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

CLOSING SUBMISSIONS AND RECOMMENDATIONS OF ADVANTAGE ONTARIO – ADVANCING SENIOR CARE

September 20, 2018

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TABLE OF CONTENTS

PART I – OVERVIEW

1. The disclosure of Elizabeth Wettlaufer's ("**EW**") crimes while working as a Registered Nurse in long-term care has been horrifying. This public inquiry is in part a recognition that the people of Ontario owe it to the victims, and the victims' family and friends, to use every opportunity and tool available to strengthen Ontario's long-term care system and ensure that measures are put in place to enhance the safety, security and care of residents, and further ensure that they are protected from intentional harm.

2. AdvantAge Ontario has been a leading advocate for senior care in Ontario for a century. It is deeply honoured to contribute to this inquiry and to continue to advance senior care.

3. AdvantAge Ontario's position has remained consistent. There is not enough public funding for long-term care. Funding levels have simply not kept up with the increasing needs and acuity of residents across the Province. Insufficient funding for staffing not only results in challenges recruiting and retaining quality regulated and unregulated staff, but also leads to staff burnout and not enough care for residents. There is a recognition that staff are overworked in long-term care, and they often seek higher wages in hospitals and other settings.

4. Due to staffing shortages, homes must often rely on nursing provided through staffing agencies. This is not ideal. Staffing agency nurses may not be familiar with the home or its residents. Further funding would reduce the need for agency staffing and would reduce high levels of full-time staff turnover. To the extent that agency staff are necessary, staffing agencies should share responsibility with licensees for screening measures, training, orientation and ensuring appropriate qualification.

5. The rules and regulations that apply to long-term care are complex and burdensome. Nurses, other care staff and other stakeholders need further training and education on compliance, mandatory reporting, human resources, clinical care, identifying "sudden and unexpected deaths" and other red flags. An additional funding envelope should be established for management and staff training and education, which includes funds for backfilling staff while they are in training.

6. The College of Nurses (the "**College**") can and should protect the public by collaborating with employers as shared partners in resident safety. The College should share more information with employers and prospective employers about its members, including employment history, investigations, complaints and mandatory reports that deal in any way with risks to patient safety.

7. We must re-think how the balance of competing interests in our current labour relations regime affects the safety and security of residents. The costs of grievance arbitration to facility operators – including both financial costs and the risk of return to work orders – together with current labour relations law, puts homes in the position of resolving grievances in ways that may prejudice residents at other homes. Grievances in long-term care should be adjudicated before a specialized board of inquiry. Negotiated reference letters and burying information about patient safety risks should become a practice of the past.

8. Medication security must be revisited. Funding should be provided for collaboration between experts in long-term care and the pharmacy industry to explore the efficacy of pharmacy technicians in long-term care homes, and of automated medication dispensers.

9. Finally, it should be recognized and addressed that the long-term care sector is excessively burdened with regulation. The transition from a "compliance" regime to an "inspection" regime, for example – in essence a transition from a collaborative to an adversarial system – was unsuccessful. We need to find ways to simplify the system, eliminate red tape and box-ticking culture and give nurses and other care staff the tools and time to provide more direct, in-person care.

10. AdvantAge Ontario's position is that, with the successful implementation of the recommendations contained in these submissions, we can begin to make much needed improvements and changes so that crimes like those committed by EW never happen in Ontario again.

PART II – ISSUES AND POSITION OF ADVANTAGE ONTARIO

Funding

11. The evidence from the public hearings demonstrates that public funding for long-term care in Ontario has failed to keep up with the rising needs of residents across the Province.

Residents' Current and Rising Needs

12. One of the issues related to funding is the fact that public funding for long-term care has not kept current with the needs of an increasingly acute resident population. One of the most consistent evidentiary themes at the public hearings was that resident acuity is on the rise, and has been for years.[1]

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[1] See for example Testimony of Brenda Van Quaetham, June 7, 2018 at page 628 line 14-19.

13. Moreover, funding that is provided is based on old data. Funding is based on a level-of-care per diem basis within four spending envelopes (nursing and personal care, program and support services, raw food and other accommodations). The nursing and personal care envelope is funded through the use of a standardized assessment tool used to determine the health status for each resident in a home (the RAI-MDS system).

14. RAI-MDS data is uploaded regularly by the home. On an annual basis, the Ministry of Health and Long-Term Care (the "**Ministry**") uses the RAI-MDS data to determine the funding levels for each home's nursing and personal care envelope. Funding under the nursing and personal care envelope is adjusted based on resident complexity and care needs.

15. On the Ministry side, there is a set level of funding to be provided through the nursing and personal care envelope to all of Ontario's long-term care homes. Accordingly, there are "winners" and "losers" in the RAI-MDS model.

16. In cross-examination, Heather Nicholas, Director of Care at Meadow Park stated[2]:

> Q. So I want help understanding the timing here. So the Ministry collects data on some regular basis for RAI/MDS; is that right?
>
> A. That's correct.
>
> Q. Do you know about how often that is?
>
> A. Uploaded monthly.
>
> Q. And is it –
>
> A. I believe.
>
> Q. And am I understanding correctly that once a year the Ministry, having calculated, I'll say, all of that data informs the home what the funding is going to be for the following year?
>
> A. That's correct. They're like a year behind.

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[2] Testimony of Heather Nicholas, June 19, 2018 at pages 2334-2335.

> Q. So the data that they've collected to make that determination is up to 12 months old? Does that sound right?
>
> A. Yes.
>
> Q. And the data that could be 12 months old is then used to calculate funding for a period going as far as 12 months into the future; is that right?
>
> A. That's correct.

17. More particularly, long-term care homes can have high turnover rates. In cases where particular residents live in the home over a long time period, the acuity of those residents often increases during that time. Therefore, funding provided on any particular day to a home on the basis of its RAI-MDS data and calculation can be on the basis of healthier, or even completely different residents.[3]

18. More broadly, long-term care funding has simply not adapted to meet the increased needs of today's resident population.

