PUBLIC INQUIRY INTO THE SAFETY AND SECURITY OF RESIDENTS IN THE LONG-TERM CARE HOMES SYSTEM

CLOSING SUBMISSIONS OF THE ONTARIO LONG TERM CARE ASSOCIATION

Pursuant to Rule 68 of the
Rules of Procedure for the Public Hearings

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OVERVIEW

1. The Ontario Long Term Care Association (the "**OLTCA**") is the largest association of long-term care providers in Canada. It is the only association in Ontario that represents all of the various types of long-term care homes, including private, not-for-profit, charitable and municipal homes. The OLTCA represents nearly 70% of Ontario's 628 long-term care homes, located in communities across the province. Its member homes provide care and accommodation services to more than 70,000 residents annually.

2. The OLTCA is not a regulatory body which governs or sets the standards for the long-term care sector. Rather, on behalf of its member homes, the OLTCA seeks to advance the quality of long-term care services in Ontario by, among other things, influencing legislative policy and regulatory change, supporting sector expansion and redevelopment, and providing educational opportunities to its members so as to ensure the increasing needs of residents are being met with safe, high-quality care.

3. Throughout the course of the evidence that was tendered during the public hearing portion of the Inquiry, witnesses identified various challenges faced by the long-term care sector which contributed to the occurrence of the offences committed by Ms. Wettlaufer. The focus of the OLTCA's Closing Submissions will be on proposing recommendations to address certain of these challenges with a view to avoiding the recurrence of any future similar offences.

PROPOSED RECOMMENDATIONS FOR THE COMMISSION TO CONSIDER

A. Addressing Long-Term Home Care Staffing Concerns

4. There are two inter-related concerns relating to the staffing of registered nurses in long-term care homes which, together, contributed to the ability of Ms. Wettlaufer to intentionally kill or harm long-term care home residents without detection over many years.

5. First, there is a shortage of registered nurses ("**RNs**") in Ontario's long-term care sector. A number of witnesses during the public hearing phase of the Inquiry attested to the fact that this has been a concern for some time and continues to be a significant problem.[1] This shortage is due to several factors, including: a large number of RNs are of retirement age and are exiting the profession; RNs are often able to secure higher-paying jobs in hospitals; and there are significant work environment demands on nurses in long-term care homes.[2] The nature of the work in long-term care is more onerous than in other healthcare settings primarily due to: the large number of residents assigned to each RN; the increased emotional and physical demands that are often required by residents of long-term care homes; and the considerable amount of paperwork and ongoing assessments required pursuant to the *Long-Term Care Homes Act, 2007* and Ontario Regulation 79/10 (the "**Regulation**").[3]

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[1] Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at paras. 15 and 20-23; Exhibit 10, Affidavit of Brenda Van Quaethem sworn June 4, 2018 at paras. 21-22; Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", paras. 34-35.

[2] Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", para. 34; Exhibit 10, Affidavit of Brenda Van Quaethem sworn June 4, 2018 at para. 22; Dian Shannon Transcript (June 26, 2018), p.3525, line 31 – p.3526, line 27 and p.3592, line 8 – p.3594, line 5.

[3] Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", para. 34; Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at paras. 15 and 21-22; Exhibit 33, Affidavit of Karen Routledge sworn June 10, 2018 at paras. 5-9; Dianne Beauregard Transcript (June 25, 2018), p.3340, line 18 – p.3341, line 19.

6. This shortage of RNs results in further over-burdening already hardworking nursing staff (not only RNs, but also Registered Practical Nurses ("**RPNs**") and Personal Support Workers ("**PSWs**")) who are tasked with providing care to an increasing number of residents who require intensive and medically complex care. This creates a self-perpetuating spiral.

7. Second, the *Long-Term Care Homes Act, 2007* requires that all long-term care homes have an RN who is both an employee of the licensee and a member of the regular nursing staff present in the home at all times.[4] Moreover, Bill 160 "Strengthening Quality and Accountability for Patients Act" will amend the *Long-Term Care Homes Act, 2007* to, among other things, establish significant administrative monetary penalties for long-term care homes that are unable to fulfill this continuous on-site RN nursing care requirement. Many homes have a difficult time complying with this requirement[5] and this requirement has the undesired effect of making long-term care home operators desperate for registered nurses, especially nurses who are willing to work less desirable evening or night shifts, like Ms. Wettlaufer.[6] This concern is particularly acute in rural and remote areas where the supply of qualified nursing staff is more limited than in urban areas.

8. In contrast to the shortage of RNs in long-term care, there is a sufficient supply of RPNs in Ontario. In fact, RPNs generally seek employment in the long-term care sector because they are more able to work to their full scope of practice. While, as a result of differing nursing

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[4] Section 8(3) of the *Long-Term Care Homes Act, 2007*. There are exceptions identified in section 45 of the Regulation which set out the circumstances in which a home may use an RN from an agency to fulfill this requirement. There are no circumstances, however, in which an RPN is able to fulfill this requirement or in which an RN need not be physically present in the home.

[5] The failure to fulfill the 24/7 RN requirement is on the 2017/2018 "top ten list" of non-compliances – Exhibit 131 (p.6)

[6] Exhibit 10, Affidavit of Brenda Van Quaethem sworn June 4, 2018 at para. 42.

education requirements, RNs and RPNs have varying levels of autonomous practice within a long-term care home, there is in fact not much difference between the tasks undertaken by RNs and RPNs.[7] Despite the willingness and competency of RPNs to work in long-term care homes, RPNs are, in some respects, underutilized as a result of the requirement that homes have an RN present in the home 24 hours each day. This is because long-term care homes will presumably initially devote their nursing budget to hiring RNs so as to ensure that they are on-side the *Long-Term Care Homes Act, 2007*, with the result being that some long-term care homes might not have additional funding to hire RPNs, or to hire the ideal mix of RNs and RPNs.

9. A number of witnesses during the public hearings phase of the inquiry acknowledged that while the level of resident acuity in long-term care has generally increased over the years, the particular needs of each resident, and the manner in which each long-term care home staffs its home based on the specific needs of their residents, will vary. Whether an RPN or an RN is best-suited to address the care needs of residents in a particular long-term care home will depend upon a number of factors, including the complexity of each resident's condition, the predictability and risk of negative outcomes, the predictability and stability of the environment and the resources available to nurses.[8] As acknowledged by Anne Coghlan, the Executive Director and CEO of the College of Nurses of Ontario (the "**College**"): "there is no one-size fits all guideline for staffing."[9] Despite this, all homes are required to comply with the 24/7 RN

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[7] Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at para. 24.

