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

REVERA LONG TERM CARE INC.

Participant

REVERA'S CLOSING SUBMISSIONS

FASKEN MARTINEAU DuMOULIN LLP
Barristers and Solicitors
333 Bay Street, Suite 2400
Bay Adelaide Centre, Box 20
Toronto, Ontario
M5H 2T6

Jennifer McAleer (LSUC: 43312R)
Tel: 416-865-4413
jmcaleer@fasken.com

Rachel Laurion (LSUC: 67831R)
Tel: 416-868-3460
rlaurion@fasken.com

Lawyers for Revera Long Term Care Inc.

TO: The Inquiry Offices
400 University Avenue
Suite 1800C
Toronto, Ontario
M7A 2R9

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INTRODUCTION

1. This Long-Term Care Homes Public Inquiry (the "**Inquiry**"), effective by Order in Council on August 1, 2017, was established to identify and make recommendations to address the circumstances and contributing factors that may have led to the offences committed by Elizabeth Wettlaufer ("**EW**"). This Inquiry was also established to inquire into any other relevant matters that the Commissioner considers necessary to avoid similar tragedies.[1]

2. The genesis of the Inquiry, as expressed in the preamble to the Order in Council, was EW's guilty plea to eight counts of first degree murder, four counts of attempted murder and two counts of aggravated assault (the "**Offences**"). The majority of the Offences were committed by EW while working as a registered nurse ("**RN**") in long-term care homes.[2]

3. The evidence before this Inquiry demonstrates that long-term care homes:

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[1] Order in Council 1549/2017, at para. 2.

[2] Order in Council 1549/2017.

(a) need additional or alternative forms of funding in order to ensure that appropriate levels of care, particularly in light of the rising resident acuity,[3] can be provided to all residents;[4]

(b) strive to comply with applicable legislation but encounter obstacles in understanding and attaining compliance in the current inspection and enforcement regime;[5]

(c) experience significant staffing challenges, including but not limited to: recruitment and retention; discipline and termination of permanent staff members; and difficulty implementing staffing plans that align to the home's needs rather than the legislative requirements;[6]

(d) need greater access to information relating to a nurse's history in order to make informed hiring decisions;[7] and

(e) require revised medication management systems that are practical, feasible and optimize the drug therapy outcomes for residents.[8]

4. These overarching deficiencies in long-term care's current structure (the "**Deficiencies**"), which will be addressed in greater detail below, constitute systemic failings which potentially compromise the safety and well-being of residents.

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[3] Acuity measures the intensity of nursing care required by a resident. An acuity based model regulates the number of nurses on a shift according to the residents' needs (i.e. acuity) rather than the total number of beds in the home.

[4] See "Funding" section below.

[5] See "Inspections" section below.

[6] See "Employment, Recruitment and Retention" section below.

[7] See "Transparency" section below.

[8] See "Medication Management" section below.

5. While the system failed to ensure the safety and well-being of those residents affected by the Offences, one cannot lose sight of the fact that the evidence before this Inquiry demonstrates that the vast majority of those who work in long-term care (whether it be licensed, administrative, or managerial staff):

(a) are committed to providing the best possible standard of care for each resident;

(b) treat each resident with dignity and respect;

(c) foster an environment that is respectful, kind, and honouring of the humanity of each resident;

(d) were shocked, saddened and frightened to learn of the Offences;[9]

(e) notwithstanding the benefit of hindsight, were unable to identify red flags or indicators that would have alerted them to EW's Offences;[10] and

(f) are angry and hurt because EW, by her heinous acts, broke the public and the residents' trust in them and their provision of long-term care - a trust that they all have worked so hard to build.[11]

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[9] See Exhibit 76, Affidavit of Dianne Beauregard, sworn June 25, 2018 at paras. 39, 58, and 59: "I never saw anything but kindness from Elizabeth Wettlaufer. I would never have thought in a million years that she would have been the type of person to deliberately harm a resident...It's been a huge shock to everyone...Since Elizabeth Wettlaufer's crimes have come to light, I have looked back to see if I missed anything. But there was nothing."

[10] See Exhibit 118, "The Forensic Pathology of Secret Homicides: A Retrospective Review", dated July 19, 2018 at p. 3 "Homicide cases that are discovered later in the process, despite being unrecognized (or unrecognizable) at the onset of the death investigation, represent a miniscule fraction of homicide cases in any death investigation system. The rarity of secret homicides presents a significant challenge to developing evidence-based methods to allow for their detection."