19. AdvantAge Ontario's position is that funding for long-term care must be consistent with the facts on the ground and reflect the reality of rising acuity. We must also recognize that, as the nursing and personal care envelope is funded based on resident care needs, quality care may result in a home's funding decreasing for the next period. These are unintended and negative consequences of improving resident outcomes. Homes and their residents are effectively financially penalized for providing quality care.

20. AdvantAge Ontario recommends that the Ministry provide more funding for long-term care, and that it consult with industry experts to establish a system based on current acuity and needs, which does not result in less funding as homes deliver higher quality care.

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[3] Testimony of Brenda Van Quaetham, June 7, 2018 at pages 628-629, lines 30-32 (628) and 1-8 (629); Testimony of Heather Nicholas, June 19, 2018 at pages 2334-2335

Staffing Levels

21. One of the issues related to funding is the number of direct care staff who work in long-term care, as well as the facilities' ability to recruit and retain them.

22. The evidence in the public hearings demonstrates a sector-wide problem with recruiting and retaining quality registered staff. Long-term care has traditionally not been the most desirable work environment for Registered Nurses[4]. Facilities generally cannot match the pay or benefits offered in a hospital environment, where many nurses-in-training see themselves in their future careers. Nurses who do wind up in long-term care are often "shocked" at how hard the work is. Often, they move on to other areas.[5]

23. The idea that full-time staff capacity must be strengthened across the long-term care sector, including by developing strategies to increase recruitment and retention of health providers (including Registered Nurses), is not new. In *Commitment to Care: A Plan for Long-Term Care in Ontario* (2004) (the "**Smith Report**")[6], key recommendations were made in relation to staffing and continuity of care. The Smith Report concluded that more full-time staff are required to provide consistent, resident-knowledgeable care, and recommended that further funds be concentrated in resident care by ensuring that "*future spending for care be tied directly to the nursing and care envelope*."[7]

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[4] In these submissions, "Registered Nurse" will refer to both Registered Nurses and Registered Practical Nurses (RPNs), unless otherwise stated.
[5] Testimony of Brenda Van Quaetham, June 6, 2018 at pages 276-277.
[6] Exhibit 9 (Source Documents), LTCI00046531.
[7] Ibid. at page 22.

24. Several years later, in *People Caring for People: Impacting the Quality of Life and Care of Residents in Long-Term Care Homes* (2008) (the "**Sharkey Report**")[8], key recommendations were made in relation to strengthening staff capacity, including by establishing provincial guidelines to support annual funding for an average of up to four (4) hours of care per resident per day within four (4) years (i.e. by 2012).

25. Cognizant of the desirability of hospital and other work outside of long-term care for Registered Nurses, the Sharkey Report also recommended that the Province develop strategies to increase recruitment and retention of health providers to the long-term care sector, including Registered Nurses.

26. To date, the sector has still not reached four (4) hour of care per day per resident. Commitments were recently made by the previous provincial government, but the goal has still not been achieved.

27. It is important to note that the Sharkey Report did not recommend the implementation of specific staffing ratios through a regulation under the *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8 (the ***"LTCHA, 2007"***). Specifically, the Sharkey Report stated: "*We are convinced that the complexity of determining staffing requirements related to residents' quality of care and quality of life requires a comprehensive approach beyond setting staffing ratios and staffing standards*." In her covering letter to Minister Smitherman, Ms. Sharkey further stated:

> *"I am convinced based on the research and stakeholder input that to address staffing requirements related to residents' quality of care and quality of life we need to take a broad approach that goes beyond setting staffing targets or a provincial staffing ratio. I am also convinced that any approach must be sensitive to the particular circumstances of*

[8] Exhibit 9 (Source Documents), LTCI00046745.

> *each LTC home and the needs of their residents. Consequently, for this reason, I am not recommending that there should be a regulation under The Long-Term Care Homes Act 2007 that provides a provincial staffing ratio or staffing standard."*

28. For clarity, AdvantAge Ontario supports the present requirement that every licensee have at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff on duty and present at the home.[9] AdvantAge Ontario was pleased to see funding allocated for an additional Registered Nurse in homes across the province in the March 2018 provincial budget. However, unless recruitment and retention issues are adequately addressed, homes will continue to face challenges complying with this rule.

29. For many years, AdvantAge Ontario has advocated for the implementation of these ideas through pragmatic action. AdvantAge Ontario continues to believe that residents are most safe and secure when they are cared for by a greater complement of full-time care staff. The funding is simply not there to attract or pay for enough nurses. More funding, more nurses, more direct care, more manageable workloads, and less attrition will all lead to safer and more secure residents.

30. Accordingly, AdvantAge Ontario recommends that a strategy be developed to recruit and retain quality direct care staff, including Registered Nurses, and that the Province provide adequate additional funding for this.

31. The need for an increase in direct care for residents is widely accepted. Since the delivery of each of the Smith Report and the Sharkey Report, various recommendations and commitments have been made to accomplish this.

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[9] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8 at section 8(3). This does not include RPNs.

32. In AdvantAge's submission, more full-time staff leads to more direct care, which in turn leads to greater checks and balances inherent in the system. Citing the scholarship of Linda Aiken, Professor Crofts Yorker testified that "*a better educated nurse and a lower nurse-patient ratio is correlated with improved patient outcomes*."[10] The current practice of relying on a single Registered Nurse to cover an overnight shift for an entire home is not best practice. We should collectively strive to do better for residents.

33. AdvantAge Ontario's position is that creating an environment where quality registered staff want to work, and where homes are able to employ enough of them to ensure a staffing complement to meet each home's particular needs, is particularly important when dealing with a vulnerable population. EW's own evidence is that she targeted residents with dementia because they were unable to report her. She took advantage of working with vulnerable people, and of working alone.

34. With greater funding available to attract and retain a range of competent full-time staff, who can provide more direct care and simultaneously act as a system of checks and balances, the risk of intentional harm to residents through the improper administration of medication by a Registered Nurse would substantially decrease.

Less Prescriptive Funding

35. Presently, Ministry funding is provided through funding "envelopes". The Ministry has the statutory power to attach conditions to funding, including how it may be used.[11] The

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[10] Testimony of Beatrice Crofts Yorker Schumacher, September 12, 2018 at page 121 at lines 20-23. See also Exhibit 163, Expert Report of Professor Beatrice Crofts Yorker Schumacher at page 15.

