PUBLIC INQUIRY INTO THE

SAFETY AND SECURITY OF RESIDENTS

IN THE LONG-TERM CARE HOMES SYSTEM

CLOSING SUBMISSIONS OF THE REGISTERED NURSES' ASSOCIATION OF ONTARIO

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1. The Registered Nurses' Association of Ontario (RNAO) called for this Public Inquiry, requested and was granted standing, and has taken an active role in the process in order to assist the Commissioner in exposing and making recommendations to remediate the systemic failings in our long-term care ("LTC") system. In doing so, the RNAO is honouring the lives of the victims and doing its utmost to prevent future tragedies. This Inquiry has already been a valuable learning process for participants and the public. In the RNAO's respectful submission, the evidence heard by this Commission has revealed many shortcomings in the LTC system which may have contributed to Elizabeth Wettlaufer's ability to commit her offences undetected over so many years.

2. The RNAO respectfully submits that in light of this evidence, the Commissioner should consider the following recommendations. The RNAO's position is informed by its expert policy work as well as its direct engagement with LTC facilities, including by devising and proactively supporting the adoption of evidence-based clinical and work environment best practices guidelines.

a. The funding model for LTC homes should be changed to encourage rather than penalize homes when they improve resident outcomes. The RNAO recommends that the funding formula be modernized to account for both complexity of resident care needs and quality outcomes. As such, LTC homes that decrease case mix index ("CMI") due to evidence-based care should be able to retain all funding to reinvest in staffing and/or programs for residents.

b. An appropriate skill mix of RNs, RPNs, NPs, and unregulated care providers should be established to meet the increasingly complex needs of LTC home residents.

c. The LTC practice environment should be improved to support nurses and the retention and recruitment of nurses by setting appropriate staffing levels and mixes, developing strong nurse leaders, and establishing supports for staff.

d. There should be mandatory disclosure of resident-safety concerns when potential employers are conducting reference checks.

e. The threshold for reporting nurses to the College of Nurses ("College") should be clarified and adjusted to better reflect the College's role as a regulator and to better serve its mandate of public protection.

f. The College's Mandatory Report Form should be clarified and altered to explicitly identify voluntary reports.

g. Guidance for nurses and employers/facilities with respect to the College's reporting thresholds and processes should be improved.

h. The College's risk assessment threshold to investigate a report should be clarified.

i. The College should be required to take a more active role in collaborating with the Ministry on staffing, funding, and other issues insofar as inadequate staffing and funding interferes with nurses' ability to meet professional standards.

j. It should be mandatory for information about resident-safety related terminations to be recorded in a nurse's private records held by the College. This information should be accessible to future employers if they request it from the College.

k. LTC homes require clarification with respect to when they should contact a local coroner in respect of a death, especially around sudden and unexpected deaths. The Coroner should be mandated to complete a review, including autopsy, if a member of the resident's care team at the LTC home recommends it.

l. The inspection report process should be adjusted to include reporting on compliance as well as non-compliance.

m. Measures should be implemented to increase use of existing best practices resources, such as the LTC Best Practices Program, in LTC homes.

n. Measures should be adopted for annual reviews of progress on implementing the Inquiry's recommendations and ongoing consultations on progress and other systemic challenges facing the LTC system.

3. In the RNAO's submission, implementing these recommendations will help ensure improved health outcomes, safety, and dignity for residents, and improved practices and conditions for LTC regulated and unregulated staff. The RNAO's submissions below review each of these recommendations and the evidence which supports them. Each of these recommendations will contribute to a stronger LTC system and preventing offences such as Elizabeth Wettlaufer's from happening. The RNAO's submissions are forward-looking, in that they are limited to making recommendations and outlining the evidence which supports those recommendations, in order to best assist the Commissioner.

a. Changes to the Funding Model

4. LTC homes are currently funded based on a formula that relies on staff to regularly assess the acuity level of residents using the Resident Assessment Instrument/Minimum Data Set ("RAI/MDS"). The RAI/MDS is an extension of each resident's care plan, which requires quarterly assessments of each resident based on daily charting and assessments conducted by LTC staff. This data is provided to the Ministry, who then determines the home's Case Mix Index ("CMI"). The home's funding from the Ministry is based on the home's CMI. Funding is linked directly to residents' conditions and needs. The higher the acuity level of residents, the more funding the home will receive. The funding provided by the Ministry is allocated to specific "envelopes" or purposes (i.e. nursing and personal care). If the home does not spend all of its budget in a given envelope, depending on the type of envelope, those funds must be returned to the Ministry.[1]

[1] Exhibit 10, Affidavit of B. Van Quaethem, paras. 12-13 (AFF000001); Evidence of B. Van Quaethem, p. 269, l. 13 to p. 273, l. 22.

5. The RNAO submits that two changes to the funding model are required: (1) the funding model should not operate so as to penalize facilities who improve resident outcomes; and (2) the funding model should take into account the importance of reinvestment in the home.

6. The RNAO submits that funding should be based on resident complexity *and* quality outcomes. The current funding policy penalizes facilities that adopt best practices. As residents' outcomes improve, funding decreases. This happens because funding is linked solely to resident complexity; when outcomes improve and thus resident complexity decreases, the funding correspondingly decreases.

7. The funding model for LTC needs to be transformed to support evidence-based practice and residents' outcomes. In particular, the funding model should be adjusted to encourage and enable – rather than penalize – improvements in resident outcomes. Under the current system, a home that has been operating well at its current level of funding, and improving resident outcomes, may find itself unable to meet the same standards when improved resident outcomes translate to a decrease in funding. Similarly, a home that has been actively trying to improve its operations to achieve better outcomes, and succeeds in doing so, may find it is no longer able to maintain improved outcomes or continue improving outcomes when its funding decreases as a result.

8. Similarly, it is important that funding recommendations speak to reinvestment. When resident outcomes improve, funding should not be clawed back. Instead, homes should retain that funding to invest it in resident care. In the RNAO's submission, homes should not face any limitations that would prevent them from using their funding towards resident care.

9. At a basic and fundamental level, the funding model can be seen as connected to Elizabeth Wettlaufer's offences, and the risk of intentional harm to residents in general. A funding model that effectively disincentivizes improving resident outcomes, or that claws back funding when homes have made improvements, is one that encourages cutting costs at the expense of adequate staffing and other resources, and at the expense of sustaining improvements to resident outcomes. Without adequate staffing and other resources, LTC will continue to be an

area that struggles to retain and recruit competent and devoted staff. Dedicated, trained staff should be at the front lines of protecting residents and preventing intentional harm.

b. Appropriate staffing level and mix to meet the complex and unpredictable needs of residents

10. The evidence heard from staff in LTC facilities about how the practice environment in these facilities has evolved had two key themes: LTC homes are chronically understaffed, and residents in LTC have increasingly complex care needs.[2] These two themes are related, in that as residents' needs have increased, LTC staffing has not kept up. In the RNAO's submission, it is essential that this Commission make recommendations that would increase the registered staffing (RNs, RPNs, and NPs) levels in LTC homes and ensure that there is an appropriate mix of nursing and personal care staff to meet residents' needs.