[11] See also Exhibit 133, "Letter to Long-Term Care Home Licensees" dated January 11, 2017 at p. 2: "As the people who own and operate the places [residents] call home, [long-term care homes] are entrusted with an enormous responsibility to provide high quality, dignified care to our cherished elderly family members, and our most vulnerable frail friends and neighbours...we cannot allow the actions of a few to tarnish the exemplary behaviour of the vast majority of long-term care homes."

6. Revera's submissions and recommendations will focus on the need for, and the potential benefits of, systemic reforms on the Deficiencies. Through a lens that appreciates and champions the kind, compassionate and capable care that is delivered by countless individuals in long-term care,[12] these submissions will demonstrate how systemic reforms to the Deficiencies will further the safety and well-being of long-term care home residents.

(A) FUNDING

7. The current approach to funding requires reform. The evidence before this Inquiry demonstrates: (i) that resident acuity levels are rising, (ii) that the current funding model strains long-term care homes' already scarce resources and does not align with the homes' current care needs, and (iii) that the unstable and unpredictable nature of the current funding model negatively affects the homes' ability to ensure consistency in care.

Rising Acuity Levels

8. Long-term care homes are experiencing increases in the volume and proportion of residents with high care needs. In or around 2004, for example, 64% of the residents that were admitted to long-term care facilities had some form of dementia or suffered from cognitive impairment and 72% of all long-term care residents required assistance with transferring.[13] Throughout the course of this Inquiry, long-term care home staff have commented on the rising acuity levels. Ms. Helen Crombez's evidence, for example, was that she's of the view that "..the funding needed is not at the resident care level".[14] Tracey Raney's evidence was that she has noticed "...an increase in the number of residents with dementia over the years...more

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[12] See Exhibit 118, "The Forensic Pathology of Secret Homicides: A Retrospective Review", dated July 19, 2018 at p. 3: a potential flaw is to "...become overly influenced by a single case or group of deaths caused by a single perpetrator. This should be avoided because policy development should not be overly determined by a single rare event."

[13] Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit C, pp. 23 and 24.

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

residents require total assistance with all aspects of their care."[15] Similarly, Dian Shannon's evidence was:[16]

> In terms of the acuity level of the long-term care residents, in my opinion, some individuals are now sent to long-term care who don't belong in long-term care. For example, we may have someone who has significant mental health or addiction issues. Further, over my career, the number of residents with dementia and responsive behaviours seemed to increase. This results in residents who can be disruptive and can provoke angry or distressed behaviours among other residents or some residents with responsive behaviours can strike out at staff or other residents when they are unable to tolerate their situation or the care approach. Residents with dementia may also wander in and out of rooms. Additionally, some residents are also exit seeking and have to be monitored.
>
> We have residents that require such a specific care approach that, if staff do not do it right, the resident may become very upset and fight with the caregivers.

9. The current funding model attempts to account for a home's resident needs by calculating each home's case mix index ("**CMI**").[17] The CMI is "...a relative value assigned to a diagnosis-related group of patients in a medical care environment. The CMI value is used in determining the allocation of resources to care for and/or treat the patients in the group."[18] In long-term care homes, the CMI informs the Nursing and Personal Care ("**NPC**")[19] envelope of funding.[20] The evidence before this Inquiry, however, is that dementia is not sufficiently

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[15] Exhibit 77, Affidavit of Tracey Raney, sworn June 25, 2018, at para. 26.

[16] Exhibit 81, Affidavit of Dian Shannon, sworn June 26, 2018, at paras. 14 and 15.

[17] See, for example, Exhibit 10, Affidavit of Brenda Van Quaethem, sworn June 4, 2018, at para. 13, "The CMI is annually adjusted based on the acuity level of the residents."

[18] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018 at exhibit B, p. 10.

[19] Exhibit 129, Affidavit of Karen Simpson, Sworn July 25, 2018, exhibit B at p. 12: The NPC envelope funds direct care staff, nursing and medical equipment, and supplies. The NPC envelope also funds training and education. As of July 1, 2018, long-term care homes receive $100.91/resident/day in the NPC envelope.

