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

The Honourable Eileen E. Gillese
Commissioner

Ontario

Commission d'enquête publique sur la sécurité des résidents des foyers de soins de longue durée

L'honorable Eileen E. Gillese
Commissaire

In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

AFFIDAVIT OF ROBYN LAYCOCK

I, Robyn Laycock, of the City of Woodstock, in the County of Oxford, MAKE OATH AND SAY:

1. I am a witness to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the "Long-Term Care Homes Inquiry"). I have firsthand knowledge of the matters to which I hereinafter depose. Where I do not have firsthand knowledge, I have identified the source of my information and belief and believe it to be true.

2. I received my Registered Practical Nurse ("RPN") diploma at Conestoga College and graduated in 2010. While at Conestoga College I took modules in geriatrics. I was scheduled for a long-term care placement but there was an issue in the Home and the placement was cancelled. I had placements in hospitals including Cambridge Memorial Hospital, Woodstock Hospital, Stratford Hospital, and the Freeport site of the Grand River Hospital.

3. Working in a hospital is different from long-term care. In the hospital you only have four or five patients. A hospital is more in-depth (in terms of patient care). It is not as busy as long-term care. In long-term care the Registered staff are charged with 30 to 40 residents and the main focus is medications. If your shift started at 7:00 AM you would begin with the morning medication pass right through breakfast, followed by an hour of wound care, followed by the lunch medication pass. You would then hope to fit in your charting before the shift was over.

WORKING AT CARESSANT CARE

4. I began working fulltime as an RPN at Caressant Care in 2010. I was employed in Section B but would also cover shifts on the second floor. I worked a mix of days and evening shifts.

5. When I was hired at Caressant Care I received orientation. There were two days training where we would review Powerpoint presentations and review policies and procedures. There was another day of RAI training and mask-fitting. I do not recall whether there was training at Caressant Care on medication.

6. I received orientation on the floor as well. It included two shifts of each shift; for example, day, afternoons, and evenings. I did not have any training on the first floor as it was always covered by a Registered Nurse except midnights and I wasn't going to be doing midnights. My orientation shifts were scattered through the building.

7. In my opinion, I did not receive as much training as I probably should have and I know that was a common complaint amongst staff. I think I should have been trained on each

shift, on each floor, in case I needed to work there. However, as I knew I was going to be on Section B, so as long as I had the training on Section B, I was confident enough in my abilities.

8. I was confident that being trained where I was going to work was sufficient, the two shifts on each shift were sufficient. There were always other nurses with you on Section B, so whether it was a RN or another RPN, you always had their assistance and that of the Personal Support Workers ("PSWs") that had been at Caressant Care for years.

9. I do not remember anyone from the pharmacy coming to do orientation on medication administration or medication policies. I know I had a package of stuff that I read through when I first started but I'm not sure it included medical administration or the policies.

10. I believe training on reporting and mandatory reporting under the *Long-Term Care Homes Act, 2007* was completed at Caressant Care by posting a document in the medication room that you were required to read and sign. In addition, there were a few times where we had in-service education and we would go over materials on the computer.

11. There were three wings on Section B of Caressant Care – south, north and east. There was an RPN on east, an RPN on north, and then the RN helped out.

12. I think it takes a special type of person to work in long-term care. It can be very difficult to deal with residents who have behaviours. For example, there are some residents who have advanced dementia. They may hit you as you are walking down the hallway, for no apparent reason. We are trained not to retaliate. It can be like they are children –

you have to be compassionate, caring, and understanding. They are often confused. If you are a grumpy or moody or a short-tempered person, then long-term care is not where you should be.

13. You have to be compassionate and caring; it is very hard work. When residents passed away I would cry with the family and it would take a toll on me. I would take it home. I would come in early on shifts to sit with my residents that were in the palliative room and I would stay after shifts to sit with them, just in case they would pass. The residents become part of your family.

14. I started nursing because I am compassionate and I like helping people. I care deeply about the residents. I recall the first time that one of my patients passed away. I knew one day that one of my patients would pass while I was caring for them, but I was nonetheless devastated. A coworker told me that eventually I would get to the point where it would not bother me anymore, or at least not as much. I disagreed with that sentiment then, and I still do. I see it as, if it doesn't bother me when a patient passes away, then it's time for me to find a new career. I can't imagine, and I don't want to be, ambivalent about a patient's death, no matter how long I have been nursing.