[8] Exhibit 121, Affidavit of Anne Coghlan sworn July 3, 2018 at para. 12; Anne Coghlan Transcript (July 26, 2018), p. 5806, line 18 – p.5808, line 4; p.5811, line 20 – p.5812, line 3; Karen Simpson Transcript (July 31, 2018), p.6581, lines 15-26; Exhibit 31, *College of Nurses of Ontario Practice Guideline: RN and RPN Practice*; LTCI00071030, *It's All About Synergies. Understanding the Role of the Registered Practical Nurse in Ontario's Health Care System*, p.29-34.

[9] Anne Coghlan Transcript (July 26, 2018), p. 5808, lines 1-4.

requirement regardless of the particular needs of the residents in a given home and regardless of whether an RPN might be best-suited (or equally-suited) for those residents.[10]

10. These staffing difficulties are widespread in the long-term care sector and are not just experienced by the particular homes that were involved in the Wettlaufer offences. In February 2018, the OLTCA conducted a survey of its members to understand the human resources concerns that were plaguing the homes.[11] Based on the 198 long-term care homes in Ontario that responded to the survey, the OLTCA found, among other things:

(a) the top human resources issues that long-term care homes were facing were with respect to the recruitment of staff, retention of staff, lack of funding to hire staff and inability to meet staffing regulatory requirements (i.e.: the 24/7 RN requirement);

(b) long-term care homes have the most difficulty filling evening shifts on the weekends;

(c) smaller homes have a harder time fulfilling the 24/7 RN requirement;

(d) the vast majority of homes have difficulty recruiting RNs (82.1% of responses received); and

(e) the top two reasons that homes believed they had difficulties recruiting and retaining nursing staff were that the workload demand on staff was too high and

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[10] Anne Coghlan Transcript (July 26, 2018), p. 5812, lines 4-19; Karen Simpson Transcript (July 31, 2018), p.6580, line 153 – p.6581, line 26.

[11] LTCI00070845, OLTCA Member Survey Human Resources (February 2018).

that the salary and benefits in long-term care were not competitive with other healthcare service providers.

11. Given the difficulties in recruiting and retaining staff in long-term care homes, the Commission ought to, when considering the recommendations proposed by the OLTCA and other participants, be cognizant of the fact that long term care homes are already heavily regulated (as was acknowledged by Karen Simpson, the former Director of the Long-Term Care Inspections Branch of the Ministry of Health and Long-Term Care)[12] and that there is a need to avoid further deterring qualified nursing and other professionals from seeking employment in the long-term care sector.

Recommendations

12. The OLTCA puts forth the following recommendations as potential ways of addressing the staffing concerns experienced by long-term care homes which contributed to the occurrence of the Wettlaufer offences:

(a) Increase funding to the Nursing and Personal Care envelope so as to enable long-term care homes to:

(i) hire additional RNs, RPNs and PSWs. As acknowledged by Karen Simpson, this will serve to alleviate the workload currently experienced by nursing staff as "more staff will always be helpful in long-term care".[13] This will also enable homes to strengthen the skill mix of nursing care

[12] Karen Simpson Transcript (July 31, 2018), p.6395, lines 8-14.

[13] Karen Simpson Transcript (July 31, 2018) at p.6578, lines 14-20.

teams to enhance direct care hours to residents during every shift so that there is not only one staff member caring for each patient. Ms. Crombez, the Director Nursing at Caressant Care, noted that having more nursing staff, more PSWs and more supervisory staff on each shift may have helped prevent some of the offences committed by Ms. Wettlaufer.[14]

(ii) increase the salaries and benefits for RNs and RPNs, which will attract more nurses to seek employment in the long-term care sector, including nurses working evening or night shifts.

(b) Expand the 24/7 requirement in section 8(3) of the *Long-Term Care Homes Act, 2007* to also include RPNs in appropriate circumstances, based on resident care needs, as assessed by the medical and nursing staff in the home.[15] This would permit flexibility in the utilization of staff in long-term care homes and recognize the ability of RPNs to work their full scope of practice. Indeed, this amendment would be consistent with the *Nursing Homes Act* as it existed prior to February 1, 2005.[16]

(c) As an alternative to recommendation (b) above, amend section 8(3) of the *Long-Term Care Homes Act, 2007* to provide that where at least one RPN is present in a

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[14] Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at para. 229.

[15] The OLTCA acknowledges that there may be instances where the resident care needs in a particular home are such that the requirement in section 8(3) of the *Long-Term Care Homes Act, 2007* can only be fulfilled by an RN.

[16] Prior to February 1, 2005, section 59(1) of Reg. 832 under the *Nursing Homes Act* required that: "a licensee of a nursing home shall ensure that twenty-four hour nursing service is available in the home." This requirement was not limited to just RNs, but included RPNs as well. As of February 1, 2005, the Regulation was amended to add section 59 (1.1) which provided as follows: "The licensee of a nursing home shall ensure that at least one registered nurse who is a member of the regular nursing staff of the home is on duty and present in the home at all times."

home and where the care needs of the residents do not require that an RN be physically present in the home, the RN that is required under that section need not be physically present in the home, but instead, be remotely available.

(d) Allow homes to have more flexibility in how to apply funding in the Nursing and Personal Care envelope. For example, as noted by the OLTCA in *This is Long Term Care 2018* (an annual report produced by the OLTCA to provide an overview of statistics and trends in the long-term care sector), long-term care homes should be permitted to use a portion of the nursing envelope funds to hire health care aides, porters and nursing attendants (and not just RNs, RPNs and PSWs) so as to allow RNs, RPNs and PSWs to be more focused on providing care to complex and frail residents.[17]

(e) Require the College and the Ontario Nurses' Association ("**ONA**") to offer nurses employee assistance programs (EAPs) so that they can receive counselling for personal, emotional and/or mental health issues.[18]

(f) Transfer certain administrative functions related to medication reconciliation and medication management from nursing staff to pharmacy technicians so as to provide nursing staff more time to care for residents. As noted by Julie Greenall, Director of Projects and Education with ISMP Canada, pharmacy technicians ought to be able to assist nursing staff in medication management activities, such

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[17] LTCI00070835, *This is Long Term Care 2018,* p.5.

[18] This would be distinct from the College's forthcoming Nurses' Health Program which is a program to divert eligible nurses who would otherwise be found to be incapacitated out of the College's formal Fitness to Practice proceedings.

as medication ordering, receiving and inventory management, all of which are currently performed by nursing staff and which occupies time that they would otherwise be spending on direct resident care.[19]

B. Improving the College's Disciplinary Process

13. The OLTCA believes that one of the factors that contributed to Ms. Wettlaufer's ability to continue to harm patients (particularly following her termination from Caressant Care) was the nature of the College's disciplinary process and intake review of reports from employers.

