from a low of about 2,750 in 2012 to a high of was just over 4,000 in 2016

PART V – RECOMMENDATIONS

115. The MHLTC offers the following both as possible recommendations and considerations to take into account in creating opportunities for improvement in the long-term care sector. These recommendations are intended to help this Commission fulfill its mandate to identify and make recommendations to address systemic failings in Ontario's long-term care homes system that may have occurred in connection with the Offences.

A. Recommendations related to Better Detection of Concerns in Long-Term Care

Education and Awareness

- **Recommendation 1:** Ministry to provide homes with staff educational materials and tools related to all mandatory reporting requirements contained in the *Long-Term Care Homes Act, 2007* (LTCHA) and O. Reg. 79/10, and develop a learning framework for homes to use with their staff to ensure understanding.
 - Public hearings highlighted that there are multiple mandatory reporting requirements and there is a need to enhance staff understanding of reporting obligations.
 - The Ministry can provide materials in a variety of formats (e.g., memos, webinars, and presentations at sector association conventions).
- **Recommendation 2:** Ministry to expand the routes through which the public can report concerns/complaints related to homes, including anonymously, to the ministry.
 - The ministry has established a dedicated LTC Action Line for the public to report complaints/concerns related to LTC. Additional reporting vehicles would be created (e.g., dedicated web portal, email etc.).

- Inspections related to abuse/care issues may be bundled, specifically for those requesting anonymity, with other inspection intakes to ensure confidentiality and reduce fear of retribution.
- **Recommendation 3:** Ministry to create broader public awareness of zero tolerance of abuse and neglect to inform anyone to report incidences of abuse.
 - Launch a communications strategy (posters, inserts for placement kits) that reinforces government's commitment to safety and security in homes and makes interested parties aware of reportable incidents and how to report. Work with sector and professional associations/organizations to develop and deliver materials.
 - Make materials available in homes for staff, residents, and families. Materials to be included in the admission package for residents/families.

Oversight

- **Recommendation 4:** Ministry to work with health regulatory colleges, including the College of Nurses of Ontario, to strengthen their ability to act in the public interest. This includes but is not limited to:
 - Implementing a common risk of harm framework for oversight of their members;
 - Establishing a formal mechanism for the sharing of information between the MHLTC and the health regulatory colleges related to the competence of members who pose a risk of harm so that the parties can take appropriate action;
 - Ensuring that any terms, conditions, limitations and restrictions on certificates of registration are comprehensive and transparent to employers, patients and the public and are kept up to date; and

- Enhancing policies, procedures and practices to ensure effective resolution of complaints in a timely manner.

Collaboration with Stakeholders:

- **Recommendation 5:** Ministry to assist Coroner in development of a tool that examines death data to identify abnormal trends.
 - Could be used by Coroner to identify homes that need investigation.
- **Recommendation 6:** Ministry to refine the risk assessment framework to weight critical incidents more heavily and include additional variables such as all publicly reported Health Quality Ontario (HQP) indicators.

Inspections

- **Recommendation 7:** Ministry to strengthen LTC home inspections by integrating abuse and neglect questions into every inspection. This may be achieved by:
 - Enhancing inspection process and tools to include added focus on abuse and neglect.
 - Educating all LTC inspectors on the changes.
 - Communicating updated practice to the sector.
- **Recommendation 8:** The Ministry will increase its focus on Critical Incidents (CIs) and ‘high-risk’ complaints. (Note: High-risk denotes areas directly impacting resident care). This may be achieved by:
 - Strengthening the program’s risk-focused approach to improve prioritization of complaint and critical incident inspections.

- Updating intake processes and systems to automate monitoring for high-risk trends.

Sharing of Information with Other Oversight Entities:

- **Recommendation 9:** Ministry to co-design with the Office of the Chief Coroner (OCC) a formal mechanism for inspectors to report deaths as required under section 10 (1) of the *Coroners Act*.
 - Public Hearings identified that every person (including ministry inspectors) has a requirement to report these deaths.
 - Currently, there is an informal process that inspectors follow. The Ministry, through training, would reinforce obligation on inspectors to make reports to the coroner.
 - The mechanism could be a best practice or Memorandum of Understanding (MoU).

B. Recommendations related to Deterrence

Education and Awareness

- **Recommendation 1:** Ministry to establish a stakeholder working group to design a curriculum and learning approach to educate the various disciplines within LTC on the legislative/regulatory requirements that each discipline must know.
 - This involves developing a framework to identify staff learning needs to target training.
 - Public Hearings highlighted the benefit of support to understand legislative/regulatory requirements.

- This would improve compliance with LTCHA requirements and could result in better inspection outcomes, improved LTC home performance scores, and potentially reduce public concerns and complaints about LTC.
- **Recommendation 2:** Ministry to expand LTC frontline staff clinical education and training in gerontology/elder care through the Centres for Learning, Research and Innovation (CLRIs).
 - Work with CLRIs on additional curriculum development and delivery (e.g., online modules, webinars, in-class training etc.).

Collaboration with Stakeholders

- **Recommendation 3:** Work directly with the Office of the Chief Coroner (OCC) and College of Nurses of Ontario (CNO) to provide education to LTC staff on the mandatory reporting obligations under s.10 (1) of the *Coroners Act* and mandatory reporting requirements to the CNO pursuant to the *Regulated Health Professions Act, 1991*.
- **Recommendation 4:** Work directly with developers of curricula for LTC Administrators (such as AdvantAge Ontario, Canadian Health Care Executives) to ensure inclusion of information on all relevant aspects of quality leadership in LTC home operations (e.g., legislative requirements, human resources, labour relations); and, consider expanding the course to include Directors of Care.
- **Recommendation 5:** Engage with Treasury Board Secretariat experts on labour relations and health care sector unions to determine the conditions/parameters that would mean the union would not defend a member's position that s/he should be able to continue to be employed within the LTC home.

- Employers and unions both have a responsibility to address fairly and with due consideration to the law, performance related matters. Through the hearings it was noted that settlements had been agreed to despite on-going and recurring performance issues in high-risk areas.

Medication Management

- **Recommendation 6:** Ministry to establish a stakeholder working group to develop recommendations for safe medication practice.
 - Engage with sector stakeholders (e.g., College of Nurses of Ontario (CNO), Institute for Safe Medication Practices (ISMP), Ontario Pharmacists Association (OPA)) to support the development and implementation of a Best Practice Guideline (BPG) for the control, usage, and tracking of insulin, including an audit mechanism for insulin and high alert medication in LTC, to ensure consistent practice across the sector (e.g., medication safety self-assessments from ISMP, Canadian Incident Analysis Framework from ISMP) .
 - The working group would explore the use of technology and innovation (e.g., medication cabinets, barcodes on medication packages, medication reconciliation processes).

Stronger Enforcement

- **Recommendation 7:** Ministry to strengthen enforcement actions for high-risk non-compliances¹⁴⁰ by:
 - Instituting early escalation of enforcement actions for poor performing homes. This will include increasing the use of cease of admissions and mandatory management orders.

¹⁴⁰ High-risk denotes areas directly impacting resident care

- **Recommendation 8:** Ministry to explore implementation of a dedicated team of investigators to investigate offences under the LTCHA and O. Reg. 79/10.
 - There are a number of offence provisions in the Long Term Care Homes Act.
 - A dedicated team, comprised of a subset of the current complement of inspectors and trained in investigative techniques, would target offences where prosecution may be required.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

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