MY DUTIES AS A RPN

15. My typical morning as an RPN in Section B of Caressant Care would include getting a report from the RN that was on duty on the night shift, while also completing the narcotic count with her. On my own medication cart I would make sure the narcotics matched what was supposed to be on hand. I would also get the medication cart ready for the

medication pass. I would pour the water, make sure there were enough spoons and medication cups, etc., and would start the medication pass.

16. The medication cart is locked. When I would go to see a resident I would lock the cart with a key and then unlock it again when I returned to the cart.

17. To ensure that I was administrating the right medication to the right resident I would confirm what was in my strip pack to what was noted on the eMAR. I would also note any extra directions contained in the eMAR such as "do not crush, give with food, give with applesauce." If the resident was not in their room and I did not know the resident, I would check their photo on the eMAR and also check their clothing, which is labelled. However, I would not rely only on the clothing as it can get mixed up, I would also double-check with other staff members.

18. This was the same process I used for administering narcotics: I would look for the resident, look for their medication, check the directions, and ensure the resident is still on that narcotic. However, narcotics are not in a strip pack, they are locked in a bin, inside the locked medication cart. There is a separate key for the narcotic bin. The medication cart has to be unlocked in order to unlock the narcotic bin.

19. A medication pass would generally take two hours. Generally residents would be in the dining room for breakfast and I would still be handing out medication. The RPN would supervise the dining room, the PSWs would feed the residents who required assistance, and the nurses would walk around the dining room, helping to serve, and making sure everybody was okay. I would watch for people that might choke. I would sit down at the

tables and assist with feeding or even talk to the PSW as they are feeding to ensure there was not any choking hazards.

20. Medication passes are not strictly without disruption. For example, a resident might fall, run away, need disempacting or have a skin tear. If a resident was in the shower, I had to stop and take care of those issues in the midst of the medication pass.

21. When responding to a resident fall I would fully assess the resident. I would check where they fell. I would check the resident over, head-to-toe, for any injuries. I would check their pupils, pulse, and reflexes. I would ask if they were in pain.

22. There was an incident report that needed to be filled out after a fall. You are required to contact the resident's power of attorney about the fall and the doctor if the fall is severe enough that the resident is sent to the hospital. There is also paperwork to be completed. If a resident hits their head when they fall, it becomes a head injury and you have to check their vitals every 15 minutes for the first hour, then every hour, then every four hours. A PSW cannot complete a head injury assessment as they are not regulated to provide those assessments.

23. The next medication pass begins at 11:00 AM and I would try to complete this by lunchtime.

24. Charting was done by exception. I would not always chart if there was nothing exceptional that happened in that particular day. However, if there was a fall, or a skin tear, I would need to chart that. If the resident requested something, or if their family

requested that they would like their meals to be pureed, for example, I would chart that and notify the dietary team.

25. I would have an ongoing tally, a piece of paper on my medication cart, where I jotted down notes of what I needed to chart on at the end of the day or when I got a chance to sit down and chart.

26. There were many times when I was not able to complete my charting before my shift was over. I often had to stay after shift change to get my charting done.

27. Caressant Care was always short-staffed and it did not seem that anything was ever done about it. We were constantly crying for nurses. I am sure it happens everywhere. They had two nurses that were extremely part-time and they would not hire anyone else, they said they did not have the budget for it. In my view it was ultimately the residents who suffered waiting to be toileted or if I walked in to give my medication and someone was crying I wanted to be able to sit there and console them. I wouldn't have the time. Absenteeism was also a problem. There was always someone who was not there. My perspective is that something should have been done about this, as it [absenteeism] was a pattern.

28. PSWs would have more charting to do; they had a care plan and their system was different than the nursing system. They kept track of bowel movements, incontinence, eating, fluid intake, etc.

29. When a new resident was admitted to the facility I had to do an initial head-to-toe assessment. I had to reconcile the medications and then get the doctor's orders to

continue on with that reconciliation to make sure everything was okay and that the doctor wanted to maintain that medication. If the doctor wanted to make any changes, I had to order the new medications. I would also work on the care plan and there were assessments for things like respiratory disease, medication history and medication conditions, fall risk assessment, etc.

30. A RAI Co-Ordinator would prepare the initial care plan. They inputted the care plan into the RAI. There were certain things from the RAI/MDS that would get handed down to the RPNs. I would have a list of different tasks that needed to be done for the RAI.

31. Assessments were generally completed between medication passes. However, while the family was present, I would want to get as much information as possible. Sometimes the family could not stay all day, so it would definitely push the medication pass back. However, generally new admissions did not arrive until late morning so the morning medication pass was done and your afternoon medication pass would not tend to be as intense so it freed up a little time.