14. As acknowledged by Ms. Coghlan, the College was aware of a variety of medication errors that Ms. Wettlaufer committed while at Caressant Care, which demonstrated to the College that Ms. Wettlaufer was practicing below the College's Standards of Practice (in particular, the Medication Standard) and that her performance was "inadequate" and "substandard".[20] Nonetheless, the College still considered that Ms. Wettlaufer posed little risk to residents as, among other things, the College considered that the majority of these errors – which included errors such as forgetting to administer medication, giving medication outside of the designated timeframe and giving a resident the wrong type of insulin – were not uncommon.[21]

15. It appears that the College does not measure its nurses' performance against a standard of excellence, but instead, appears to use the standard of poorly performing nurses in the profession as the appropriate benchmark. As Ms. Yee, the Intake Investigator for the College who reviewed

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[19] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.27.

[20] Anne Coghlan Transcript (July 25, 2018), p.5447 lines 16-29; Anne Coghlan Transcript (July 26, 2018), p.5667, lines 23-30.

[21] Anne Coghlan Transcript (July 24, 2018), p. 5267, lines 2-4; Anne Coghlan Transcript (July 25, 2018), p.5653, line 24 – p.5654, line 5; Trial Exhibit 121A, Tab 40 (LTCI00036833).

Caressant Care's termination report of Ms. Wettlaufer, stated, Ms. Wettlaufer's practice "was not the greatest" and was on the "low range of nursing practice", but that she "had seen reports where there were more [medication errors]."[22]

16. While the OLTCA acknowledges that fostering a "just culture" within long-term care homes is important (which is premised on the notion of not initially disciplining healthcare providers for human factor errors so as to encourage them to voluntarily disclose mistakes), the OLTCA also believes that the College should more strictly enforce contraventions of the Standards of Practice (in particular, the Medication Standard) especially where numerous contraventions have been reported about that nurse, where there is pattern of conduct which indicates sloppy nursing practice and/or where there is no clear indication that the nurse is learning from his/her past mistakes. Even though Ms. Coghlan believed that some of the types of errors that Ms. Wettlaufer made might be best addressed by the home at the point of care, Ms. Coghlan also acknowledged that each contravention of the Standards of Practice is still an act of professional misconduct and that the College is ultimately responsible for ensuring that its Standards of Practice are being met.[23]

17. There were also various examples of instances where the College did not take steps to inquire into the particular details of each of Ms. Wettlaufer's incidents and medication errors in order to assess the true severity and level of risk of each error.[24] Had further information been

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[22] Karen Yee Transcript (July 27, 2018), p.5882, line 32 – p.5883, line 11; p.5901, lines 1 –14.

[23] Exhibit 121, Affidavit of Anne Coghlan sworn July 3, 2018 at para. 23; Anne Coghlan Transcript (July 26, 2018), p.5616, lines 8-24.

[24] For example, there is no evidence that the College asked Ms. Crombez what types of insulin Ms. Wettlaufer had mistakenly interchanged, but other witnesses explained that given the different colours of the insulin, it would not have been an easy mistake to make. (Anne Coghlan Transcript (July 26, 2018), p.5651, line 1 – p.5652, line 17).

sought out by the College, it is possible that a clearer picture may have emerged of Ms. Wettlaufer that demonstrated that many of her errors were not ones that the majority of nurses would have made.

Recommendation

18. The OLTCA suggests that the College should engage in a more comprehensive review of medication errors that are reported to the College (and, where appropriate, discipline the nurses who committed those errors), particularly where there are a number of medication errors that have been reported, where there is evidence of past reckless behaviour and/or where the nurse had prior findings of incapacity or health issues. As part of this review, the College should be more thorough in its collection of information at the intake stage regarding the specific details of each medication error. This approach should apply to nurses practicing in any sector, not just in long-term care since a different standard in long-term care would merely serve to further deter nurses from seeking employment in that sector.

C. Enhancing Transparency of Nurses' Employment History

19. Another factor that contributed to Ms. Wettlaufer's ability to continue to harm patients at different homes over the span of many years was the fact that she was able to move between organizations within the healthcare sector without new employers being advised of the true nature of her past employment history.

Similarly, in respect of the incident where Ms. Wettlaufer did not assess a resident when required, there was no evidence that the College took steps to inquire into the reasons for the assessment and the urgency of the assessment. (Anne Coghlan Transcript (July 26, 2018), p.5666, line 31 – 5667, line 11).

20. When hiring nursing staff, long-term care home operators are at an informational disadvantage as they generally can only rely on the accuracy of the information disclosed by the applicant and the references noted by the applicant (who are generally presumed to be supportive of the applicant).[25] This asymmetry in information was glaringly apparent each time Ms. Wettlaufer was hired by a long-term care home.

21. There was no disclosure to prospective future employers of Ms. Wettlaufer's terminations or resignations from Geraldton District Hospital, Caressant Care or Meadow Park. For example, when Ms. Wettlaufer applied to Caressant Care, she had not voluntarily included in her resume that she had previously worked at Geraldton Hospital. Ms. Crombez stated during the public hearings that had she known about the circumstances surrounding Ms. Wettlaufer's termination from Geraldton District Hospital, that certainly would have affected Caressant Care's decision to hire her.[26]

22. None of the homes had complete information about Ms. Wettlaufer's past employment history. Instead, it was left up to the particular practices and habits of each interviewer to determine how much farther to look behind the employment history and references provided by Ms. Wettlaufer. For example, after her termination from Caressant Care, when Ms. Wettlaufer applied to work at Meadow Park, Heather Nicholas, the Director of Care at Meadow Park, contacted the nurses at Caressant Care who were identified by Ms. Wettlaufer as references, but did not contact an administrator at the home as it was her practice not to contact the applicant's

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[25] Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", para. 29.

[26] Helen Crombez Transcript (June 11, 2018), p.928, line 25- p.929, line 6.

supervisor.[27] Similarly, when Ms. Wettlaufer interviewed with Lifeguard Homecare Inc. (which ultimately hired her and placed her as an agency nurse at Telfer Place), she did not indicate on her resume that she no longer worked with Meadow Park. Ms. Wilmot-Smith, the President and part-owner of Lifeguard, was under the impression that she was still employed with Meadow Park at the time of the interview and, as it is her practice not contact current employers for references, did not contact Meadow Park to inquire about Ms. Wettlaufer.[28]

23. The OLTCA agrees with Professor Beatrice Crofts Yorker Schumacher's opinion that the communication of meaningful information to prospective employers about a previous employee is one of the readily available methods to protect residents against health care serial killers.[29]

24. A related concern that further contributes to the incomplete information regarding the performance of nurses in long-term care is that while the Ministry of Health and Long-Term Care (the "**Ministry**") receives reports of every critical incident that occurs in a long-term care home and of the particular staff members that are involved in these incidents, the Ministry does not track staff members that are involved in these critical incident reports, nor does the Ministry have any consistent practice with respect to sharing with the College information regarding critical incidents that concern nursing staff.[30] The College's mandatory reporting guidelines are

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[27] Exhibit 43, Affidavit of Heather Nicholas sworn June 13, 2018 at paras. 56-58; Heather Nicholas Transcript (June 19, 2018), p.2136, line 20 – p.2137, line 16.