[11] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8 at section 90(2).

rules relating to what funds can and cannot be spent on apply across the board to each of the Province's 627 long-term care homes.

36. This umbrella form of micromanaging Ontario's hundreds of long-term care homes is not in the best interests of residents. Each home and each resident population is unique and has unique needs. Shirlee Sharkey recognized this when she recommended against mandated staffing ratios.

37. In AdvantAge Ontario's submission, Administrators are in the best position to understand the needs of their homes, which includes their residents and work force. Overly prescriptive funding requirements prevent individual Administrators from having the flexibility to manage their funds accordingly.

38. AdvantAge Ontario recommends that long-term care homes be empowered to use funds and staff as they see fit, to a greater degree. By doing so, they can create a sustainable environment with more full-time staff, that can ultimately help detect and prevent intentional harm of residents by a Registered Nurse and/or other care staff.

Education and Training

39. The evidence from the public hearings demonstrates that further education and training is needed in a number of key areas, including compliance, mandatory reporting, human resources, clinical care and sudden and unexpected deaths.

Compliance, Mandatory Reporting and Human Resources

40. The evidence in the public hearings demonstrates a need for further education and training relating to compliance, mandatory reporting and human resources.

41. In relation to compliance, the provincial long-term care homes framework, which includes the *LTCHA, 2007* and regulations, is complex.

42. In relation to mandatory reporting, there are statutory obligations imposed on long-term care management, staff and other stakeholders (in some cases, including the public at large) to make reports to the Ministry, the College and the Office of the Chief Coroner. The evidence from the public hearings demonstrated shortcomings in people's knowledge or execution of these obligations.

Reports to the College of Nurses

43. The *Regulated Health Professions Act, 1991* mandates reports by health professionals, facilities and employers where incompetence or incapacity of a member is suspected, or where a member's employment is terminated for professional misconduct, incompetence or incapacity.[12]

44. Notwithstanding Caressant Care Woodstock's (**"CCW"**) delivery of a Report Form for Facility Operators and Employers to the College following EW's termination, the evidence demonstrated that the report did not provide a complete and accurate picture of EW's discipline history or other identified issues. The evidence also demonstrated that it was not sent until several weeks later.[13] These mandatory reports are mandatory for a reason, and one can only speculate what may have been done differently had the College been provided with a comprehensive report on EW's known misconduct and other identified issues.

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[12] *Regulated Health Professions Act, 1991,* S.O. 1991, c. 18 ("***Regulated Health Professions Act***") at sections 85.1-85.5.

[13] Testimony of Brenda Van Quaetham, June 7, 2018 at pages 566-572.

Reports to the Ministry of Health and Long-Term Care

45. The *LTCHA, 2007* mandates reports to the Ministry where a person has reasonable grounds to suspect improper or incompetent treatment or care that led to harm or risk of harm to a resident, abuse, neglect or unlawful conduct (among other things).[14] Karen Simpson, former Director of the Ministry's Long-Term Care Inspections Branch gave evidence that certain homes had reporting issues and that without the proper information, the Ministry is unable to adequately identify risks.[15]

46. Administrators come from diverse educational and training backgrounds. They are responsible for the long-term care home and for its management.[16] O. Reg. 79/10 sets out certain prescribed educational and experience requirements for persons fulfilling the statutory Administrator role.[17] The prescribed requirements include a post-secondary degree or post-secondary diploma in health or social services; working experience in a managerial or supervisory capacity in the health or social services sector; and completion or enrolment in a program in long-term care home administration or management.

47. Testifying about the prescribed education and experience-based requirements for Administrators, Karen Simpson stated in cross-examination[18]:

> Q. And so then with respect to the purpose of this provision, could you help us, why is it important to set out actually in a regulation to a statute the education and required qualifications of these Administrators and Directors of Nursing in long-term care?
>
> A. Because the leadership in long-term care is often indicative of the actual care provided to residents, and you know, I have said this many, many times, that when we run into problems in a long-term care home, generally speaking, there

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[14] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8 at section 24(1).
[15] Testimony of Karen Simpson, July 30, 2018 at page 6226 lines 4-31.
[16] *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8 at section 70(2).
[17] O. Reg. 79/10: General under *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 at section 212.
[18] Testimony of Karen Simpson, July 31, 2018 at pages 6515-6516.

> are issues with the leadership in that home. So leadership is absolutely critical, and in actual fact, I think that Administrators should have more than this minimum 100 hours of instruction time.

48. Similarly, former CCW Administrator Brenda Van Quaetham stated in cross-examination[19]:

> Q. … in your role as Administrator of the facility during that period, which I understand to be 2009 until 2016, would it have been helpful to you to have further training in areas like human resources or discipline or compliance?
>
> A. Yes.
>
> Q. And for clarity, I'm speaking about either formal education or something that was, you know, provided by your employer or both?
>
> A. Yeah, both.

49. Mandatory reporting obligations are one of the key checks on the long-term care sector. Proper reporting is critical to ensuring the safety and security of residents and from protecting them from intentional harm. Accordingly, AdvantAge Ontario recommends that long-term care stakeholders, including Administrators, Directors of Care, staff (including registered staff), as well as residents and their families be provided with better education, training and information related to compliance, mandatory reporting, human resources (as applicable) as well as clinical skills, and that access to better resources be provided to assist with this.

50. AdvantAge Ontario further recommends that a further funding envelope be established for education and training of long-term care management and staff, which includes funds for backfilling staff while they are in training.

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[19] Testimony of Brenda Van Quaetham, June 7, 2018 (Day 3) at page 630 lines 21-32.