11. Low levels of registered nursing staff (RNs and RPNs) may have contributed to Elizabeth Wettlaufer's ability to inflict intentional harm on an ongoing basis in that her practice was not visible to her peers. She frequently worked the night shift, which meant that she did not have her peers (RNs and RPNs) present to observe her practice and she was the only nurse caring for certain residents during those shifts.[3]

12. Increased levels of registered nursing staff will mean that staff have more time to spend on direct resident care. Staff will have more time to assess residents, thereby improving their ability to detect and prevent intentional harm. It is likewise important that there be an appropriate mix of nursing and personal care staff at LTC homes, to ensure that the staff monitoring residents have the skill level necessary to respond to their needs and any changes in condition that may be the result of intentional harm.

13. In the RNAO's submission, the current legislated requirement for at least one RN to be present in a LTC home at all times (the "One RN Rule")[4] must remain in place, at a bare minimum.

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[2] See, for example, Evidence of H. Crombez, p. 768, ll. 10-24; Exhibit 10, Affidavit of B. Van Quaethem, at paras. 20-22 (AFF000001); Exhibit 16, Affidavit of H. Crombez, paras. 20-22 (AFF000002).
[3] Exhibit 1, Agreed Statement of Fact, paras. 9, 20, 37, 44, 63, 75-78 (LTCI00057683).
[4] *Long Term Care Homes Act, 2007*, S.O. 2007, c. 8, s. 8(3).

However, except for very small homes, one RN is insufficient to meet the complex and at times unpredictable needs of today's LTC residents.

14. It is important that there be enough registered nursing staff to be able to adequately monitor all residents and catch intentional (and non-intentional) harm. If staff are overworked and spread too thin, they do not have sufficient time to spend on resident care to catch intentional harm to residents, especially if – as was the case here – the harm is not obvious or it resembles the kinds of symptoms residents might experience from other conditions.[5]

15. The RNAO further recommends that the government legislate minimum RN, RPN, and NP staffing and skill mix requirements in LTC homes, accompanied by the necessary funding to support this change. There should be one attending Nurse Practitioner for every 120 residents, and a nursing and personal care staff mix consisting of no less than 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent unregulated staff such as PSWs.

16. The RNAO has been an advocate for an appropriate staffing and skill mix requirement in LTC, to enable LTC homes to best meet the needs of residents.[6] An effective skill mix is crucial to ensuring that residents have timely access to the care they need and to improving outcomes for residents and LTC homes. Inappropriate skill mixes put residents at risk and undermine their care. An appropriate skill mix is designed to match resident needs with the competencies of providers, to ensure that nurses can foster continuity of care and care provider, react appropriately and quickly to emerging complications or emergencies, assess their residents accurately, and communicate with the rest of the care team.

17. The RNAO expects that the RPNAO will recommend eliminating the "One RN Rule" in favour of having more RPNs. Respectfully, while there is no doubt that there are many capable and dedicated RPNs working in the LTC sector, given the uncontested evidence that residents' conditions and needs are becoming increasingly complex and unpredictable, LTC homes must

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[5] Exhibit 1, Agreed Statement of Facts, para. 14 (LTCI00057683).

[6] For example, the RNAO has issued reports on this subject, such as *Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN,* which it looks forward to sharing with the Commissioner as part of the next phase of this Inquiry.

have at least one and preferably more RNs on site at all times. This requirement must remain in the *Long-Term Care Homes Act (LTCHA)*.

18. As indicated above, many residents in LTC have complex needs and do not have predictable outcomes. These residents require the care of an RN, in accordance with the College's Practice Guideline, *RN and RPN Practice: The Client, the Nurse, and the Environment* (also known as the three-factor framework).[7] It is a matter of professional accountability for RNs and RPNs to ensure that residents receive care from a professional who has the required knowledge, competencies and skills. Further, when the status of a resident being cared for by an RPN changes (i.e. from stable to unpredictable), there must be an RN there to take over their care. In the absence of an RN, there would be no one on-site to take over the care of residents with complex needs and unpredictable, high risk outcomes absent a transfer to the emergency department of the nearest hospital. An RN must be present to prevent vulnerable and frail residents from being transferred unnecessarily to hospital to receive the required care.

19. The College expects that RPNs will not handle complex or unpredictable cases on their own. RPNs are expected to work in collaboration with RNs and other members of the health care team. Given the fact that RNs should be the ones handling complex and/or unpredictable cases, or at least managing those cases in collaboration with other members of the health team, professional standards demand that there be a sufficient number and ratio of RNs in LTC homes.[8]

20. The solution to insufficient staffing in LTC homes is not to reduce the qualifications of staff in favour of simply having more staff. It is essential that LTC homes have not only enough staff, but also staff with the appropriate knowledge, competencies and skills, to meet residents' increasingly complex needs.

21. In the RNAO's view, the complex needs of residents mean that Nurse Practitioners should be funded in LTC homes to a minimum of one attending NP per 120 residents. The role of attending NPs should be primarily focused on resident care. To achieve this, the government should develop and implement an accountability framework to hold LTC homes accountable for

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[7] Exhibit 31 (LTCI00054989).
[8] Evidence of A. Coghlan, p. 5778, l. 4 to p. 5779, l. 17.

hiring attending NPs to serve as most responsible providers (MRP) and practice to their full scope. These NPs must be hired on a full-time basis so they have good knowledge of the residents and their health.

22. The RNAO further recommends that the government legislate minimum hours of care per resident per day. Residents should receive a minimum of four hours of nursing and personal care per day, as an average per home (though of course some residents may require more). Therapeutic care (i.e. physiotherapy, occupational therapy, and recreational therapy) should be in addition to these four hours. The minimum hours of care will enable registered staff to monitor residents more closely, providing better care and making it more likely that they will catch intentional harm.