[28] Exhibit 38, Affidavit of Heidi Wilmot-Smith sworn June 12, 2018 at para. 29; Heidi Wilmot-Smit Transcript (June 13, 2018), p. 1588, lines 1 – 31; p.1602, lines 2 – 30.

[29] Exhibit 163, Report of Beatrice Crofts Yorker Schumacher dated May 27, 2018 at p.19.

[30] Karen Simpson Transcript (July 30, 2018), p.6170, line 5 - p.6171, line 6.

only applicable to inspectors who happen to also be nurses and only to specific situations (such as sexual abuse).[31]

25. Ministry inspectors otherwise have no mandatory obligation to report to the College, and have been given no guidance about whether to voluntarily report to the College nurse competency or capacity issues that they may come to learn through their investigation of a critical incident.[32] Ms. Simpson agreed that such guidelines would be helpful for Ministry inspectors and could have been specifically helpful in the context of Ms. Wettlaufer's offences, as the Ministry was aware - but the College was not aware - that Meadow Park suspected Ms. Wettlaufer of stealing narcotics from the home. Had the College received this information from the Ministry, it may have caused the College to re-consider its earlier decision not to investigate Ms. Wettlaufer following her termination from Caressant Care.[33]

Recommendations

26. In light of the particular vulnerability of the resident population in long-term care homes, the OLTCA suggests the following recommendations as potential means of enhancing the transparency of the employment history of potential nursing position applicants:

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[31] Exhibit 121, Exhibit "O" to Affidavit of Anne Coghlan sworn July 3, 2018, *CNO Mandatory Reporting Guidelines.*

[32] Karen Simpson Transcript (July 30, 2018), p.6287, line 2 – p.6289, line 27; Karen Simpson Transcript (July 31, 2018), p.6362, line 9 – p.6368, line 17.

[33] Karen Simpson Transcript (July 31, 2018), p.6362, line 9 – p.6368, line 17.

(a) Create one or more registries which contain information about the employment history of nursing staff.[34] These registries could take various forms, including:

(i) a registry maintained by the College that healthcare organizations can easily access which provides information regarding all instances of historical terminations. (This need not be a new registry, but could just be an expanded version of the current Find a Nurse registry that the College maintains.)[35];

(ii) with respect to multi-home operators, an intra-organizational registry of nurses who have either been terminated from one of the homes within the organization or of concerns with nurses who have been placed in a particular home through an agency service;

(iii) an inter-organizational registry which permits long-term care home operators and other healthcare organizations to identify those nurses which they have terminated[36]; and/or

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[34] Ms. Crombez made a similar recommendation to the CNO – see Helen Crombez Transcript (June 11, 2018), p. 972, lines 10-23.

[35] This registry would not only include information about any past disciplinary or incapacity findings (which are already contained on the Find a Nurse registry) but would also indicate all instances where the College has become aware that an employee has been terminated from their employment.

[36] Although the OLTCA does not consider that the same concerns which prompted Professor Crofts Yorker Schumacher to recommend legislation protecting prior employers from defamation suits for providing honest information to prospective employers about past employees, necessarily apply in Canada or are directly relevant to the Wettlaufer offences, the OLTCA is not opposed to the introduction of such legislation. (Exhibit 163, Report of Beatrice Crofts Yorker Schumacher dated May 27, 2018 at p.19).

(iv) a registry maintained by placement agencies that place registered staff in long-term care homes of any concerns that other organizations have had with that nurse.

In order to prevent nurses from being able to move between homes immediately following a termination without the next employer being aware of the circumstances of the last employment, these registries must be updated in real-time, even if a termination is subject to an internal investigation by the College or a pending grievance process.

(b) The long-term care sector should establish best practices guidelines regarding hiring procedures which would include, for example: guidance with respect to checking applicants' references; when to contact supervisors that are not identified as a reference by the applicant; what types of information to request from previous employers, etc.

(c) The Ministry should track staff members that are involved in critical incident reports or compliance orders for the purpose of identifying any patterns or trends of incidents relating to certain staff members and, where appropriate, share such information with the College and/or the home. (Ms. Simpson acknowledged that this was a recommendation that the Commission should consider.)[37]

(d) The College should create specific reporting guidelines to describe circumstances where Ministry inspectors ought to (or must) report to the College nurse

[37] Karen Simpson Transcript (July 30, 2018), p.6170, lines 5 – 13.

competency or capacity issues that are uncovered during the Ministry's inspection process.

D. Improving the Ontario Nurses' Association's Grievance Process

27. Another contributing factor to Ms. Wettlaufer's ability to continue to harm patients at different homes over the span of many years was ONA's grievance process.

28. ONA filed grievances on behalf of Ms. Wettlaufer with respect to her terminations from Geraldton District Hospital and Caressant Care. These grievances were settled by, among other things, the employers agreeing to amend Ms. Wettlaufer's personnel file to indicate that she voluntarily resigned from her employment (rather than having been terminated) and, in the case of Caressant Care, to also provide a positive reference letter (which was in fact provided to Meadow Park when Ms. Wettlaufer sought employment there.)[38] As a consequence, none of Ms. Wettlaufer's future employers would have known or been easily able to find out – absent Ms. Wettlaufer or one of her references offering up this information – that she was in fact terminated from two other institutions.

29. As Ms. Routledge, the ONA representative at Caressant Care, explained, ONA has an unwritten rule that all five-day suspensions and terminations are automatically grieved, regardless of the circumstances (unless, of course, the member in question requests that ONA not grieve the suspension or termination).[39] ONA is generally perceived by long-term care homes as being quite forceful in its representation of its members and tends to pursue unresolved

[38] Exhibit 6, LTCI00054872 (Minutes of Settlement between ONA and Geraldton Hospital dated November 15, 1996); Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", paras. 108 and 114-121.

[39] Exhibit 33, Affidavit of Karen Routledge sworn June 10, 2018 at para. 34.

grievances to arbitration.[40] While the OLTCA respects the rights of ONA and its members to file grievances in appropriate circumstances and believes that ONA is a valuable check on the disciplinary decisions of long-term care homes, the OLTCA also maintains that in certain circumstances, it is appropriate for a home to contest grievances. However, faced with significant legal and other costs associated with contesting a grievance through to arbitration[41] as well as the risk of having to pay any amounts which are awarded to the nurse[42], long-term care homes often find themselves in the position of agreeing to settle grievances to avoid the costs associated with arbitration.[43] In addition, long-term care homes often have an incentive to settle the grievance for fear that if they proceed to arbitration and lose, the nurse will be reinstated in their home, to the detriment of the other nursing staff and the residents.[44]

Recommendation

30. The OLTCA recommends that long-term care homes receive additional Ministry funding that would be specifically ear-marked to subsidize the legal and other associated costs of responding to a grievance, both before and at any arbitration, so that long-term care homes have the financial resources to dispute grievances where they consider it appropriate to do so.