Reports to the Office of the Coroner - Sudden and Unexpected Deaths

51. The *Coroners Act* mandates that any person who has reason to believe that a person died suddenly and unexpectedly shall immediately notify a coroner or police officer.[20] However, the evidence from the public hearings demonstrates a lack of consistency in how people understand and interpret the words "suddenly and unexpectedly".[21]

52. The totality of the evidence emphasizes the importance of this issue. Dr. Dirk Huyer, the Chief Coroner for Ontario, testified that the Coroner's interpretation of "suddenly and unexpectedly" means "*sudden and unanticipated given medical history*."[22]

53. Dr. William George, investigating coroner, gave different evidence. He testified in-chief that[23]:

> Q. And in the context of a death in a long-term care home what does "sudden and unexpected" mean to you?
>
> A. I'm not sure that the term "sudden and unexpected" in a nursing home is entirely appropriate. I think a death can be sudden but it may have been foreseeable or expected. Many of these unfortunate people have lots of co-morbid conditions. They're deconditioned -- they have -- that's their whole reason they're in a nursing home.
>
> Q. But can the death of an elderly person with multiple co-morbidities can that death be considered sudden and unexpected?
>
> A. I'm not entirely sure that that's a good term to be used in a nursing home. I think a better term would be was the death foreseeable or expected?
>
> Q. Okay. So if we take your terms then, is the death of an elderly person with co-morbidities in a long-term care home, is it always foreseeable and expected or can it be not foreseeable and unexpected, in your view?
>
> A. No, I think it's more expected than the general population.
>
> Q. It's more expected?
>
> A. More expected.
>
> Q. But are there cases where it could be considered unexpected?

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[20] *Coroners Act*, R.S.O. 1990, c. C.37 at section 10(1)(d).
[21] Testimony of Dr. Richard Mann, July 18, 2018 at page 4630-4631.
[22] Exhibit 98, Affidavit of Dr. Dirk Huyer affirmed July 3, 2018 at Exhibit "E".
[23] Testimony of Dr. William George, July 18, 2018 at pages 4672-4674.

> A. There may be a nursing home resident with -- who is there for -- who is generally -- doesn't have a lot of co-morbidities. In that kind of situation it may be somebody that's been there for many years that's mentally challenged or something and doesn't have a lot of other illnesses. And so in that case, you know, it could be sudden and unexpected.
>
> Q. And can you think of another example for an elderly person with co-morbidities where the death would be sudden and unexpected or not foreseeable?
>
> A. If, for example, they were assaulted by another patient.

54. The differences between Dr. Huyer's and Dr. George's interpretations are subtle but important. AdvantAge Ontario has no doubt that Dr. George is a hard-working and caring coroner who performs his work for the public good. However, AdvantAge Ontario's position is that Dr. George's interpretation is demonstrative of a widely held belief that in long-term care, few deaths (if any) are truly sudden or unexpected. However, as we now know, some of EW's murder victims are examples of a failure to identify deaths that were sudden and unexpected, regardless of whether the coroner or forensic pathology system would have been able to confirm that to be the case.

55. AdvantAge Ontario's position is that steps must be taken to educate long-term care management and staff as well as the general public about the meaning of "sudden and unexpected"[24], and to eliminate a culture that has difficulty accepting that there are in fact sudden and unexpected deaths in long-term care.

College of Nurses

56. The evidence from the public hearings highlighted the importance of the role that the College of Nurses plays in the oversight and regulation of Registered Nurses. The College's mandate is to protect the public. From AdvantAge Ontario's perspective, the

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[24] Dr. Dirk Huyer testified that it is "*an area we need to educate more effectively*", July 16, 2018 at page 4197, lines 25-26.

evidence provided insight into what the College can do better to fulfill that mandate. More specifically, AdvantAge Ontario's position is that the College's information about a member's employment history, investigation, complaint and mandatory report history should be made available to employers and prospective employers, either through a secure employer portal, or through a more comprehensive public register.

Employment History

57. The College has information about the employment history of Registered Nurses that it does not share with employers or prospective employers.

58. EW lied to her employers and potential employers about her employment history. She hid the fact of her employment at Geraldton District Hospital ("**GDH**"), where she diverted medication (Lorazepam) and ingested it while at work, putting herself, the patients and her fellow staff members in potential danger.

59. The incident at GDH ultimately resulted in a consent Decision of the College's Fitness to Practice Committee, which found that EW was incapacitated and imposed terms, conditions and limitations on her certificate of registration for one (1) year.

60. Of course, the College knew about EW's employment at GDH. It knew that her history at GDH would be important to current and future employers. Notwithstanding, that information was removed from the public register and made unavailable to anyone outside the College (other than EW).

61. Anne Coghlan, Executive Director and Chief Executive Officer of the College, testified that the purpose of requiring members to inform the College about an employment

change is so the College has a current business address on file.[25] Ms. Coghlan testified that the College removes older employment information from the public register for a variety of reasons, including that there is a large volume of members of the College and that, as stated above, the primary purpose is to have a current business address.

62. Ms. Coghlan also confirmed that while employment history is removed from the public register, the College keeps that history internally.[26] Information about employment history that the College maintains internally is not accessible to any members of the public, including prospective employers.[27]

63. Ms. Coghlan further testified on cross-examination that[28]:

> Q. … do you believe that employers would benefit from having the full employment history that the College has at their disposal?
>
> A. They may well. I think the best source of that is the employee.

64. While AdvantAge Ontario agrees that long-term care employers would benefit from having the full employment history of Registered Nurses at their disposal, regrettably, it cannot agree that the best source of that information in each case is the prospective employee.

65. EW is an example of an employee who was not a good source for potential employers of her own employment history. In fact, she lied about her employment history, and her prospective employers were not armed with the tools to detect that. In this case, those tools could have been provided by the College without a great deal of trouble. There was

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[25] Testimony of Anne Coghlan, July 26, 2018 at page 5771, lines 10-21.
[26] Testimony of Anne Coghlan, July 26, 2018 at page 5772, lines 6-7.
[27] Ibid. at page 5300-5301, lines 23-32 and 1-11.
[28] Ibid. at page 5773, lines 14-20.

no evidence at the public hearings to suggest that there is any disadvantage to the College, its members, the public or long-term care residents in having the College make available a member's complete employment history, at least to employers.