23. On a related note, the RNAO expects that the Commissioner will consider many recommendations that will create additional demands on the time of staff in LTC homes. For example, the recommendations of Julie Greenall, who testified about safe medication practices, include limiting the supply of insulin in homes. Limiting the supply of insulin in homes would require more frequent deliveries from pharmacies, and accordingly, more staff time to process deliveries.[9] Many of Ms. Greenall's recommendations were logical and likely effective. However, all or almost all would place additional demands on existing LTC staff who are already stretched too thin. Ms. Greenall's recommendation for the involvement of pharmacy technicians would be a welcome addition to help alleviate the burden on LTC staff.

24. The RNAO urges the Commissioner not to adopt any recommendations without considering the impact of these recommendations on staffing needs in LTC homes, and recommending corresponding staffing increases. In the RNAO's respectful submission, to be meaningful, all recommendations must be backed up by adequate resources, and particularly staffing resources.

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[9] Evidence of J. Greenall, p. 8395 ll. 17-31.

c. Improving the LTC professional practice environment

25. The RNAO submits that it is crucial to make recommendations that will improve the LTC practice environment. The Commission heard evidence from numerous employees in LTC about the challenges posed by the practice environment. The Commission also heard evidence that the challenges posed by the practice environment have consequences for recruiting and retaining registered nursing staff.[10]

26. Apart from the issue of funding for adequate staff, improving the quality of the LTC practice environment is essential to addressing the staffing issues raised above. If the LTC practice environment continues to be perceived as undesirable, LTC homes will struggle to retain and recruit staff regardless of funding.

27. The staffing and practice environment issues are linked: part of what makes the LTC practice environment so challenging and thus unattractive to nurses is the limited staffing. Nurses cannot spend as much time on individual resident care as they would like and as needed to provide quality care – because of resident load, which can lead to feelings of professional and moral distress, and difficulty in meeting standards of practice. Addressing the staffing issues will go a long way to improving the practice environment.

28. Nurses must also have adequate practice supports to cope with the stresses inherent in working in the LTC environment. Counselling should be available to nurses, at least through employee benefits, and promoted by LTC homes.

29. One key part of improving the LTC practice environment from the RNAO's perspective is developing strong nurse leadership within the LTC sector. Strong leaders within LTC homes will help other staff navigate the inherent challenges of the practice environment. This is particularly important in the LTC setting given the diminished supports and reduced availability of regulated colleagues to consult (as compared to a hospital setting).

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[10] See, for example, Exhibit 10, Affidavit of B. Van Quaethem, at paras. 20-22 (AFF000001); Exhibit 16, Affidavit of H. Crombez, paras. 20-22 (AFF000002); Exhibit 43, Affidavit of H. Nicholas, para. 28 (AFF000010).

30. An important factor for developing strong leaders is time. The RNAO respectfully submits that the scope of work and workload for LTC administrators and Directors of Care ("DOCs") must be clarified. DOCs and administrators, like nurses on the floor, are overworked. DOCs from multiple homes provided evidence that their days were never free from interruption and they struggled to keep on top of all of their work.[11] As a result, things got missed.

31. The evidence demonstrated that DOCs had inconsistent levels of knowledge surrounding, among other things, the reporting requirements to the College and the definition of neglect.

32. DOCs must be Registered Nurses (RNs) who have the appropriate knowledge and skills, including leadership skills, to perform the role. To that end, the RNAO recommends that all DOCs be required to complete a standardized training course within their first year of employment as a DOC. This training should include:

a. Knowledge to maintain a professional practice environment within the organization (leadership; College's mandatory reporting requirements);

b. Knowledge of human resource management and planning (the scope of practice for regulated and unregulated staff; requirements of regulatory bodies; ongoing performance appraisal; collective agreements and working with unions; disciplinary processes; succession planning; retention and recruitment);

c. Knowledge of corporate governance (program and policy development);

d. Knowledge transfer skills (change management principles; leadership development);

e. Understanding of resident quality, risk, and safety (LTCHA legislation and regulations; clinical knowledge; quality improvement plans; monitoring, evaluation, and data analysis); and

f. Workplace health and safety (conflict management; whistleblower protection).

33. The RNAO is able and ready to work with the government and other stakeholders to develop and deliver training to meet these needs.

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[11] See, for example, Exhibit 16, Affidavit of H. Crombez, at paras. 14-16, 226-227 (AFF000002).

34. Similarly, the RNAO recommends that LTC home administrators should be regulated health professionals. An individual with a health care provider background will approach the administration of a LTC home differently than an individual who is a management professional (who may also be less likely to take a holistic view).

35. The RNAO views ongoing education and training for nurse leaders as essential. The RNAO recommends that there be annual stipends for LTC nurse leaders to take leadership and administrative training courses, such as with the RNAO's annual Nursing Executive Leadership Academy.

d. Mandatory disclosure of resident-safety concerns to potential employers

36. Elizabeth Wettlaufer was terminated twice from roles as an RN – first from Geraldton Hospital in 1995, and then from Caressant in 2014. In both instances, despite the fact that she was terminated, her personnel file was amended to reflect that she voluntarily resigned.[12] Elizabeth Wettlaufer omitted Geraldton Hospital from her resume, presumably so that potential employers would not know about her history there.[13] She grieved her termination from Caressant Care, and obtained a favourable reference letter, which she used to claim that she had been "cleared" in an investigation.[14] When she provided references to subsequent employers, she selected people who did not know her full history or, in the case of Caressant Care, the details of her termination and employment file.[15] The incomplete information provided to potential employers was a factor in her continuing to be employed in LTC.

37. Notably, Professor Beatrice Crofts Yorker's evidence was that falsifying credentials is something many health care serial killers have in common.[16] This commonality makes the

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[12] Exhibit 6, Overview Report – The Facilities and Agencies, pp. 12, 14, 57-58, 60 (REP0000025).
[13] Evidence of H. Nicholas, p. 2116, l. 20 to p. 2117 l. 14; Exhibit 43, Affidavit of H. Nicholas, Exhibit K (AFF 000010).
[14] Evidence of H. Nicholas, p. 2246, l. 21 to p. 2248, l. 9.
[15] Exhibit 43, Affidavit of H. Nicholas, Exhibit K (AFF000010).
[16] Exhibit 163, Expert report of Professor Beatrice Crofts Yorker, p. 17 (LTCI00072896); see, also, her article An Analysis of Murder Charges against Nurses, attached to her report, at p. 44-45, and her article Serial Murder by Healthcare Professionals, attached to her report, at pp. 1367, 1370.

reference check process all the more important. Employers must have access to accurate information about employment history, past performance, and reasons for termination.

38. In the RNAO's submission, during reference checks, employers should be mandated to disclose any practice concerns that impact resident safety if a nurse is terminated for reasons relating to resident-safety, or resigns in lieu of termination. The RNAO further submits that it is important for potential employers to speak directly to the nurse's current or most recent immediate supervisor or DOC.