[20] "Funding for long-term care facilities is provided through four funding envelopes: nursing and personal care; program and support services; raw food; and other accommodation costs (facility costs, administration, housekeeping, building and operational maintenance and dietary and laundry services." Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit C, p. 25.

factored into the CMI system.[21] In fact, the present "...CMI system of funding allocation does not recognize the level of care required by sufferers of dementia."[22] [23]

10. In addition, the evidence before this Inquiry is the CMI system does not meet small long-term care homes' needs because a high CMI in smaller long-term care homes does not result in significant increased funding for that home. This is so because small long-term care homes (many of which are in rural areas) are unable to take advantage of the economies of scale.[24] In fact, the current system causes small long-term care homes to suffer a disadvantage compared to their larger counterparts since the total cost to care for residents is lower when occupancy rates are higher. An illustrative example is the 24-hour RN care requirement. All long-term care homes must have 24-hour RN care, however, fulfilling that requirement impacts smaller long-term care homes' budgets much more since the overall funding is less at smaller homes.[25]

11. Additionally, the evidence before this Inquiry is that the CMI is only used to adjust the NPC envelope. "...All of the other envelopes are not adjusted based on CMI, and the additional supplementary funding are not adjusted based on CMI. So it's a very --it's one specific pot that is adjusted by CMI."[26] Only the NPC envelope is affected by a home's CMI and yet we know that residents with dementia or reduced cognitive functioning require specific

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[21] Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit C, p. 26.

[22] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018 at exhibit E, p. 23.

[23] We note that, if a resident poses a risk to him or herself or others, a home can receive additional High Intensity Needs funding in order to put one-on-one staffing with that resident. See transcript of the Inquiry Day 28/Volume 28, dated July 31, 2018, testimony of Karen Simpson, p. 6336 at lines 9-15.

[24] Exhibit 81, Affidavit of Dian Shannon, sworn June 26, 2018, at para. 22.

[25] In 2017-2018, for example, Telfer Place (with 45 beds) received $2.39 million, whereas Caressant Care (with 163 beds) received $8.50 million. See Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018, at exhibit B, p. 16.

[26] Transcript of the Inquiry Day 28/Volume 28, dated July 31, 2018, testimony of Karen Simpson, p. 6327 at lines 4-12.

therapies, support services and programs.[27] The funding for such support services and programs flows from the Program and Support Services ("**PSS**")[28] envelope and yet there is no increase to the PSS envelope based upon these rising acuity levels. Similarly, if a home wishes to improve its infrastructure in order to improve the care that its residents receive, then such costs must be covered by the home's Other Accommodate ("**OA**")[29] envelope. The OA envelope is not affected by the CMI funding system.

12. Residents of long-term care homes are some of the most vulnerable members of society. The vulnerabilities of long-term care home residents increase further when the resident suffers from dementia or other forms of cognitive impairment. In fact, the evidence before this Inquiry is that EW targeted residents with dementia because their diminished cognitive abilities allowed the Offences to remain unnoticed and unseen:

> And it was because they couldn't
> self—report. I chose them based on the
> fact that they couldn't self—report
> because they had dementia, and they
> wouldn't fight back because the one was on
> insulin, the other I could tell her it was
> a vitamin injection.[30]
> ...

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[27] See, for example, Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018, at exhibit E, p. 26.

[28] Exhibit 129, Affidavit of Karen Simpson, Sworn July 25, 2018, exhibit B at p. 12: The PSS envelope funds program staff, therapy, recreation equipment and supplies. As of July 1, 2018, long-term care homes receive $9.79/resident/day in the PSS envelope.

[29] Exhibit 129, Affidavit of Karen Simpson, Sworn July 25, 2018, exhibit B at p. 12: The OA envelope funds wages; equipment and supplies for dietary, laundry, and housekeeping; furnishings; maintenance; and operating and administration cost. As of July 1, 2018, long-term care homes receive $56.52/resident/day in the OA envelope.

[30] Exhibit 5, Transcript of Interview with Elizabeth Wettlaufer, dated February 14, 2018, at p. 53, lines 23-29.

> Every patient I ever picked
> had some dementia and that was part of
> what became my criteria. If they had
> dementia so they couldn't report or if
> they reported they wouldn't be believed.[31]
> ...
> Anybody I ever did that to had dementia.
> That was -- part of the not getting caught ...32

13. Adequate and suitable funding must be provided to long-term care homes so that the homes can adjust their treatment models, staffing compliment, infrastructure, and programs and services[33] to meet the needs of all residents, including those with cognitive impairment, those who are demonstrating behavioural symptoms, or those who require assistance with transferring.