66. As stated above, the College's mandate is to protect the public. The College has information about its members (i.e. their complete employment history) that can be used to corroborate information provided to long-term care facilities and agencies that employ Registered Nurses. The evidence shows that, at least in this case, inclusion of that information by the College in a secure employer-only portal, or on the public register, could have advanced the College's public protection mandate, while advancing the public's interest in protecting residents for harm and abuse. AdvantAge Ontario's position is that these tools are necessary to ensure the safety and security of residents, including the protection of residents from intentional harm.

67. We note as an aside that common sense suggests that there will be significant overlap between Registered Nurses who are at risk of intentionally harming residents and Registered Nurses who will intentionally hide unfavourable details about their own employment history.

Investigations, Complaints, and Mandatory Reports

68. The College has information about investigations, complaints and mandatory reports about its members, including information directly related to patient and resident safety, that is not available to employers or prospective employers of Registered Nurses.

69. As described, CCW provided a mandatory report to the College when it terminated EW from her employment in 2014. The report set out some of EW's repeated and escalating

misconduct and discipline history while at CCW.[29] The history included multiple medication errors, unprofessional communication with residents and staff, improper treatment and improper charting. Discipline measures included counselling, education sessions, written warnings, suspensions and ultimately termination.

70. Information of this nature is critical to employers or potential employers of Registered Nurses. In EW's case, intentional harm carried out by EW may have been prevented if this information had been more widely shared (again, either through a secure employer portal, or on the public register).

71. AdvantAge Ontario acknowledges that there are competing interests which require balancing. There may be cases where information is brought to the attention of the College about patient safety, where that information ultimately proves to have no merit. However, AdvantAge Ontario's position is that the way in which these interests are presently balanced does not give enough weight to the importance of protecting a vulnerable sector of our population. We have learned this the hard way, and the public hearings have demonstrated that we need new tools to assist with advancing the zero tolerance policy.

72. Accordingly, AdvantAge Ontario's position is that there should be increased transparency in relation to mandatory reports, complaints and investigations, particularly where the issues relate to patient safety. More specifically, this information should be available to any current or prospective employer of a regulated health professional, and include a

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[29] Exhibit 55, LTCI00036841.

complete and accurate account of the health professional's employment and complaint/investigation history.

Labour Relations and the Grievance Process

73. The evidence from the public hearings highlighted the fact that the labour relations grievance process does not prioritize the safety and security of residents, nor does it seek to protect them from intentional harm. Instead, the grievance process prioritizes the interests of union members over the safety of residents. The process puts employers and facilities in difficult positions and can result in potentially critical information about the safety and security of residents being buried.

74. After EW was terminated from GDH, the Ontario Nurses' Association (**"ONA"**) grieved her termination. Ultimately, GDH and ONA settled the grievance on the basis that EW's personnel file would be amended to reflect that she resigned for "health reasons" as a result of a medical condition for which she had since sought treatment. Further, GDH agreed to respond to any reference requests by advising others that EW resigned for health reasons.[30]

75. Similarly, in 2014, EW was terminated from her employment at CCW following a dangerous medication error which resulted in harm to a resident. By that point EW had a lengthy discipline history at CCW ranging from harassment, failing to complete required duties, not meeting the needs of the residents in a timely manner, inappropriate comments and various medication errors.

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[30] Exhibit 6, Overview Report: Facilities and Agencies at Volume 1 at page 14, paragraphs 42-43.

76. Again, EW grieved her termination at CCW. Several months later, a settlement was reached which required CCW to provide EW with a letter of reference, to amend her personnel file to indicate that she left her employment as a result of "voluntary resignation" and to make a payment to her of $2,000.00.

77. Of course, in labour relations there are competing interests which must be appropriately balanced. AdvantAge Ontario's position is that at least in the long-term care context, the balance of interests is weighed in favour of unionized care staff at the undue expense and prejudice of the safety and security of residents.

78. As the people of Ontario have now seen, this imbalance can have fatal consequences. More than once, EW was able to protect her own interests through the grievance process, while the interests of those around her, including residents, employers and prospective employers were severely prejudiced.

79. The evidence also demonstrates the poor range of choices that employers often have in the face of a grievance filing. Even the potential of a future grievance for a unionized employee informs the way employers discipline employees from the outset. The type of negotiation and ultimately, resolution that took place between CCW and ONA in EW's case is typical in the long-term care sector.[31] Long-term care homes are often put to the difficult decision of a) taking the matter to arbitration (often a prohibitively expensive undertaking with an uncertain result, paid for by funds drawn from the nursing and personal care envelope), and risking that a problematic and/or unsafe employee is ordered to return to work at the home; or b) resolving the matter in a manner that may unfairly

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[31] Testimony of Wanda Sanginesi, June 21, 2018 at page 2820, lines 18-28.

prejudice, or put at risk, residents or staff either at that home or at other long-term care homes.

80. AdvantAge Ontario's position is that we cannot collectively say that we believe in and enforce a "zero tolerance" policy while these rules and practices prevail. Effectively, where resolutions are reached, problematic and/or unsafe nurses are often passed on to other long-term care homes instead of out of the system, and out of the way of potential harm to residents. In EW's case, the attempt to balance employer and employee rights, and labour and union rights, has failed residents and the system as a whole.

81. CCW's settlement with ONA meant that the information it had about her unsafe practice was hidden from future employers (it is important to note here that simultaneously, the information the College had about EW's unsafe practice was also hidden from future employers). Where favourable reference letters are negotiated, not only is information withheld, but information provided is often intentionally incorrect and intended to hide critical details.

82. While ONA's position is that it considers the interests of residents when handling any grievance or potential grievance, AdvantAge Ontario's position is that the evidence demonstrates otherwise.[32] Residents cannot rely on ONA's ability to appropriately investigate the conduct of its own members and refuse to file, or withdraw a grievance where resident safety may be at risk. While ONA has complete discretion when handling

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[32] See for example, Testimony of Jill Allingham, June 21, 2018 at page 2959 in relation to ONA's statutory obligations under section 74 of the *Labour Relations Act, 1995,* S.O. 1995, c. 1, Sched. A to not act in a manner that is arbitrary, discriminatory or in bad faith in the representation of the employees in the unit.

a grievance[33], the organization views its role as primarily, if not exclusively to support its members and advance their interests.