39. To that end, the RNAO submits that LTC homes or agency employers should adopt internal policies regarding both obtaining and providing references which promote accurate and complete references. These policies could include, among other things:

a. Employees who are contacted to *provide* a reference must obtain permission from the home's DOC to give the reference. This policy would avoid the circumstances which arose at Caressant Care, where employees provided references for Elizabeth Wettlaufer although the DOC, Helen Crombez, testified that she would not have given her a reference.[17]

b. When a former employer is contacted to provide a reference, the former employer must advise the nurse's most recent immediate supervisor and make that person available to provide the reference, if possible.

c. When a home is conducting reference checks, the home should require prospective employees to provide their current or most recent immediate supervisor as a reference as part of the hiring process.

40. Unions that represent nurses must not negotiate to influence the content of reference letters or reference checks where there are resident safety concerns at play in the termination.

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[17] Evidence of H. Crombez, p. 974, ll. 12-23; Exhibit 43, Affidavit of H. Nicholas, Exhibit K (AFF000010).

e. The threshold for mandatory reporting to the CNO should be clarified and adjusted

41. To meet its mandate of public protection, the College needs a fulsome picture of a nurse's practice. In Elizabeth Wettlaufer's case, the College did not have a full picture, both because her employers did not report some of the concerning incidents, and because when she was reported, the report did not include her whole practice history. The Commission heard evidence of several concerning incidents and behaviours that went unreported. The Commission also heard evidence that facilities and employers were confused or unaware about their reporting obligations, or thought that the incidents did not meet the threshold for reporting.[18]

42. In the RNAO's submission, the mandatory reporting thresholds must be clarified to help facilities and employers understand their reporting obligation and to ensure the College can fulfill its mandate of public protection.

43. The RNAO submits that the current mandatory reporting thresholds are too high. For instance, facility operators must report to the College when they have "reasonable grounds to believe that the member is incompetent or incapacitated". Employers have an obligation to report a termination "for reasons of misconduct, incompetence, or incapacity".[19] The latter can be interpreted to mean that the member was terminated because she was deemed incompetent. "Incompetence" is defined as showing "such significant and repeated deficiencies in knowledge, skill, or judgment that the nurse's practice must be restricted to ensure client safety". Similarly, incapacity is defined as the member having "a health condition that impairs her or his ability to provide care. The impairment must be of such a degree that the facility operator finds it necessary to restrict the nurse's practice or remove the nurse from practice to protect clients".[20] These incompetence and incapacity thresholds are tantamount to the thresholds that need to be met at the Inquiries, Complaints and Reports Committee ("ICRC") stage to refer a matter to a discipline or capacity hearing. As such, the thresholds are too high.

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[18] Evidence of H. Crombez, p. 924, l. 128, p. 953 l. 20 to p. 954, l. 19; p. 1100, l. 23 to p. 1105, l. 16; p. 1117 l. 1 to p. 1118, l. 5; Evidence of H. Nicholas, p. 2173, l. 28 to p. 2184, l. 17.
[19] Exhibit 121, Affidavit of A. Coghlan, p. 247, paras. 61 and ff (AFF000034).
[20] Exhibit 121, Affidavit of A. Coghlan, pp. 257-58, Exhibit O, p. 5-6 (AFF000034).

44. First, it is important that the thresholds not be too high to ensure that the College obtains a global picture of a nurse's competence or capacity across all employers. If the incompetence or incapacity threshold needs to be met in the assessment of a single facility or employer before the College is ever notified, there may be gaps in the picture that the College obtains in respect of a given nurse. Nurses may move from one facility or employer to another, and thereby not raise sufficient concerns in a single location so as to trigger a reporting obligation. If the College had a more complete picture across different employers and facilities, it may lead to a determination that there are in fact competency or capacity concerns when looking at the totality of the member's history with the College. In other words, multiple reports from different entities may serve to establish incompetence where reports from a single location on its own might not. The reporting threshold for any individual employer or facility therefore cannot be akin to the ultimate threshold to be applied by the ICRC.

45. Second, the reporting threshold should be lower than the threshold applied by the Registrar to refer a matter for investigation. Currently, an investigation is undertaken by the College following a mandatory report where there are *reasonable and probable grounds to believe* that the member may be incompetent or incapacitated, or may be guilty of professional misconduct.[21] As indicated above, the mandatory reporting threshold for employers can arguably be interpreted to mean that the employer has concluded that the member is incompetent. It is incongruous for the reporting threshold to appear to be higher than the threshold to report a matter to the ICRC following an investigation. As further explained below, the framework needs to provide the ICRC with the ability to impose terms or conditions in instances that raise concerns but that fall short of incompetence or incapacity. Cases that warrant such an outcome may not make their way to the ICRC if the reporting threshold is set too high.

46. Finally, the current mandatory thresholds do not line up with the stated purpose of mandatory reporting, which is to "ensure that the College is alerted if there is a concern that a nurse is not practicing safely".[22] The College's expectation is also that key partners will ensure safe and ethical care by reporting "concerns about a member's conduct which *may* create a risk

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[21] Evidence of A. Coghlan, p. 5797, l. 27 to p. 5798, l. 3.
[22] Exhibit 121, Affidavit of A. Coghlan, p. 255, Exhibit O, p. 6 (AFF000034).

of harm to the public".[23] Ms. Coghlan similarly testified that the College expects facilities to report incapacity concerns where a health condition "*may* be interfering with safe practice" or where they have information to suggest that residents could potentially be at risk. In the RNAO's respectful submission, these expectations and the stated purpose of mandatory reporting are not in line with what the reporting thresholds in fact are.

47. The formulation of the current mandatory thresholds is also insufficiently clear such that these thresholds are applied inconsistently by employers and facilities. The legislation should be revised to be more specific about what constitutes incompetence or incapacity, or what circumstances should prompt a mandatory report as being indicative of potential competency and capacity concerns. The current formulation allows for too much subjectivity. Additionally, there may be some reluctance on the part of employers or facilities to pronounce themselves on a nurse's competence in a way that appears conclusive, which may lead to non-reports in cases where there ought to be a report.

48. The circumstances that mandate a report should be devised in line with what the College *expects* will be reported and what they *want* to be made aware of. In the RNAO's submission, there is a disconnect between the current expectations and the mandatory reporting thresholds.