Current Model Strains Resources and Does not Align with Current Needs

14. The current CMI system strains long-term care homes' resources because a numeric value for a home's resident care needs can only be established if nurses assess, collect and chart all clinical data. In regard to the way in which charting has strained resources, Dian Shannon's evidence was that, "the registered staff may complete 7 to 8 quarterly assessments a week...Adequate documentation is required to develop a comprehensive care plan for each resident to achieve optimum funding...Registered nurses often stay after their shift is over to

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[31] Exhibit 5, Transcript of Interview with Elizabeth Wettlaufer, dated February 14, 2018, at p. 73, lines 21-25.

[32] Exhibit 5, Transcript of Interview with Elizabeth Wettlaufer, dated February 14, 2018, at p. 74, lines 8-10.

[33] See Exhibit 9, Tab 59, "Long-Term Care Task Force on Resident Care and Safety, An Action Plan to Address Abuse and Neglect in Long-Term Care Homes" (May 2012), p. 8 at para. 14, "the Ministry of Health and Long-Term Care should address and resolve issues related to meeting the needs of residents with specialised (complex care) needs...areas to be addressed include, but are not limited to, specialised facilities, dedicated specialised units in long-term care homes, appropriate physical plant conditions, funding to cover specialised programs and the high needs of residents, and appropriate staffing with specialised skills."

catch up on their paperwork."[34] Similarly, Karen Routledge's evidence was that, in her opinion, "...the work has risen exponentially...from the time that I started until the time I retired the responsibility and the paperwork almost doubled...with the introduction of RAI/MDS[35] in addition to the care plans that created an increased workload."[36] Additionally, Helen Crombez's evidence was that "the introduction of the RAI-MDS took away from resident care time". In her opinion, "...there is too much paperwork and the long-term care home sector is over-regulated. It is difficult to find the time to walk down the hall to talk to the residents".[37]

15. Once a home has charted and submitted all of its clinical data, the timing of the funding that flows from a home's CMI is problematic. There is a significant time lag between when the home inputs its clinical data and when the Ministry calculates the index. In fact, "some estimate that 40% of the residents' conditions have changed from the time when the classifications are decided in September to when the funding is allocated six months later."[38]

16. At present, therefore, the funding system for the NPC envelope, which is the only envelope that accounts for resident acuity, depends upon the charting of behaviours and such behaviours or conditions have likely changed by the time the home receives its funding. "...[T]he system should ensure that those RN's [*sic*] who are assessing and charting the behaviours have sufficient time to actually assess and record the behaviours"[39] and the system

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[34] Exhibit 81, Affidavit of Dian Shannon, sworn June 26, 2018, at paras. 21 and 23.

[35] RAI/MDS is the Resident Assessment Instrument/Minimum Data set. See, for example, Exhibit 10, Affidavit of Brenda Van Quathem, sworn June 4, 2018, at para. 12: "The RAI/MDS system was an extension of [the] care plans. It was a computerized system...which required quarterly assessments of the residents, based on daily charting and assessments by the nursing staff and the PSW staff. That information would be reviewed by our RAI Coordinator, inputted into the Canadian Institute for Health Information ("CIHI") system and eventually translate into Caressant Care's Case Mix Index."

[36] Exhibit 33, Affidavit of Karen Routledge, sworn June 10, 2018 at paras. 7-9.

[37] Exhibit 16, Affidavit of Helen Crombez, sworn June 7, 2018 at para 15.

[38] Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit C, p. 26.

[39] Exhibit 135, "Report on the Inquest into the Deaths of Ezzeldine El Roubi and Pedro Lopez", July 2006, p. 13.

should be revised to ensure that homes receive funding to meet their current care needs (rather than their needs 6 months ago).

17. One of the methods through which an RN could earmark more time for assessments and charting would be if the Ministry were to provide more funding for unregulated staff through the NPC envelope. The reality in long-term care homes is that many of the activities that support the quality of life for long-term care residents, and support the care provided to the residents, could be completed or performed by unregulated staff. Such activities would include, for example: escorting residents, providing mealtime assistance, assisting with transfers, and other tasks which do not require the training which RNs and RPNs must have. Tracey Raney's evidence, for example, was that PSWs help the residents eat at mealtime, but Ms. Raney would sometimes be required to assist.[40]

18. Moreover, "there is some evidence that health care serial killers are looking for opportunities - times when they are working alone..."[41] By providing more funding for unregulated staff through the NPC envelope, the system could be more financially efficient and homes would be able to increase their total staff compliment so that there are fewer instances during which staff members are left alone.