83. It is important to note in this section that payments made to settle labour grievances are required to be taken from a home's nursing and personal care envelope – funds that are otherwise to be used to provide care to residents.[34] This is a critical fact that homes must take into account when weighing their options in the face of a grievance.

84. AdvantAge Ontario's position is that appropriate legislative amendments that more clearly set out the paramountcy of patient and resident safety as against rights of unionized healthcare employees are required. It is important that we appreciate that the labour arbitration process originated in an entirely different setting with an entirely different set of competing interests. In long-term care, the safety and security of members of a vulnerable portion of the population can be at stake.

85. AdvantAge Ontario recommends legislative amendments that establish a central board of inquiry or other adjudicative body to adjudicate grievances in the long-term care sector, where adjudicators have special expertise in long-term care issues.

86. AdvantAge Ontario further recommends the establishment of a legislative prohibition against providing false information, of any kind, to prospective employers of unionized healthcare employees, and a positive requirement to provide information about known risks or potential risks to patient safety.

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[33] Testimony of Jill Allingham, June 21, 2018 at pages 2953-2954.
[34] Testimony of Wanda Sanginesi, June 20, 2018 at page 2602-2603, lines 28-32 and 1-5.

Agency Staff

87. The evidence from the public hearings highlights the need for additional legislative responsibility applied to staffing agencies.

88. At present, agency staff play an important role in the long-term care setting. Staffing agencies act as a necessary "lender of last resort", providing care staff when no full-time staff are available at the home. These scenarios often arise at the last minute and, unfortunately, have become more the norm than the exception.

89. Providing quality care as an agency nurse can be challenging. An agency nurse usually will have little or no personal familiarity with a home or its residents. It is difficult to replace first-hand experience and familiarity with a short orientation and chart review.

90. These limitations were identified and addressed by the legislature. Section 74(1) of the *LTCHA, 2007* states:

> **Continuity of care – limit on temporary, casual or agency staff**
> **74** (1) In order to provide a stable and consistent workforce and to improve continuity of care to residents, every licensee of a long-term care home shall ensure that the use of temporary, casual or agency staff is limited in accordance with the regulations.

91. Additionally, Heidi Wilmot-Smith, the President and Owner of Lifeguard Homecare Inc. ("**Lifeguard**"), where EW worked in 2015, stated in cross-examination[35]:

> Q. … You said a number of times now that agency nurses are often seen as a last resort kind of thing for long-term care homes. I'm sure there are a number of reasons for that, but one of them would be that, simply put, it's more challenging for an agency nurse to go into a home and provide quality care and continuity of care to residents that they don't know; is that right?
>
> A. Yes.

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[35] Testimony of Heidi Wilmot-Smith, June 14, 2018 at page 1835 at lines 6-20.

> Q. They don't know the histories of the residents, they don't know their moods or their behaviours, and it's quite a challenging role; right?
>
> A. Yes.

92. For this reason, and as stated above, AdvantAge Ontario has advocated for funding and strategies to strengthen full-time staff capacities in long-term care (as opposed to funding for agency or casual staff).

93. Staffing agencies appear to exist in a regulatory "no man's land". Statutory obligations for screening measures (including criminal reference checks and vulnerable sector screens) and training and orientation are imposed on the licensee. AdvantAge has concerns that staffing agencies are overly reliant on this. In her testimony, Ms. Wilmot-Smith emphasized the fact that she was a salesperson by training and experience, that she had no nursing qualifications, that on occasion, nurses were interviewed by Ms. Wilmot-Smith alone without another nurse present, and that Lifeguard's only role was to supply nurses who were registered and in good standing with the College.[36]

94. In addition, it was not always clear whether she was familiar with important rules and regulations. For example, while Ms. Wilmot-Smith was adamant that a one-year-old criminal reference check was industry standard, other witnesses testified that a maximum of six months was industry standard.

95. In cross-examination, Ms. Wilmot-Smith stated[37]:

> Q. … Regarding criminal reference checks, you had indicated in your affidavit that you would make sure that they had one going back for one year?
>
> A. Within a year, yes.

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[36] Testimony of Heidi Wilmot-Smith, June 13 and 14, 2018 at pages 1573, 1582, 1831,
[37] Testimony of Heidi Wilmot-Smith, June 14, 2018 at pages 1792-1793, lines 12-32 and 1-4.

> Q. All right. And whose obligation was it to provide that to the home? Would that be you or the staff member?
>
> A. Again, it wasn't consistent so -- well, the staff member would provide it to us, but it wasn't consistent that all homes required that information. Sometimes they would call us for information on background checks, but I would say, as a general rule, no, they left it to us to ensure that we had that documentation on file.
>
> Q. All right. And were you aware of what the legislation requires, the Long-Term Care Homes Act requires in terms of a vulnerable sector check?
>
> A. I was unaware.
>
> Q. All right. And so you weren't aware that it required it to be up to date every six months?
>
> A. I was not aware of that, no.

96. Addressing the police service check she obtained during her January 2015 interview with EW for a Registered Nurse position, Ms. Wilmot-Smith stated in her examination in-chief[38]:

> Q. Now, the actual Police Service check is dated April 22nd, 2014. Did that give you any cause for concern that it was some eight months old?
>
> A. I don't believe so, and I think the rationale behind that was anecdotally our long-term care partners had indicated that they either need to get their staff to produce a new background check yearly or make a declaration yearly, and so since we were at the I think eight-month mark, I elected to accept it.

97. Other witnesses were consistent in their evidence that checks for full-time staff needed to be no more than six months old. For example, Dian Shannon, Executive Director/Administrator at Telfer Place, stated in cross-examination that[39]:

> Q. … Are you able to tell us what the policy was when it came to hiring full-time registered staff at Telfer or through Revera for how current the vulnerable sector screening tests or checks or the criminal record checks had to be?
>
> A. Within six months.

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[38] Testimony of Heidi Wilmot-Smith, June 13, 2018 at page 1591, lines 15-26.