32. For readmissions from hospitals, I would perform the same function. I would have the hospital medication requisition and also the medication list from prior to admission to hospital and I would compare them. I would note any changes and contact the doctor and indicate, "This is what happened in hospital. Is everything staying the same? Are there any changes being made?" I would also complete an initial head-to-toe to make sure there were no bedsores etc., present when the resident returned from the hospital. This process had to be completed where residents were admitted to hospital, but not in instances where they were only at hospitals for a few hours.

INSULIN

33. During my time at Caressant Care, residents would receive insulin via a pen and cartridge. If a resident was running low there was a reorder button on the eMAR to input the order. It was sent straight to the pharmacy.

34. There was also a drug record book but not all medications that were reordered were recorded in the drug record book. Insulin could also be reordered by peeling off the label of the box, putting it in the drug record book, signing it, and faxing it to the pharmacy. In my experience, I used the eMAR.

35. Insulin was stored in the fridge in the treatment room. The treatment room was beside the medication room in Section B. It was locked with a key that would open both the medication room and the treatment room.

36. When administering insulin via the pen, the pens were kept in the medication cart. The pens would be kept in the resident's bin with their strip package.

37. When administering insulin, if the cartridge was getting low, I would try to dial the dose up. If I did not have enough to dial up what I was expected to administer, I would dispose of the old one in the Sharps bin and start a new one. I thought it was too invasive to be poking the resident twice.

38. Insulin is not a controlled substance. When I disposed of it in the Sharps bin I did not have to record anywhere that I finished one cartridge and started another. Other staff may have used the non-controlled substance bin to dispose of the cartridge, but I used the Sharps bin. I think the non-controlled substance bin was a cardboard box.

39. When administering insulin I would check the eMAR to the insulin that was in the pen and the resident's name on the pen to ensure it was the right medication – that was my first check. I would dial up and then I would compare when I was dialling up again to my eMAR. I would take the blood sugar and I would come back and record the blood sugar and I would dial up my pen and go and administer it.

40. During the night shift on Section B the nurse would do the insulin and they would take all the blood sugar readings, so when the 7:00 AM nurse came in a lot of the times the pens were laid out on top of the medication carts already dialled up. The medication cart would be locked in the medication room.

41. There was no mechanism on the pens that would prevent anyone from dialing up more insulin into the pen.

42. Once you administer the insulin the dose goes back to zero. It is not possible to check how much was administered.

43. In terms of independent double-checks, I do not think there is a long-term care home out there that is going to put on extra staff to have two people go through and deal with all the insulin.

44. Insulin is hard to monitor. For example, if you have a 3ml (300 units) cartridge and you are trying to monitor how much insulin has been administered, you cannot always monitor because you do not know how much was used to prime the needle or if the needle sticks – there is no way of tracking that.

45. If you are working too quickly some insulin could be wasted; for example, if you remove the needle too quickly.

46. When taking blood sugar, each resident has their own glucometer. The glucometer has a memory which could recall previous blood sugar readings. There was no double-check in terms of what you record on the eMAR for the blood sugar reading. Nobody goes back to the glucometer and actually checks the actual reading.

WORKING WITH ELIZABETH WETTLAUFER

47. Elizabeth Wettlaufer worked afternoons and evenings on Section B. I started working with her in 2011. She was already working at Caressant Care when I started.

48. Elizabeth Wettlaufer tried to befriend. She tried to be more of a friend to the staff, the PSWs mainly or dietary aids. She joked around with them and took her breaks with them. I think there are a few students she hung out with after work. They would stand up at the nursing desk and talk to her for 20 minutes.

49. But I do remember at one point a PSW coming on an afternoon shift and talking to me in complete tears because Elizabeth Wettlaufer had reprimanded her for doing something that Elizabeth Wettlaufer didn't agree with and she had done it in front of other staff and residents. The PSW cried to me about it. The PSW didn't want to get in

trouble by Elizabeth Wettlaufer and I said I'll deal with it. Because I wasn't afraid of Beth. She tried to throw her weight around and I wouldn't take it. I knew I was confident in my abilities as a nurse but I didn't let her push me around.

50. I would hear stories all the time about Elizabeth Wettlaufer; about how she would sleep during her breaks. If she was on a break and something happened to one of the residents, you were not allowed to approach her. She would get very very angry and she would combine breaks into an hour long break on midnights so that she could sleep.