49. For instance, given the fact that there is currently an expectation by the College that terminations for patient safety need to be reported,[24] that should be expressly stated as a basis for a mandatory report. While facility operators who are not also employers – typically where the employer is an agency – are not responsible for terminations, the RNAO submits that the equivalent of a termination by the facility operator should lead to a mandatory report. In other words, facility operators should have an independent obligation to report when they inform the employer/agency that they do not want a particular nurse to return to the facility because of resident safety concerns.

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[23] Exhibit 121, Affidavit of A. Coghlan, p. 29, para. 67 (AFF000034); emphasis added.

[24] Evidence of A. Coghlan, p. 5788, ll. 22-260. Subject to "patient safety" being appropriately defined and circumscribed: see p. 5791, ll. 1-5.

50. Given the College's desire to know about nurses who pose "a continued immediate risk to patient safety",[25] that should also be expressly stipulated as a basis for a mandatory report.

51. In the RNAO's submission, there should also be mandatory reports for *any form* of abuse of a patient or resident (including physical, verbal, or emotional abuse), not only sexual abuse, so long as the employer perceives an allegation of abuse by a resident to warrant an internal inquiry or investigation. To be clear, allegations of abuse of a resident should be subject to a mandatory reporting obligation *regardless of the results of the employer's investigation.* It is only where the employer determines that an investigation is not warranted at all (for instance where it is deemed frivolous) that there would not be a reporting obligation. This excludes instances where the resident may perceive abuse but the employer is satisfied that the perception is inaccurate or the conduct does not constitute abuse, but would include allegations that can be taken seriously enough to be looked into.[26]

52. Regardless of whether the home conducts an investigation, the home should have a well-documented process for dealing with all complaints related to abuse to ensure full accountability. LTC homes must document the results of all such complaints, including whether the complaints were made the subject of a mandatory report to the College, and if not, why not.

53. Moreover, there should be a mandatory report where a member makes medication errors that are "posing a serious risk of harm to clients" and measures in the workplace have not been successful in preventing these errors, or where there is a "pattern" of medication errors that could be attributed to recklessness or that may be intentional, rather than simple mistakes.[27] The College's Mandatory Reporting Guideline should be amended to provide explicit guidance on medication errors.

54. The RNAO however submits that a "pattern" of medication errors should not solely be interpreted as relating to a pattern of *similar* errors. The *volume* of errors should be as significant a consideration as similarity in the *types* of errors. Moreover, the volume of errors may be just

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[25] Evidence of A. Coghlan, p. 5790, ll. 17-30.
[26] Evidence of A. Coghlan, p. 5796, ll. 9-26.
[27] Evidence of A. Coghlan, p. 5797, ll. 1-26.

as significant as the severity of any given error. There should be no rigid hierarchy of errors based on the significance of the consequences to the resident. That is because a significant number of errors, even if minor in nature, can be indicative of recklessness, intent, a lack of care, or poor insight on the part of the nurse regarding the risk of harm to residents that should be of concern to the College. All errors are potential red flags.

55. For the reasons set out above, it is also important that the threshold as it applies to medication errors not be so high as to effectively amount to incompetence. The Commissioner may wish to consider whether the mandatory reporting threshold should be defined as including repeated medication errors. Again, nurses may change employment and never make enough medication errors in a single location so as to trigger a reporting obligation. The reporting threshold for any individual employer or facility needs to be lower to ensure that the College has the ability to properly monitor nurses across different employers or facilities over time.

f. Changes to the College's Mandatory Report Form

56. While the College responds to reports from employers and facilities regardless of the form they take (such as calls or emails), there is currently only a single *form* that employers and facilities can use to report their concerns: the Mandatory Report Form.[28] Given that employers may wish to report an incident in circumstances that may not be deemed to trigger a mandatory reporting obligation under current requirements (i.e. a voluntary report), there should be a separate checkbox on the form so that the employer can clearly indicate whether they are submitting a report voluntarily or based on a statutory obligation.

57. It is important for this distinction to be made clear to the College at the outset because it signals the extent of the employer's concerns – for instance, whether they deem a nurse to be incompetent or incapacitated – which is valuable information for the College.[29] While employers may currently decide to submit a "Mandatory Report Form" voluntarily and not check the "incapacity" or "incompetence" boxes, adding an additional "voluntary report" box to check or

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[28] Evidence of A. Coghlan, p. 5791, ll. 6-21; p. 5792, l. 24 to p. 5793, l. 31.
[29] Evidence of A. Coghlan, p. 5791, l. 22 to p. 5794, l. 4.

creating a separate form for voluntary reports could serve to avoid any confusion on the part of employers and any inaccuracies in the way the College interprets the forms submitted.[30]

58. Additional questions about the level of concern the employer has regarding resident safety could also specifically be asked on these forms. The RNAO submits that receiving this information on the initial form rather than waiting until the Intake investigator makes that assessment during a later discussion with the reporter, as is currently done, would be more useful so that the College can better assess, at the initial triaging stage, how quickly the Intake investigator should respond.[31]

g. Clarify the College's risk assessment threshold to investigate a report

59. Ms. Coghlan testified that investigations are ordered in cases that present a moderate *or* high risk.[32] However, there did appear to be some inconsistency or lack of clarity in the evidence in this regard.[33] Ms. Coghlan also testified that "low risk" cases are referred for investigation where there is a persistent course of conduct, even if the various low-risk forms of conduct are all different in kind.[34] The RNAO is of the view that the College should continue its practice of investigating all such low and moderate risk cases. To ensure consistency in application, the College's policies should expressly stipulate that nurses that are deemed to pose a moderate or high risk are to be the subject of investigation, and that "low risk" cases may also be investigated where there is a persistent course of poor conduct, even if the conduct is not always the same or similar in nature.

60. In particular, differing types of medication errors ought not to be dismissed. As explained above, the fact that there are several medication errors, even if they are not similar in kind, should still raise red flags as they are demonstrative of an overall lack of care and attention, a potential competence issue, or worse – intentional conduct.

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[30] Evidence of A. Coghlan, p. 5794, l. 1 to p. 5795, l. 13.
[31] Evidence of A. Coghlan, p. 5795, l. 6 to p. 5796, l. 6.
[32] Evidence of A. Coghlan, p. 5799, ll. 22-28.
[33] See, for instance, Evidence of A. Coghlan, p. 5798, l. 4 to p. 5799, l. 28.
[34] Evidence of A. Coghlan, p. 5800, l. 25 to p. 5801, l. 11.