[39] Testimony of Dian Shannon, June 26, 2018 at page 3652, lines 2-8. See also, Testimony of Melanie Smith, June 20, 2018 at page 2371, lines 9-23 and pages 2520-2522. *Long-Term Care Homes Act, 2007,* S.O. 2007, c. 8 at section 75 and . Reg. 79/10: General under *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 at section 215.

98. AdvantAge Ontario agrees with Lifeguard's concern that, when it hired EW, it did so in a vacuum of information that could have otherwise been available from former employers and from the College. It also agrees that facilities have a different opportunity to observe the agency nurses in the work environment than Lifeguard would.

99. However, without taking away any responsibility from licensees, it is sensible policy to impose rules and regulations on the employers providing care staff to long-term care facilities.

100. Staffing agencies should not just be "go between" businesses. They need to be familiar with the rules and regulations and maintain some accountability for ensuring that they are complied with. Accordingly, AdvantAge Ontario recommends legislative amendments that impose a responsibility for screening measures, training, orientation, and appropriate qualifications of agency staff.

Medication Security

101. The evidence from the public hearings highlights the need to revisit ideas about medication safety and security in long-term care.

102. AdvantAge Ontario supports efforts to improve safety and security for insulin and other medications used in long-term care. AdvantAge Ontario recommends that the Ministry provide funding and work with long-term care providers to develop pilot programs to test the efficacy of having pharmacy technicians in long-term care homes to increase medication safety and security. AdvantAge Ontario further recommends that the Ministry provide funding for the sector to work with pharmacy vendors to introduce automated dispensers in homes.

103. AdvantAge Ontario also supports the double checking of medication doses, but believes that without improved staffing capacity it is not a feasible goal.

Overregulation

104. The evidence at the public hearings highlighted the fact that the rules and regulations applying to long-term care in Ontario are dense and complex. The amount of time and resources committed to ensuring compliance can be a tremendous burden on facilities, Registered Nurses and others.

105. The overregulation contributes to the workload of direct care staff in long-term care. The workload of these care staff contributes to the challenges the sector faces recruiting and retaining quality staff.

106. In her affidavit, Dian Shannon, Executive Director/Administrator at Telfer Place stated[40]:

> 19. There are a lot of regulations and demands for documentation under the LTCHA. Nurses are very concerned about completing all of their documentation requirements because of their fear of not meeting Ministry and policy requirements or compromising their nursing licence. There are numerous policies for registered staff to follow.
>
> 20. In terms of the RN's shift routine, documentation probably takes two hours of the nurse's time per shift.
>
> …
>
> 23. Registered Nurses often stay after their shift is over to catch up on their paperwork.

107. When asked about workload in long-term care for Registered Nurses and the scope of regulations Registered Nurses must comply with, Ms. Shannon stated in cross-examination that[41] (bold emphasis added):

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[40] Exhibit 81, Affidavit of Dian Shannon sworn June 26, 2018 at paragraphs 19-20 and 23.

> Q. … So my question relating to is, in your own observations, did the amount of paperwork and the amount of regulation and requirements, did that interfere in any way with the RN's ability to deliver actual hands-on care? … what I am trying to understand and to have the Commissioner understand is whether the amount of administrative kind of work and regulation compliance kind of work that RNs do interferes with what might otherwise be their core function, which is delivering care?
>
> A. **I think the more administrative work that nurses are required to do, the less time they have with residents, yes.**
>
> Q. And that applies to what you have stated here about spending the time on shift trying to make sure that they have complied with all of the applicable rules and regulations?
>
> A. **There are extensive requirements for documentation by the nurses.** If a resident falls, there could be an additional two hours' worth of documentation by the time they wrap up all of the assessments, the referrals, sending a resident out to the hospital, bringing a resident back in, notifying everyone. It is an extraordinary amount of paperwork that they are required to do. **Do I think that it interferes with the way that they are able or wish to give care to the resident? I think it does. I think the amount of face time that nurses get with residents is diminished.**

108. Notwithstanding the extensive overhaul of long-term care law and regulation through the enactment of the *LTCHA, 2007*, including the new inspection regime[42], EW was able to intentionally harm residents over a period of many years without detection.

109. AdvantAge Ontario's position is that regulation of long-term care has gone too far and has lost its effectiveness in the process. Accordingly, AdvantAge Ontario recommends that consultations take place geared toward adopting legislative amendments that simplify the regulatory environment, with greater emphasis on direct, in-person care and away from a culture driven by paperwork and "box-ticking".

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[41] Testimony of Dian Shannon, June 26, 2018 at page 3592-3594.

[42] The complex transition from the *Nursing Homes Act* regime to the *LTCHA, 2007* regime, as well as the organization of the Ministry and its various branches that play a role in long-term care, is set out in Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018.

The "Inspection" vs. "Compliance Advisor" System

110. The evidence from the public hearings highlights the fact that the legislative transition from "Compliance Advisors" to "Inspectors" did not provide a net benefit to residents' safety, or to the system as a whole.

111. When the *LTCHA, 2007* came into force to replace the *Nursing Homes Act*[43], the former role of "Compliance Advisor" was abolished in favour of "Inspectors". Unlike Compliance Advisors, who were assigned to specific homes and could develop professional relationships with the licensees and their staff, Inspectors were now expected to inspect at any and all licensees.

112. Further, Inspectors no longer provide advice to homes about how to comply with the *LTCHA, 2007* or O. Reg. 79/10, unlike their Compliance Advisor predecessors.[44] In her examination in-chief, Ms. Simpson stated[45]:

> Q. When you were a Senior Manager there, it was Compliance Advisors who would be assigned to go into the long-term care homes, and they were originally assigned to specific homes; is that correct?
>
> A. That's right. They each had about 12, 12 to 14, I think it was, long-term care homes that they were responsible for, and they did everything with those homes. So they did the inspections; they reviewed the information coming in and were sort of accountable for that group. You know, I think at that time they would help others if need be, but they had sort of primary responsibility for a set group of homes.
>
> Q. Okay, and as I understand it Compliance Advisors would also play a role in providing advice to the homes at that time; is that correct?
>
> A. So there was a different relationship at that time with the homes. If the homes were struggling to deal with an issue, they would ask their Compliance Advisor about some suggestions on how they might be able to deal with that issue and get some advice in relation to that.