51. I knew she suffered from mental illness; she told me she did. Elizabeth Wettlaufer said she and her husband split up, she discovered she was bisexual, and her family abandoned her. She said she suffered from depression.

52. I also had personal conversations with a lot of my colleagues, but not to the extent of the details she went into. She could be very inappropriate when she spoke about her sexual encounters because she was very blunt. I don't know if anybody complained about it.

53. There was one time when Elizabeth Wettlaufer came back and I was leaving a shift and I thought I smelled alcohol on her breath. I notified the other Registered Nurse that was working afternoons. I just said, "You know, I'm not sure but do you want to go and have a conversation with Beth. I think she's had alcohol". I don't know if it was necessarily a problem, or maybe she had just gone out for dinner and had a drink or two while out for dinner before coming in to work.

54. She was always friendly and would joke with the residents and their families. I know there was a few residents with whom she buttted heads and would not go running right away and could be rude but for the most part she was friendly. She was nice.

55. I know that she was occasionally called in about one difficult resident in particular. This resident was much younger. She was a very independent lady. She would come and go as she pleased. She was on a diabetic diet, for for example, and she was supposed to be on monitored portions. But we would bring her dessert of a banana and she would say she did not want that, she wanted the cake. And you couldn't say no to her because she was very close to the Director of Nursing, Helen Crombez. If you did cross this resident the first thing she did was run to Mrs. Crombez and then we would be spoken to even if we were following the rules.

56. From what I was told this resident did have a tendency to retaliate by making up stories about staff. We got along fine so she never did it with me. I was firm with her and she trusted me. I don't remember the stories but I just remember Elizabeth Wettlaufer being called in to the office because I remember her joking about "it doesn't bother me when I get called in because I just throw around my lesbian card".

57. She said that she was picked on because she was a lesbian and that she was being discriminated against because of her sexuality.

58. I know that if this resident had a problem she would never go to Elizabeth Wettlaufer. She would go to anybody else. She had never spoken to me about anything said or done to her. I know a few times she had said that Elizabeth Wettlaufer made comments.

But I head from some staff members that the resident did make up stories and you took what she said with a grain of salt.

59. I found Helen Crombez's management style to be very strict. She expected things to be done a certain way that was unrealistic as to how it actually was on the floor. The only time we really saw her is when she would stand behind us and hover and watch what we were doing.

60. As far as I know I think Helen Crombez would call a lot of people into her office. I don't recall people being suspended or let go while I was at Caressant Care. I went to Helen Crombez once when I had a problem with one of the other nurses with whom I worked. This nurse was slow, she did things incorrectly, she was constantly making mistakes, and, to my knowledge, she was never ever reprimanded. After I told Helen Crombez, I was told that I needed to learn to get along with her. After that, I tried to avoid going to Helen Crombez as much as I could. I would deal with stuff on my own or I would voice my concerns to the other RN.

61. I didn't get along with Elizabeth Wettlaufer very well for a long time because we "butted heads" a lot. I was a new graduate and had some ideas on how to do things differently – newer, improved methods that I had learned in school, and she just wouldn't have it. She was very old school, stuck in her ways. She was very lazy.

62. For example, a resident would complain and the PSW would ask Elizabeth Wettlaufer for some Tylenol for the resident and she would not get up and go to her cart right away. She would finish what she was doing and or maybe go 10 or 20 minutes later. She had a "I'll get there when I get there" kind of attitude.

63. I think she had just been nursing for so long that she had separated her emotions from her job very well and became distrusting. In nursing you are taught that somebody's pain is what they say it is and, though I am speculating, I think that she had the mentality that the resident was lying, that they were not in pain, that they were saying they were in pain because they would know they were going to get some attention.

64. You would still have to stay within doctor's orders. So if the order was every four hours and only three had passed, then you are made to wait. By you would try other measures, such as a cold pack etc.

65. I had an argument with Elizabeth Wettlaufer once because one of my residents was palliative and in the palliative care room. These residents were in the palliative room for a reason: they were declining and death was expected. You never know if you are going to have an hour or if you are going to have a week when a resident goes into the palliative room. With this particular resident, on one occasion I came across Elizabeth Wettlaufer leaning over them and telling them; "If you want to, let go, it's okay. Your family will understand. Your time is here. See the light. If you want to let go, it's okay. Your body needs to rest." It was almost spiritual talk about "letting go."

66. I told her I disapproved because it was not her place to have this sort of conversation with residents, whether they were religious or not. I didn't believe it was up to her, to have this sort of conversation. I remember thinking that if that were my mother in that bed, I would be livid. Elizabeth Wettlaufer didn't see anything wrong with it.