61. Contrary to the College's perspective,[35] the RNAO is of the view that the Caressant report regarding Elizabeth Wettlaufer, considered alongside the earlier report relating to Geraldton Hospital, demonstrated that Elizabeth Wettlaufer posed a moderate risk and ought to have been investigated by the College. Accordingly, the RNAO submits that the College's interpretation of the "moderate risk" threshold may need to be lowered or expanded to include a broader range of cases. For instance, it did not in fact appear that Elizabeth Wettlaufer was learning from her mistakes and correcting her behaviour. Moreover, the number of issues and errors tended to demonstrate an all-around lack of care and attention. While the errors were somewhat different in kind, they all fell under an umbrella of generally similar types of errors. In the RNAO's submission, the fact that the errors were not identical should not have carried so much weight in the College's assessment. While making the same error repeatedly is certainly concerning, making many different types of errors should be equally concerning.

62. Regardless of risk, the RNAO further submits that all terminations based on resident-safety considerations should be investigated by the College, where there is at least one previously documented termination report (for any reason). The latter requirement is included in recognition of the fact that terminations may occur for any number of less concerning reasons, and that reasons for termination are not infrequently diffuse or less than fully transparent. Nevertheless, if a situation is serious enough to warrant a nurse's termination, it should minimally be investigated by the College (and thereby considered by the ICRC) where there is more than one termination in a member's history. In the RNAO's submission, there should be a review of such cases by the ICRC to determine what measures, including possible referral to discipline, may be warranted.

h. Improved guidance for nurses and employers/facilities in LTC

63. Nurses who work in LTC do not have other registered nursing staff to go to for support in the way that nurses who work in hospital or primary care settings might have.[36] The College

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[35] Evidence of A. Coghlan, p. 5799, ll. 29-32.
[36] Evidence of A. Coghlan, p. 5785, ll. 16-24.

currently advises certain nurses that they should consider whether the LTC practice setting is a good fit for them, given this reality.[37]

64. Respectfully, the College should not be advising nurses to leave the LTC practice sector, which is under-resourced, because of the practice environment. The College should instead be doing more to support nurses practicing in this environment and to improve the practice environment. For example, the College should be referring nurses as well as employers and facilities to resources that are available to them to provide support and guidance. While that may occasionally occur in an informal manner,[38] the process should be more formalized and the College should be expected to make such recommendations as they come across gaps in the particular work setting over the course of their investigation. In other words, the College's investigations provide an opportunity not only to provide advice to the individual nurse that is the subject of a report or complaint, but also to offer guidance to employers and facilities if the circumstances warrant it.

65. The College should also improve their outreach and provide interpretative support to inquiring facilities and employers. Consideration should be given to reintroducing the Outreach Program, whereby the College made practice consultants available to different practice sectors for education and orientation on the College's standards.[39] Despite the broader availability of online resources today, such a program may be an effective way of complementing paper and e-resources and supplementing the guidance that certain practice sectors may require.

66. There should also be better education on the reporting threshold. It is apparent that many facilities/employers did not properly understand their reporting obligations. There was a disconnect between what the College expected to be reported – and what was in fact reported. When questioned, many DOCs and administrators did not seem to appreciate the extent of their reporting obligations. The College's Process Guide on Mandatory Reporting needs to be clearer.

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[37] Evidence of A. Coghlan, p. 5785, ll. 16-24.
[38] Evidence of A. Coghlan, p. 5786, l. 13 to p. 5787, l. 27.
[39] Evidence of A. Coghlan, p. 5788, ll. 1-19.

67. Similarly, LTC homes and the College must work together to educate all staff at facilities about their reporting obligations. While the College has worked hard and continues to work hard to make reporting obligations easy to understand for nurses and employers, ongoing education and outreach is required. Registered nursing staff must take appropriate action to escalate concerns to their supervisor, clinical manager, DOC, or by reporting to the College themselves as part of their professional accountabilities.

68. The College has an important role to play in proactively educating and reminding nurses, facility operators, DOCs, and others about their reporting obligations. The RNAO recommends that the College clarify and provide continuing education for DOCs, administrators, and facility operators regarding their reporting requirements.

i. Collaboration between the College and Ministry on staffing, funding, and other concerns that interfere with nurses' ability to meet professional standards

69. The public does not expect less from nurses who practice in LTC homes. The College's standards apply to any member of the College (and the same risk assessments are conducted), regardless of the work environment.[40] Nevertheless, the College considers the nurse's work setting to inform the kinds of risks the particular sector poses, and the fact, for instance, that employers may not be providing the necessary supports to nurses.[41] The College hears from nurses in the LTC sector that there are times when the workload is a factor in their ability to practice according to standards.[42] In determining what response to give any report from LTC homes, the College takes into account the realities of that work environment, which includes how busy nurses are.[43] This would include the nurse-resident ratio.

70. In the RNAO's submission, while the number of residents per nurse can be considered in assessing the circumstances that led to a report or complaint, it is also important to factor in that nurses in the LTC sector may know their residents better than in the hospital sector because of

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[40] Evidence of A. Coghlan, p. 5784, ll. 16-22.
[41] Evidence of A. Coghlan, p. 5785, ll. 1-11.
[42] Evidence of A. Coghlan, p. 5782, ll. 10-12.
[43] Evidence of A. Coghlan, p. 5780, ll. 11-17.

continuity in providing care to residents over a longer period of time. Fewer errors should be occurring with known residents and familiar medications and medication dosages.

71. More importantly, we should guard against having lesser expectations of care in the LTC sector based on the nurses' workload. Such expectations could never be acceptable. If workload is an issue, as indeed it is, then staffing and funding for LTC must improve. Ontarians should not expect less from the LTC sector.

72. In the RNAO's submission, there is potentially a broader role for the College to play in the assessment of whether resident needs are being met. Section 2.1 of the *Health Professions Procedural Code* ("the *Code*")[44] provides that it is the duty of the College (and other colleges of health professionals) to work in consultation with the Ministry of Health and Long Term Care "to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals".

73. The College's current understanding of its role under s. 2.1 of the *Code* is to provide to the Ministry the data that assists with health human resource planning in the province.[45] In the RNAO's submission, the College should also be in a position to access data relating to staffing needs that is not available to others, and to act on that data. By virtue of its role, the College has information regarding the extent to which nurses breach the standards of practice in particular settings, such as in respect of medication errors, and acquires some understanding of the fact that that is at least in part due to staffing shortages or overworked nurses.[46] That being the case, the College ought to be raising the issue with the Ministry and collaborating to address it at the appropriate levels. If nurses aren't able to meet the standards that are expected of them by their regulator, there should be a process for that to be formally raised at the provincial level.