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[40] See, for example, Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", para. 110.

[41] Legal and related fees would come out of the Other Accommodation funding envelope.

[42] Amounts paid to nurses would come out of the Nursing and Personal Care envelope.

[43] Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", para. 124; Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at para. 65.

[44] Exhibit 51, Affidavit of Wanda Sanginesi sworn June 15, 2018 at Exhibit "A", paras. 119.

E. Revising the Ministry's Inspection Program and Risk Assessment Protocol

31. One of the factors which contributes to the poor public perception of long-term care homes in Ontario and adds to the overburdening of nursing staff (which, in turn, deters qualified nursing staff from seeking employment in this sector) is the nature of the Ministry's regulation of the long-term care sector. This manifests itself in at least three ways.

(i) The Nature of the Ministry's Inspection Program

32. First, not only are there extensive and detailed requirements contained in the *Long-Term Care Homes Act, 2007* and the Regulation which long-term care homes must follow as they conduct their daily business[45], but further, the manner in which the Ministry enforces compliance with these requirements is singularly focused on imposing sanctions for non-compliance on homes and not specifically concerned with how to best improve future compliance by the homes.

33. Prior to the coming into force of the *Long-Term Care Homes Act, 2007* in 2010, the nature of the Ministry's inspection regime was markedly different than it is today. Most significantly, compliance advisors (as they were then called) were assigned to specific long-term care homes and provided those homes with advice about how to comply with the myriad of regulations; under the current regime, inspectors (as they are now called) are no longer assigned to specific homes, do not provide homes with guidance or advice regarding how to achieve compliance and do not have any regard to mitigating factors such as due diligence or the steps a home has taken towards achieving compliance.[46] In addition, in the face of non-compliance

[45] Karen Simpson Transcript (July 31, 2018), p.6398, lines 21 – 31.

[46] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at paras. 19, 21, 22, 46, 60, 63 and 64.

under the previous regime, compliance advisors were entitled to exercise their judgment and give homes a verbal warning; under the current regime, inspectors are now, at minimum, required to issue homes a written notification.

34. This regime change has had a significant impact on long-term care homes which miss having a relationship with a particular compliance advisor and no longer have a person at the Ministry that they can seek advice from with respect to compliance issues.[47]

35. One of the reasons given by the Ministry for this change in the inspection system is that the inspector giving the home advice could be providing the wrong advice. This concern falls somewhat flat, though, as Ms. Simpson went on to acknowledge that a Ministry inspector would know more than the homes about what the Ministry expects the homes to do in order to be compliant.[48]

36. The other reason given by the Ministry for this change in the inspection process is that an inspector should not be both giving a home advice and then inspecting that home so as to avoid a conflict of interest situation where a home has taken an inspector's advice but is still not in compliance when an inspector comes to inspect.[49] Ms. Simpson acknowledged, though, that this concern could be addressed by setting up a separate branch within the Ministry – unrelated to the

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[47] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at para. 77; Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at paras. 16-18; Helen Crombez Transcript (June 12, 2018), p.1195, line 17-p.1196, line 8.

[48] Karen Simpson Transcript (July 31, 2018), p.6414, line 20 – p.6415, line 18.

[49] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at para. 75.

inspection branch – to provide education, support and training to long-term care homes, as is done in some jurisdictions in the United States.[50]

(ii) The Significant Administrative Burden of the Inspection Program on Homes

37. Second, the Ministry's inspection program (both the annual Resident Quality Inspection ("**RQI**") and the Critical Incident, Complaint and Follow-Up Inspection ("**CCF**")) creates a significant administrative burden for staff at long-term care homes, adding to the nursing staff's existing workload and taking away from the direct care that these staff could otherwise be providing to residents.[51] Despite this apparent burden, though, there is no evidence that the Ministry has given any consideration to the number of hours being spent by staff responding to and assisting with inspections, nor does the amount of government funding that homes receive take into account the time nurses are required to spend responding to these inspections.[52] The fact that the number of inspectors and the number of inspections continues to increase over the years seems counter-productive where the vast majority of long-term care homes (81%) are substantially compliant.[53] (Even the shorter risk-focused RQIs for "substantially compliant" (Level 1) homes still require at least 10 inspector days to complete.)[54]

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[50] Karen Simpson Transcript (July 31, 2018), p.6423, line 20 – p.6424, line 23. Helen Crombez also agreed with this recommendation of setting up a separate branch to provide advice to long-term care homes (see Helen Crombez Transcript (June 12, 2018), p.1195, line 17-p.1196, line 8).

[51] Exhibit 10, Affidavit of Brenda Van Quaethem sworn June 4, 2018 at paras. 14, 15 and 18.

[52] Karin Fairchild Transcript (August 7, 2018), p.7529, line 16 – p. 7530, line 19; Karen Simpson Transcript (July 31, 2018), p.6466, line 30 – p.6468, line 1.

[53] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at para. 135.

[54] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at para. 116.

(iii) The Utility of the Ministry's LQIP Performance Assessment

38. Third, the publication of each long-term care home's LQIP Performance Assessment ("**LPA**") as a proxy for that home's level of risk is at least partially misguided. The LPA was created as an internal Ministry resource to identify those homes that pose serious risks to residents for the purpose of assisting the Ministry in the proper allocation of its inspection resources; it was not intended to be used as proof that there was – or was not – a problem in a particular home.[55]

39. Despite its intended purpose, the LPA is now used by the Ministry to create and distribute a public ranking of all long-term care homes. There are various reasons why the LPA is not necessarily a complete or accurate assessment of any given's home level of risk, including the following:

(a) some of the data sources used in the LPA are stale by the time they are used for the LPA and thus the risk levels are not current;[56]

(b) there is duplication of some of the data inputs used in the LPA;[57]

(c) there may be multiple non-compliances for the same issue, which would overstate the level of risk;[58]

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[55] Exhibit 130, PowerPoint Presentation of Philip Moorman Evidence, slide 1; Exhibit 9, Overview Report – Ministry of Health and Long Term Care, Vol.1, p.46; Exhibit 9, LTCI00055577, LQIP Risk and Priority Assessment Framework, at p.3.

[56] Exhibit 9, Overview Report – Ministry of Health and Long Term Care, Vol. 1, p.46; Philip Moorman Transcript (August 7, 2018), p.7412, lines 13-19.

[57] Philip Moorman Transcript (August 7, 2018), p.7406, line 17 – p.7407, line 3; p.7408, lines 14-18.