67. I spoke with a few colleagues about my concerns regarding the manner in which Elizabeth Wettlaufer was speaking to the palliative residents. I did not like it and I held

on to it. It wasn't her right. It irked me. Whenever there was anybody in the palliative room I would go on and on and on about how I wished Elizabeth Wettlaufer was not working.

68. There was also another time that I had a palliative resident and Elizabeth Wettlaufer came out and told me to give the resident their pain medication. I said I was just in to assess the resident and I did not believe they needed it. She said it did not matter, the order was every 1 hour. I argued back that it was every 1 hour *as a PRN* and I indicated that I did not feel that the resident needed it, so I was not going to administer it because in my opinion the resident was not in distress and did not require the medication. She took it upon herself to administer it.

69. I didn't report it. I was very new at the time and figured she was my RN so any reporting would be done to the RN. Based on doctors orders she didn't do anything wrong because she was able to give that medication. It was not a timeframe issue, it was that my assessment and her assessment were completely different and then she just pulled the "I've been a nurse longer card". She said that on several occasions.

70. At one point I gave her the nickname to my family of the Angel of Death because there were a lot of palliative patients passing away. Now, if they are palliative they are expected to go, and she did work a lot of midnights so most of the residents if they passed away in the night it would be on her shift.

71. On one occasion I had started to look through the death registry looking at different residents that had passed away. It just seemed like we had a lot of residents passing away and I had just pulled out the binder one day, one afternoon - because afternoon

shifts were pretty slow - and I was looking on the computer as to which nurse was there and I had noticed that there was a lot of them that it was Elizabeth Wettlaufer. It was maybe 2010 or 2011 and there was a month where we had lost five residents, for example.

72. I had no definitive proof to bring it to anybody's attention. I just thought in my own way that it was extremely weird, knowing how she was with me about the Dilaudid that she had wanted administered to the palliative resident when I didn't think they needed it.

73. I had shown Karen Routledge at one point on the computer the amount of deaths in a certain amount of time. She acknowledged what I was saying and asked if I was going to say anything to anybody else and I said well not until I had any proof or anything. It just seemed weird and then I ended up going off on maternity leave and that's kind of where it stayed and I didn't come back. I had also talked with Karen Routledge about what Elizabeth Wettlaufer was saying to palliative patients.

74. I did not go to management with this information. I had no proof. I didn't know if it was complete coincidence and I would not want to get somebody in trouble for not doing anything wrong. And her and I had butted heads so I also thought maybe was I thinking this because of my personal dislike for her.

75. I did not follow-up on this line of thought any further. It just seemed like an odd coincidence. Then, I took my maternity leave and I did not come back. I even her a reference years later when she applied to St. Elizabeth Health Care. She messaged me and asked me if I would give it for her I believe it was an online report where I inputted comments. I was vague and gave point-form comments. I said she was compassionate,

reliable and educated. Under "areas for improvement" I said "accepting that she is not solely responsible to help everyone alone – could delegate tasks better – realizing upgraded skills are essential".

THE IMPACT OF ELIZABETH WETTLAUFER'S CRIMES

76. I was devastated by the offences. It has had a huge impact on my life. I could not sleep. I cried with these families when their loved ones passed; I cared for the residents. I spent more waking hours with these residents than I did with my own family. Through most of my time at Caressant Care, I was a single mom of an eight-year old boy and when I worked days, I wouldn't see him. I would pick him up home from school. I would bring him home, feed him, and I'd put him to bed. I spent four hours with him while I was spending eight hours with the residents at Caressant Care. When I was on the afternoon shift my son was at school and I would see him an hour in the morning getting him ready for school and I would not see him again until the next morning, so these residents were essentially my family.

77. Looking back, I feel horribly guilty about the nickname I gave Elizabeth Wettlaufer and then it turned out years later that she had been intentionally harming residents. I feared that I would be in trouble for labelling her that. I had no evidence, I just knew she worked the night shift and a lot of people passed away on the night shift, which happens anyway. I did call her the Angel of Death, she thought she could go in and whisper that it was okay to die.

78. After the offences became known I would break down at work crying and then I would start speculating even more. No one had any idea this was happening.

79. I swear this affidavit for no improper purpose.

SWORN BEFORE ME at the City of St. Thomas, in the County of Middlesex on Jan 25, 2018

Commissioner for Taking Affidavits
(or as may be)

Robyn Lynch