74. While the Ministry may well also have an understanding of staffing needs in certain practice settings,[47] the College has an independent set of data regarding breaches of College

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[44] Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.
[45] Evidence of A. Coghlan, p. 5781, ll. 9-28; p. 5783, ll. 1-17, p. 5784, l. 31 to p. 5785.
[46] Evidence of A. Coghlan, p. 5782, ll. 7-28.
[47] Evidence of A. Coghlan, p. 5783, ll. 18-23.

standards in various settings, including the LTC setting, which the Ministry would not have.[48] The Commissioner should recommend that the College's data collection and analysis capability be improved so that it may have the requisite ability to raise the issue of staffing needs with the Ministry in an informed manner, so as to ensure that appropriate action is taken to address these needs as they evolve over time.

75. In short, the College should take a more active role in its collaboration with the Ministry by flagging critical staffing needs in LTC or other sectors that render nurses unable to meet the standards of practice. Section 2.1 of the *Code* ought to be amended or interpreted more broadly to capture that obligation.

j. Make information about resident-safety related terminations available to employers on request

76. The RNAO submits that information about any resident-safety related terminations should be held by the College in each nurse's private record. This information should be available to be disclosed to potential employers upon request.

77. The evidence established that Elizabeth Wettlaufer concealed the circumstances of her terminations from Geraldton Hospital and Caressant Care in whole or in part when she sought employment elsewhere. In the RNAO's submission, it is crucial that information about resident-safety related terminations be available to prospective employers. The College is uniquely placed to provide that information, because the College already collects it through the mandatory reporting process.

78. The College should be empowered to disclose information about resident-safety related terminations to prospective employers who request it as part of the reference check process. The information the College discloses should be sufficient to allow the prospective employer to conduct an effective reference check and interview of the nurse (i.e. by contacting a previous

[48] Evidence of A. Coghlan, p. 5784, ll. 3-15.

employer and by interviewing the nurse about the circumstances of her termination). The information the College should be empowered to disclose includes:

a. Whether the nurse has been terminated for resident-safety related reasons;

b. If so, on how many occasions, when and from which employers;

c. The general nature of the reason behind the termination (i.e. physical abuse, medication error); and

d. Whether the termination is the subject of an ongoing or completed investigation by the College.

k. Provide clarification for LTC homes regarding when to contact a local coroner in respect of a death and mandate Coroner reviews where a member of the resident's care team recommends it

79. The RNAO submits that further guidance is needed for LTC homes in respect of when they should report a death to a local coroner. Section 2.1 of the *Coroners Act*[49] currently mandates LTC homes to give notice of each death to the Coroner. This is accomplished by means of an Institutional Patient Death Record (IPD). The IPD itself contains a series of questions designed to guide staff in determining whether to contact a local coroner in addition to submitting the IPD.[50] These questions include whether the death was both sudden and unexpected, which the IPD describes as "not reasonably foreseeable".[51]

80. To prevent ageism, LTC homes require further guidance from the Office of the Chief Coroner regarding what a "not reasonably foreseeable" death means in the context of LTC.[52]

81. In the RNAO's submission, the Coroner should also be mandated to complete a review, including autopsy, if a member of the resident's care team at the LTC home recommends it. The

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[49] R.S.O. 1990, c. C.37.
[50] Exhibit 7, Overview Report: Office of the Chief Coroner and the Ontario Forensic Pathology Service, p. 1 (REP0000022).
[51] Exhibit 98, Affidavit of Dr. Huyer, Exhibit Z (AFF000035).
[52] For a discussion of this issue, see the evidence of Dr. Huyer, p. 4196, l. 19 to p. 4202 l. 32.

resident's care team will be best placed to assess whether there were any concerning circumstances surrounding the death, as the resident's care team will most likely have known the resident well and been present for the resident's final days and hours.

l. Change approach to inspection reports

82. In the RNAO's submission, Ministry inspection reports should report on both areas of compliance and areas of non-compliance. Currently, only areas of non-compliance are reported on. This change is important for two reasons: first, it makes a difference to the morale of staff in LTC, and second, it is important to recognize when LTC homes are doing well to push back against the perception that LTC is not a quality practice environment or desirable care option for loved ones.

m. Increase use of existing best practices resources

83. There are many existing best practices resources ("BPRs") available to LTC homes, but not necessarily used by them. These BPRs would assist homes in improving resident care, and preventing neglect and abuse. The RNAO makes several recommendations for the Ministry's inspection and compliance process directed at increasing the use of BPRs by LTC homes.

84. First, the Ministry should create clear guidelines for inspectors on directing LTC homes to consult with resources on best practices. These guidelines should provide direction on when and how inspectors should direct LTC homes to consult best practice resources. Best practice resources would include:

a. best practice guidelines produced by third parties, such as the RNAO and other organizations;

b. best practices programs such as the RNAO's LTC best practices coordinators; and

c. consultation with other LTC homes that have adopted successful practices.

85. Inspectors should be given guidance to direct homes to include reference to BPRs in their Verbal Plans of Compliance. In addition, inspectors should include reference to third party BPRs as part of compliance orders. The same guidance should apply where the Director is involved through a Director's referral or a Director's Order.

86. Compliance inspectors should recommend in their inspection reports that homes – at the written notification stage and the voluntary plan of correction stage – work with the RNAO's LTC Best Practices Program and coordinators to achieve compliance. LTC homes should be mandated to use BPRs to assist in the preparation and execution of a plan to achieve compliance.

87. Under the former *Nursing Homes Act*, R.S.O. 1990. c. N7 ("*NHA*"), inspections and inspection-related functions were performed by Compliance Advisors. Among other things, Compliance Advisors triaged complaints and Unusual Occurrences (now Critical Incidents) and conducted inspections and issued observations or unmet standards where non-compliance was found.[53] At all these stages, Compliance Advisors also gave advice and recommendations to homes.[54] Compliance Advisors could suggest specific steps a home could take to bring itself into compliance. Since Compliance Advisors were assigned to particular sets of homes, they would develop on-going professional relationships with these homes which, in turn, came to value and rely on the Compliance Advisors' advice.[55]

88. When the *LTCHA* came into force on July 1, 2010, Compliance Advisors became Inspectors and Inspectors were no longer assigned to a set of homes but simply to their Service Area Office ("SAO").[56] In addition, Inspectors were barred from giving homes advice.[57] The purpose of these two changes in particular was to improve inspector objectivity. The Ministry implemented both changes as matters of practice and policy in the administration of the *LTCHA*. The *LTCHA* itself does not specifically prohibit inspectors from giving advice.[58]

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[53] Exhibit 9, Overview Report of the Ministry of Health and Long Term Care, Volume 3A, p. 1-2 (REP0000024).
[54] Exhibit 154, Affidavit of Karen Fairchild at para. 17 (AFF000047).
[55] Evidence of R. Kukoly, p. 6620 ll. 3-12.
[56] Exhibit 129, Affidavit of K. Simpson, at para. 19 (AFF000043).
[57] Exhibit 129, Affidavit of K. Simpson, at para. 22 (AFF000043).
[58] Evidence of K. Simpson, p. 6587.