(d) there is no differentiation between high-risk and low-risk non-compliance findings;[59]

(e) the LPA takes into account the subjective clinical judgment of Ministry inspectors and Service Area Office managers by factoring in "qualitative data" (an open-ended category of "soft data"), with the result being that these inputs will not be consistently applied across all homes, but instead, will depend on the particular practices of each inspector or manager;[60]

(f) with respect to the RAI-MDS data input in the LPA, only three out of a possible twenty-three indicators are taken into account, despite the fact that the remaining twenty indicators might also be relevant indicators of a home's performance.[61] In addition, the RAI-MDS data inputs are not risk-adjusted to account for the varying acuity of the resident population across different homes; and

(g) whether a home has received accreditation from Accreditation Canada or the Commission on Accreditation of Rehabilitation Facilities is not taken into account in the LPA assessment.[62]

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[58] Exhibit 154, Affidavit of Karin Fairchild sworn July 31, 2018 at para. 60.

[59] Philip Moorman Transcript (August 7, 2018), p.7408, line 32 – p.7409, line 16.

[60] Exhibit 148, Affidavit of Philip Moorman sworn July 27, 2018 at paras. 12(4) and 15.

[61] Philip Moorman Transcript (August 7, 2018), p.7410, line 28 – p.7412, line 7.

[62] Philip Moorman Transcript (August 7, 2018), p.7419, lines 13-26.

40. Adding up the number of past findings of non-compliance (as the LPA does), without looking behind the data to understand the root causes of these non-compliances, is not necessarily a useful predictor of risk going forward.

Recommendations

41. The OLTCA believes that the following changes to the Ministry's inspection process and risk assessment protocol will help improve the public perception of long-term care and reduce the administrative burden that the current inspections and compliance program has on homes so that the staff can better focus on providing quality care to residents:

(a) Create a division within the Ministry, separate from the inspections branch, to provide advice to long-term care homes regarding how to achieve compliance.

(b) Maintain the original purpose of the LPA as a means of allocating Ministry inspection resources and suspend the public reporting of each long-term care home's LPA classification.

(c) Require the Ministry, with input from the long-term care sector and other stakeholders, to develop an improved methodology for analyzing the vast amount of data that the Ministry has collected from its CCF inspections and RQIs so that inspections are focused on homes that fall below an objective level of risk. This type of data analysis should go beyond merely identifying the number and types of non-compliances, but instead, seek to identify, for example:

(i) patterns or trends between homes of different sizes;

(ii) patterns or trends between homes in different regions;

(iii) patterns or trends over time within each home and within the sector as a whole;

(iv) possible causal links between different non-compliances;

(v) correlations between compliance with the *Long-Term Care Homes Act, 2007* and outcomes of care or quality of care; and

(vi) the ability of historical non-compliances to predict future performance.

(d) Based on the improved methodology discussed in (c) above, remove the annual risk-focused RQI requirement for all substantially compliant homes (Level 1), and, instead, require an annual RQI only once every three years, so as to reduce the administrative burden on homes and free-up time nursing staff otherwise spends on responding to annual RQIs.

F. Strengthening Internal Disciplinary Procedures

42. There is generally little consistency among long-term care homes with respect to their own internal policies related to management of medication errors and disciplining nurses for work performance concerns. Although Caressant Care followed a progressive discipline framework when responding to errors and other concerns raised about Ms. Wettlaufer, the evidence during the public hearings was clear that home administrators and Directors of Nursing and Personal Care received little or no formal human resources training or any formal training

with respect to investigating incidents or dealing with problematic employees.[63] In addition, even though there is often such expertise at the corporate head office level, there generally is no human resources expertise within a home itself.[64]

Recommendation

43. The OLTCA recommends that:

(a) Long-term care homes receive additional government funding for the specific purpose of providing their administrators and Directors of Nursing and Personal Care with specific human resources or leadership training (above and beyond the managerial experience that is required under the Regulation to qualify as an administrator or Director of Nursing) and/or for the purpose of hiring staff with specific human resources expertise to work in each home; and

(b) The long-term care sector adopt a standard framework (such as the Canadian Incident Analysis Framework suggested by Julie Greenall) which would provide each long-term care home with a guide to reviewing incidents, including determining the contributing factors of the incident and identifying strategies for implementing system improvements.[65] As part of this review, long-term care homes would be prompted to ask themselves whether the incident was a result of human error (which, consistent with the "just culture" concept, would not be

[63] Helen Crombez Transcript (June 8, 2018), p. 794, line 27 – p.795, line 11; Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at para. 72; Brenda Van Quaethem Transcript (June 6, 2018), p.281, line 29 – p.282, line 29. Brenda Van Quaethem Transcript (June 7, 2018), p.630, lines 20-32.

[64] Exhibit 16, Affidavit of Helen Crombez sworn June 7, 2018 at para. 74.

[65] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.31-32.

disciplined), or whether, in contrast, the incident is considered to be an "at-risk behaviour" or reckless, in which case those errors need to be not only corrected but also disciplined.[66]

G. Improving Medication Management and Enhancing Surveillance Mechanisms

44. At the outset, it should be noted that there is a high level of consistency in medication management systems across long-term care homes in Ontario, more so than in acute care hospitals.[67]

45. Nonetheless, Ms. Wettlaufer, as a registered nurse, obtained the insulin (and spare insulin pens/needles) that she used to commit most, if not all, of her offences from locked medical storage rooms at the relevant long-term care homes. According to Ms. Wettlaufer's own statement, one of the factors which enabled Ms. Wettlaufer to commit her offences was the fact that the medication storage rooms did not have windows and nobody was watching what she was doing in the room.[68]

46. Another key factor that enabled Ms. Wettlaufer to commit her offences – and the reason why insulin was her weapon of choice – was the availability of excess insulin in the long-term care homes and the fact that insulin is not counted or monitored in the same manner as controlled drugs, even though it is considered a "high-alert" medication.[69] While re-ordering of significant

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[66] Julie Greenall Transcript (September 13, 2018) at p.82982, line 4 – p.8295, line 5; Exhibit 163, Exhibit "I" to Report of Beatrice Crofts Yorker Schumacher dated May 27, 2018, *AONE Guiding Principles.*

[67] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.16.

[68] Exhibit 5, Elizabeth Wettlaufer Interview Transcript, p.60, lines 9-29; p.67, lines 6-28.

[69] Exhibit 5, Elizabeth Wettlaufer Interview Transcript, p.60, lines 2-8; p.61, line 15 - p.64, line 23; p.67, line 6 – p.68, line 20; p.69, lines 23-25.

amounts of insulin in a short time period from the pharmacy might have raised a red flag with either the pharmacy or the home, the sporadic diversion of one or two insulin cartridges (which is enough to kill a resident) would likely go unnoticed.