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[43] *Nursing Homes Act,* R.S.O. 1990, c. N.7 *("**Nursing Homes Act**").*
[44] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at paragraphs 21-22 and 74-75.
[45] Testimony of Karen Simpson, July 30, 2018 at pages 6077-6079.

> Q. And on July 1st, 2010, when the Long-Term Care Homes Act came into effect, all these Compliance Advisors then became Inspectors; is that right?
>
> A. That's correct, yes.
>
> Q. And were they still assigned to specific homes?
>
> A. No, we made changes to it. We had done a lot of research associated with inspection best practice as part of our changes to the methodology and approach to inspections, and what was identified was that when you had a Compliance Advisor or an Inspector associated with just a small group of homes and only those homes, there were relationships that would build up that were either positive or negative for that matter, and as a result of that, it was harder for the Inspector to be objective. So inspection best practice was that you, you know, were assigned to all of the homes in your area, and in fact, we have Inspectors who help with other Service Area Offices as well, so they could be anywhere in the province. So that was seen as a more objective approach to inspecting.
>
> Q. Okay. So they are no longer assigned to the specific homes. Were they still able to provide advice to the homes when they were going in to inspect?
>
> A. So we did make changes on that as well, because it was determined as part of our research as well that Inspectors also needed to ensure they maintained their objectivity, and it is very difficult to be objective if you are the one who actually advised the home on how to change it and yet you go back in and the home is still not compliant. So we did change that approach and said you don't give advice specifically to homes on how to be compliant. That is the responsibility of the licensee under the Act.

113. AdvantAge Ontario agrees with the description of the transition to the new inspection regime provided by Ms. Simpson, but it respectfully disagrees with her perspective on the nature of the changes. Of note, Ms. Simpson did acknowledge that the "*licensees' reaction to the change associated with the LTCHA was not all positive. They missed having a relationship with a Compliance Advisor, a person they could go to and ask for help on how to fix their compliance issues.*"[46]

114. In her affidavit, Ms. Simpson stated that, as a matter of policy, "*Inspectors should not give advice to a home about what specific actions they need to take to achieve*

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[46] Exhibit 129, Affidavit of Karen Simpson sworn July 25, 2018 at paragraph 77.

compliance. This is important in order to avoid a situation in which a home has taken an Inspector's advice but is still not in compliance when an Inspector comes to inspect."[47]

115. AdvantAge Ontario disagrees with this as a policy position, and disagrees that it puts residents in the best position to be safe from intentional harm. The effect of this policy is to make what was once a collaborative system into an adversarial one.

116. It is important to note that significant resources were directed toward the Ministry to enable the transition from the *Nursing Homes Act* to the *LTCHA, 2007*. For example, the Ministry now employs well over one hundred (100) Inspectors to carry out inspection of licensees under the *LTCHA, 2007*. However, corresponding funding and resources were never directed to the sector itself.

117. Rhetorically, if the Ministry is concerned about its Inspectors being in the position of providing advice and working collaboratively with licensees, how can it expect licensees to be in compliance? AdvantAge Ontario recommends legislative amendments that moves the inspection regime back into a "compliance" regime, where the Ministry can work together with facilities and other stakeholders to ensure that the sector is delivering the best quality care, and ensuring the safety and security of residents across Ontario.

PART III – CONCLUSION AND RECOMMENDATIONS

118. In connection with the mandate of this public inquiry, AdvantAge Ontario respectfully suggests and requests that the Commissioner make the following:

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

a) That the Ministry provide more funding to long-term care homes, and that such funding adequately reflect the rising care needs of residents in Ontario and the need to strengthen full-time staff capacity in long-term care;

b) That the Ministry develop a strategy as part of its funding initiatives to improve recruitment and retaining of quality registered staff in long-term care;

c) That the Ministry implement improvements to the RAI-MDS system, and the way it informs funding of the nursing and personal care envelope, that enables funding based on the most current data;

d) That the Ministry provide greater discretion to licensees in their use of public funds in recognition of the unique needs of different operators and resident groups;

e) That long-term care stakeholders, including Administrators, Directors of Care, staff (including registered staff), as well as residents and their families be provided with better education, training and information related to compliance, mandatory reporting, human resources (as applicable), clinical care (as applicable) and identification of sudden and unexpected deaths and other red flags;

f) That the Ministry establish a further funding envelope for the education and training of long-term care management and staff which includes funds for backfilling staff while they are in training;

g) That the College of Nurses share information with employers about its members relating to employment history, complaints, investigations, and mandatory reports dealing with patient safety issues (either directly through an employer portal, or through a more comprehensive public register), including, if necessary, applicable amendments to the *Regulated Health Professions Act*;

h) That legislative amendments be implemented to establish a central board of inquiry or other adjudicative body to adjudicate grievances in the long-term care sector, where adjudicators have special expertise in long-term care issues;

i) That legislative amendments be implemented prohibiting the provision of false information, of any kind, to prospective employers of care staff in long-term care; a requirement that information provided to prospective employers include known risks or potential risks to patient or resident safety; and a requirement that reference checks by prospective employers for long-term care staff include a verbal discussion with anyone providing a written reference;

j) That legislative amendments be implemented that impose a responsibility for screening measures, training, orientation, and appropriate qualifications of agency staff on staffing agencies themselves;

k) That the Ministry provide funding for and work with long-term care providers to develop pilot programs to test the efficacy of having pharmacy technicians in long-term care homes to increase medication safety and security. AdvantAge Ontario further recommends that Ministry fund collaboration between the long-

term care sector work and pharmacy vendors to introduce automated dispensers in homes;

l) That the Ministry engage long-term care stakeholders in efforts to simplify the regulatory environment, with an emphasis on the provision of more direct, in-person care, and on a movement away from the "inspection" regime back toward the "compliance" regime under the former *Nursing Homes Act*; and

m) That the Ministry shall conduct an annual review of progress on the recommendations made by the Commissioner as a result of this public inquiry, with the results to be made public.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 20th day of September, 2018.

FOGLER, RUBINOFF LLP

Per: Michael B. Fraleigh and Jared B. Schwartz