89. A number of witnesses affirmed that eliminating advice was a key part of the new focus on inspector objectivity.[59] The evidence is that there are two primary risks in allowing inspectors to give advice. First, having inspectors inspect on their own advice or that of another inspector could understandably cause them to be reluctant to make repeated findings of non-compliance.[60] Inspectors may understandably not want to be critical of another inspector's recommendations or have to explain to the home that their own recommendations were incorrect. Second, advice giving could unnecessarily confuse service providers if they get conflicting advice from multiple inspectors.[61]

90. As Karen Simpson, the Director of the MOHLTC Inspections Branch noted, it would not be enough to have inspectors from an outside SAO provide advice as that still leaves the issue of inspectors inspecting on each other's advice and the potential for confusion.[62] Dedicated advisors would have to come from an entirely separate branch of the Ministry from the inspections branch.[63]

91. Notwithstanding the benefits of more objective Inspectors from the point of view of ensuring compliance with the *LTCHA*, the change was not universally welcomed by homes. As noted by Ms. Kukoly, who had worked for more than 15 years in a LTC home, homes would often come to rely on the advice they received from their compliance advisors and the loss of this advice is something homes still comment on today.[64]

92. In order to assist homes in the transition, the Ministry instituted a number of educational programs.[65] For example, they provided homes with the decision trees to assist in understanding the new mandatory reporting standards for the different kinds of abuse defined under the

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[59] Evidence of K. Simpson, p. 6079
[60] Evidence of K. Simpson, p. 6079-6080.
[61] *Ibid.*
[62] Evidence of K. Simpson, p. 6568 ll. 19-22.
[63] Evidence of K. Simpson, p. 6567 ll. 30 – p. 6568 ll. 24.
[64] Exhibit 134, Affidavit of R. Kukoly, at para. 3 (AFF000042); Evidence of R. Kukoly, p. 6620 ll. 3-12.
[65] Evidence of K. Simpson, p. 6130-6131;

LTCHA.[66] These educational efforts continue with the Centres for Learning, Research and Innovation in Long-Term Care (CLRI).[67]

93. However, there remains a gap in converting information about the legislative scheme into practical and actionable advice. The *LTCHA* provides a comprehensive legislative slate of standards covering areas from how food should be served to medication administration. However, the *LTCHA* does not (and could not) legislate in advance the practices that homes should adopt to meet these standards. As a result, homes must devise their own practices for achieving these standards and must ensure that these standards stay current given the increasing acuity and complexity of the resident population.

94. In this context, clear guidance to Inspectors to mandate that homes consider or adopt best practices or consult with third party programs has a number of advantages.

95. First, it will bridge the gap between the legislative requirements of the *LTCHA* and practical measures needed to meet those requirements which was left by the elimination of advice.

96. Second, encouraging homes to use best practices developed by expert third parties or to consult with programs or other homes should ease the compliance burden on homes. Workers in the industry already report being overburdened.[68] By reducing the need for homes to devise their own practices, this recommendation would free up resources to attend to other concerns such as satisfying mandatory reporting obligations and detecting improper practices by registered or unregistered staff.

97. Third, this recommendation could be implemented quickly and at minimal cost. It requires no legislative change and limited policy adaptation. Inspectors are already allowed to do what the RNAO is suggesting. Karen Simpson agreed that inspectors can provide direction including referring homes to specific third-party programs or best practice guidelines.[69] She also agreed

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[66] Evidence of K. Simpson, p. 6152 ll. 17-21.
[67] Evidence of K. Simpson, p. 6302, ll. 5-22.
[68] Evidence of K. Simpson, p. 6352 ll. 14-22, p. 6465 ll. 14-20.
[69] Evidence of K. Simpson, p. 6587-6588. See also, Exhibit 144, Affidavit of L. Vink, at para. 23 (AFF000041).

that such direction could be incorporated into Compliance orders.[70] The RNAO submits that its recommendation is a modest and incremental adjustment to the Ministry's existing practices. The recommendation is simply that there be a clear set of guidelines requiring that inspectors do more of what they already do.

98. Moreover, in terms of the guidelines and programs that inspectors would be referring homes to, that infrastructure already exists. The point is to use the enforcement mechanisms that Inspectors already have to require that homes engage with resources that are already available.

99. Finally, this recommendation would not threaten the objectivity of inspectors. Again, this kind of direction is already allowed under current legislation and practices. Moreover, two sections of the *LTCHA* will mitigate any increased risk that homes will pressure inspectors to avoid findings of non-compliance on the basis that they have followed the direction of inspectors. First, under s. 152 inspectors must issue a written report where non-compliance is found. Findings of compliance are no longer discretionary as they were under the *NHA*. Second, s. 159 eliminated any due diligence argument that homes might put forward. Where an inspector finds non-compliance, the home cannot point to its diligence or reasonable steps to avoid orders or penalties.

100. BPRs should be used throughout the stages of non-compliance to support LTC homes to achieve and maintain compliance, before financial penalties are imposed. Financial penalties should only be used as a measure of last resort.

n. Annual review of progress on implementing the Inquiry's recommendations and ongoing consultation on progress and other systemic challenges facing the LTC system.

101. The RNAO joins the Interfaith Social Assistance Reform Commission ("ISARC") and others in recommending that the Ministry adopt measures for annual follow-up and review of progress in implementing the recommendations from this Inquiry. The RNAO agrees with ISARC that the

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[70] *Ibid.*

Ministry should issue annual reports to address its progress and the progress of other parties in implementing the recommendations from this Inquiry. The RNAO further agrees with ISARC that the Ministry should convene annual conferences of stakeholders to review the annual progress reports and discuss other systemic changes that may be required to improve the safety and security of residents in LTC homes.

102. It is crucial that the mission of this Inquiry continue on long after it has concluded. Many of the challenges faced by our LTC system require long-term commitment on the part of many stakeholders. In the RNAO's submission, the mandate of this Inquiry will be well served by recommending measures that will require stakeholders to consider the Inquiry's recommendations and progress on an annual basis.

Christine Mainville
Lauren Binhammer
Gabriel Edelson

HENEIN HUTCHISON LLP
235 King St. E., First Floor
Toronto, Ontario M5A 1J9
Tel: (416) 368-5000
Fax: (416) 368-6640

Counsel for the RNAO