47. It should also be noted that since insulin can be obtained from pharmacies (outside long-term care homes) without a prescription in Ontario, an individual intending to harm a long-term care home resident could circumvent any medication management systems in a home by merely obtaining the insulin from elsewhere.[70]

Recommendation

48. While recognizing that none of these measures, on their own, would always stop a nurse who intentionally seeks to harm residents using insulin, the OLTCA believes that the following measures might deter the commission of such offences or might enable a home to more readily identify a killer nurse before multiple offences occur:

(a) Provide long-term care homes with additional government funding for the express purpose of installing cameras in medical storage rooms and hallways to both aid in the detection of individuals who intentionally seek to harm residents and to potentially deter them such individuals from committing these offences in the first place. Professor Crofts Yorker Schumacher has similarly recommended the implementation of video surveillance in long-term care homes.[71] The implementation of any additional surveillance methods would require the careful

[70] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.26-27.

[71] Exhibit 163, Report of Beatrice Crofts Yorker Schumacher dated May 27, 2018 at p.22.

balancing of various competing interests, including the vulnerability of the residents in the long-term care sector, the privacy of residents and the desire not to further deter qualified nursing staff from seeking employment in the long-term care sector.

(b) The OLTCA expressly adopts the following recommendations of Julie Greenall (who the OLTCA recommended be called as a witness in this Inquiry):

(i) limit the supply of insulin per resident to a current pen and a spare pen;[72]

(ii) provide long-term care homes with additional government funding so as to implement a central supply process for replacement insulin pens in long-term care homes through the use of automated dispensing cabinets which store each resident's medications in a particular drawer and only enable the nurse who is treating those specific patients to have access to their medications;[73]

(iii) establish a clear set of intervention responses (such as vital signs and finger glucose determinations) to assist healthcare staff in evaluating and responding to sudden changes in resident condition;[74] and

(iv) implement a systemic review by each home of the use of rescue or symptom management medications from the emergency drug box.[75]

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[72] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.26.

[73] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.26.

[74] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.29.

(c) Require that every number of years (possibly every three years), the Ministry, with input from stakeholders in the long-term care sector, should conduct a survey of any new available technology that can be leveraged to improve medication management systems in long-term care homes.

(d) Require that insulin be available from pharmacies in Ontario only with a prescription.

H. Improving the Death Investigation Process

49. The OLTCA believes that there may have been opportunities for the Office of the Chief Coroner for Ontario ("**OCC**") to identify a trend or pattern in the deaths caused by Ms. Wettlaufer.

50. All deaths in long-term care homes are reported to the OCC through an Institutional Patient Death record ("**IPDR**"). Despite having this significant amount of information about deaths in long-term care homes, Dr. Dirk Huyer, the Chief Coroner for Ontario, acknowledged that the OCC does not currently conduct any analysis of this data to identify trends or patterns of death within institutions and/or within regions. The reason given for this is that a small number of long-term care homes (approximately 8%) do not submit the IPDRs electronically, which prevents them from performing an analysis on these homes absent a manual input by the OCC of this data into the system.[76] Nonetheless, the OCC is currently sitting on valuable information from 92% of long-term care homes and should still be able to identify trends within a given

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[75] Exhibit 166, Report of Julie Greenall dated June 1, 2018 at p.29.

[76] Exhibit 98, Affidavit of Dr. Dirk Huyer sworn July 3, 2018 at paras. 99 and 104; Dirk Huyer Transcript (July 16, 2018) at p.4215, line 24-p.4216, line 31.

home (especially since any given home that submits some IPDRs online, likely submits all of its IPDRs online).

51. A second opportunity that the OCC may have had to identify the offences being committed by Ms. Wettlaufer was through the automatic investigation of every tenth death in a long term care home.[77] As part of the mandatory threshold death review, which ended in 2013, the investigating coroner would conduct a review of the deaths in that home since the last threshold review in an attempt to identify any patterns or clusters of deaths.[78] As Dr. Huyer explained, this practice was terminated by the OCC as it was anecdotally believed that these threshold death investigations did not uncover patterns or concerns that would not have otherwise been identified.[79] There was, however, no statistical analysis done to support this conclusion. There was also a belief within the OCC that the Ministry inspectors review all deaths in long-term care homes as part of their regulatory oversight; however Ms. Simpson confirmed that the Ministry does not look at the causes of death and thus is not a substitute for the role that the OCC historically performed in conducting its threshold death review.[80]

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[77] Exhibit 98, Affidavit of Dr. Dirk Huyer sworn July 3, 2018 at paras. 112-113.

[78] Dirk Huyer Transcript (July 16, 2018), p.4329, line 24 – p.4330, line 23 and p.4332, lines 2-22; Exhibit 98, Affidavit of Dr. Dirk Huyer sworn July 3, 2018 at paras. 112-113.

[79] Exhibit 98, Affidavit of Dr. Dirk Huyer sworn July 3, 2018 at paras. 113 and 115.

[80] Exhibit 98, Affidavit of Dr. Dirk Huyer sworn July 3, 2018 at paras. 113; Exhibit "GG" to the Affidavit of Dr. Dirk Huyer, *Transformation – Reduction in Long-Term Care Facility Threshold Death Investigations,* p.2; Karen Simpson Transcript (July 31, 2018), p.6336, line 19 – p.6337, line 22.

Recommendations

52. The OLTCA believes that the following changes to the death investigation system in Ontario could help identify trends or patterns in deaths in long-term care homes which may enable early detection of a future serial killer:

(a) Reinstate the automatic threshold death investigation by the OCC so as to possibly reveal patterns or clusters of deaths in a given long-term care home. Further consideration should also be given to ways in which the OCC can improve the threshold death investigation process (by, for example, using data analytics) to address some of the past concerns that the process was not identifying patterns or clusters of death.

(b) The OCC should conduct a review of the IPDR data it currently has from long-term homes to identify patterns or trends in deaths in long-term care homes. The ultimate goal should be the creation of a tool, such as that described by Dr. Michael Hillmer, which combines and analyzes the data already in the possession of both the Ministry and the OCC which may enable the detection of an increase in death in certain long-term care homes about what he predicted rate of death in that home ought to be.[81]

(c) Related to the recommendation in (b) above, as noted by Professor Crofts Yorker Schumacher, healthcare staff in long-term care homes should have a clear and uniform understanding of what would be considered a “normal” or “typical” death

[81] Dirk Huyer Transcript (July 16, 2018) at p.4321, line 5 – p.4325, line 6.

so that unexpected patient decline could be quickly identified and addressed.[82] There should also be enhanced awareness amongst staff of long-term care homes regarding the existence of the health care serial killer phenomenon, which may also assist in distinguishing "unexpected" deaths from "expected" deaths.[83]

CONCLUSION

53. The OLTCA looks forward to assisting the Commission during the second phase of the Inquiry and further discussing the recommendations put forward by the OLTCA and other participants.

September 20, 2018

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Tom Friedland/Melanie Ouanounou

Lawyers for the Ontario Long Term Care Association

[82] Exhibit 163, Report of Beatrice Crofts Yorker Schumacher dated May 27, 2018 at p.13 and 21.

[83] Exhibit 163, Report of Beatrice Crofts Yorker Schumacher dated May 27, 2018 at p.19.

APPENDIX I

COMPOSITE LIST OF OLTCA RECOMMENDATIONS

Addressing Long-Term Home Care Staffing Concerns

1. Increase funding to the Nursing and Personal Care envelope so as to enable long-term care homes to:

    (a) hire additional RNs, RPNs and PSWs; and

    (b) increase the salaries and benefits for RNs and RPNs.

2. Expand the 24/7 requirement in section 8(3) of the *Long-Term Care Homes Act, 2007* to also include RPNs in appropriate circumstances, based on resident care needs, as assessed by the medical and nursing staff in the home.

3. As an alternative to the recommendation in Recommendation #2 above, amend section 8(3) of the *Long-Term Care Homes Act, 2007* to provide that where at least one RPN is present in a home and where the care needs of the residents do not require that an RN be physically present in the home, the RN that is required under that section need not be physically present in the home, but instead, be remotely available.

4. Allow homes to have more flexibility in how to apply funding in the Nursing and Personal Care envelope.

5. Require the College and ONA to offer nurses employee assistance programs (EAPs).

6. Transfer certain administrative functions related to medication reconciliation and medication management from nursing staff to pharmacy technicians so as to provide nursing staff more time to care for residents.

Improving the College's Disciplinary Process

7. The College should engage in a more comprehensive review of medication errors that are reported to the College (and, where appropriate, discipline the nurses who committed those errors), particularly where there are a number of medication errors that have been reported and/or where the nurse had prior findings of incapacity or health issues. As part of this review, the College should be more thorough in its collection of information at the intake stage regarding the specific details of each medication error. (This approach should apply to nurses practicing in any sector, not just in long-term care.)

Enhancing Transparency of Nurses' Employment History

8. Create one or more registries which contain information about the employment history of nursing staff. These registries could take various forms, including:

(a) a registry maintained by the College that healthcare organizations can easily access which provides information regarding all instances of historical terminations;

(b) with respect to multi-home operators, an intra-organizational registry of nurses who have either been terminated from one of the homes within the organization or

of concerns with nurses who have been placed in a particular home through an agency service;

(c) an inter-organizational registry which permits long-term care home operators and other healthcare organizations to identify those nurses which they have terminated; and/or

(d) a registry maintained by placement agencies that place registered staff in long-term care homes of any concerns that other organizations have had with that nurse.

In order to prevent nurses from being able to move between homes immediately following a termination without the next employer being aware of the circumstances of the last employment, these registries must be updated in real-time, even if a termination is subject to an internal investigation by the College or a pending grievance process.

9. The long-term care sector should establish best practices guidelines regarding hiring procedures which would include, for example: guidance with respect to checking applicants' references; when to contact supervisors that are not identified as a reference by the applicant; what types of information to request from previous employers, etc.

10. The Ministry should track staff members that are involved in critical incident reports or compliance orders for the purpose of identifying any patterns or trends of incidents relating to certain staff members and, where appropriate, share such information with the College and/or the home.

11. The College should create specific reporting guidelines to describe circumstances where Ministry inspectors ought to (or must) report to the College nurse competency or capacity issues that are uncovered during the Ministry's inspection process.

Improving the Ontario Nurses' Association's Grievance Process

12. Long-term care homes receive additional Ministry funding that would be specifically earmarked to subsidize the legal and other associated costs of responding to a grievance, both before and at any arbitration.

Revising the Ministry's Inspection Program and Risk Assessment Protocol

13. Create a division within the Ministry, separate from the inspections branch, to provide advice to long-term care homes regarding how to achieve compliance.

14. Maintain the original purpose of the LPA as a means of allocating Ministry inspection resources and suspend the public reporting of each long-term care home's LPA classification.

15. Require the Ministry, with input from the long-term care sector and other stakeholders, to develop an improved methodology for analyzing the vast amount of data that the Ministry has collected from its CCF inspections and RQIs so that inspections are focused on homes that fall below an objective level of risk.

16. Based on the improved methodology discussed in Recommendation #15 above, remove the annual risk-focused RQI requirement for all substantially compliant homes (Level 1), and, instead, require an annual RQI only once every three years.

Strengthening Internal Disciplinary Procedures

17. Provide long-term care homes with additional government funding for the specific purpose of providing their administrators and Directors of Nursing and Personal Care with specific human resources or leadership training and/or for the purpose of hiring staff with specific human resources expertise to work in each home.

18. Adopt a standard framework (such as the Canadian Incident Analysis Framework) in the long-term care sector which would provide each long-term care home with a guide to reviewing incidents, including determining the contributing factors of the incident and identifying strategies for implementing system improvements.

Improving Medication Management and Enhancing Surveillance Mechanisms

19. Provide long-term care homes with additional government funding for the express purpose of installing cameras in medical storage rooms and hallways.

20. Limit the supply of insulin per resident to a current pen and a spare pen.

21. Provide long-term care homes with additional government funding so as to implement a central supply process for replacement insulin pens in long-term care homes through the use of automated dispensing cabinets.

22. Establish a clear set of intervention responses (such as vital signs and finger glucose determinations) to assist healthcare staff in evaluating and responding to sudden changes in resident condition.

23. Implement a systemic review by each home of the use of rescue or symptom management medications from the emergency drug box.

24. Require that every number of years (possibly every three years), the Ministry, with input from stakeholders in the long-term care sector, should conduct a survey of any new available technology that can be leveraged to improve medication management systems in long-term care homes.

25. Require that insulin be available from pharmacies in Ontario only with a prescription.

Improving the Death Investigation Process

26. Reinstate the automatic threshold death investigation by the OCC. Further consideration should also be given to ways in which the OCC can improve the threshold death investigation process (by, for example, using data analytics) to address some of the past concerns that the process was not identifying patterns or clusters of death.

27. The OCC should conduct a review of the IPDR data it currently has from long-term homes to identify patterns or trends in deaths in long-term care homes.

28. Healthcare staff in long-term care homes should have a clear and uniform understanding of what would be considered a “normal” or “typical” death so that unexpected patient decline could be quickly identified and addressed. There should also be enhanced awareness amongst staff of long-term care homes regarding the existence of the health care serial killer phenomenon, which may also assist in distinguishing “unexpected” deaths from “expected” deaths.