Current Funding Model is Unstable and Unpredictable

19. The four funding envelopes (NPC, PSS, RF and OA) account for approximately 83% of a home's total funding.[42] In addition to the funding envelopes, long-term care homes may receive "supplementary funding from the ministry to support specific policy objectives

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[40] Exhibit 77, Affidavit of Tracey Raney, sworn June 25, 2018 at para. 22.

[41] Exhibit 128, "Identifying risks: Learnings from the literature on health care serial killers", dated May 25, 2018, p. 128.

[42] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018 at exhibit B, p. 14.

such as the High Intensity Needs Fund Program, Behavioural Supports Ontario, property tax rebates under the Municipal Allowance Fund, funding for Physiotherapy, etc."[43] The variable and unpredictable nature of these specialty funding streams negatively affects a home's ability to increase its staffing compliment in order to meet the resident care needs because the home cannot know if it will be able to fund that additional staff member's salary from one year to the next. In the result, the funding system needs to be revised so that it can provide, "...homes with a base level of funding for consistency while still allowing some flexibility for the fluctuating levels of care. Stable funding is required to ensure more full time, resident knowledgeable staff. Consistency in funding would go a long way to ensuring consistency of care".[44]

FUNDING RECOMMENDATIONS

Recommendation #1: Increase the total overall funding for long-term care homes in order to ensure that the funding matches the current acuity of residents since acuity levels are currently outpacing the amount of money available to long-term care homes.[45]

Recommendation #2: Increase the total overall funding so that long-term care homes can have a larger compliment of staff.

Recommendation #3: Institute an additional funding stream or "top up" funding for smaller long-term care homes.

Recommendation #4: Revise the timing of the funding model so that funding decisions align with the home's current acuity levels.

Recommendation #5: Eliminate ad hoc pots of funding and implement stability in funding.

Recommendation #6: If the Ministry elects to continue to provide ad hoc funding then the Ministry should establish longer timeframes within which homes can spend the resources.

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[43] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018 at exhibit B, p. 12.

[44] Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit C, p. 26.

[45] See, for example, Exhibit 135, "Report on the Inquest into the Deaths of Ezzeldine El Roubi and Pedro Lopez", July 2006, at p. 11: "The MOHLTC should fund specialized facilities to care for demented or cognitively impaired residents exhibiting aggressive behaviour as an alternative to LTC facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of these residents in order that the facility be staffed by regulated Health Care Professionals...and in sufficient numbers to care for these complex and behaviourally difficult residents."

Recommendation #7: Implement rolling funding (rather than a hard stop at year end), in order to provide homes with the opportunity to spend money strategically and efficiently.

Recommendation #8: Expand the list of individuals whose salaries may be funded through the NPC envelope.

Recommendation #9: Without prior approval and permission, allow for funding to be moved from one long-term care home to another so that the homes can capitalize on economies of scale.

Recommendation #10: Increase the number of bed licenses available, and the pace at which homes are being approved for redevelopment, so that homes can optimize staffing and capitalize on economies of scale. Homes should have a minimum number of 128 beds, however, the optimal number is 256 beds.

Recommendation #11: Standardize the funding requirements (eligibility, timing, reporting, use) across all LHINs and allow for funding from different LHINs to be merged so that homes can take advantage of economies of scale.

Recommendation #12: Either, (a) eliminate restrictions on funding that prevent homes from determining how to appropriately deal with the needs of the residents in their home; or (b) create more funding streams that provide homes with adequate funding for their specific needs.

If the Ministry elects to create additional funding streams, rather than eliminating restrictions on funding, then:

Recommendation #13: Create a supplementary funding stream for training, education and staff development so that the home is not required to spend NPC money that could have otherwise gone to the direct care of residents.

Recommendation #14: Create a supplementary funding stream that is specifically targeted at providing long-term care staff with the tools and training to care for high-need residents, such as those with dementia or cognitive impairment.[46]

Recommendation #15: Create a supplementary funding stream that supports the proper placements of residents who cannot be cared for in a traditional long-term care home.

Recommendation #16: Create a supplementary funding stream that allows homes to respond to outbreaks, as outbreak management is a significant strain on a home's resources.[47]

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[46] Such training could include the Alzheimer Society's PIECES or U-First training, for example. See Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit C, p. 23.

[47] Every long-term care home must have an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, protocols for receiving and responding to health alerts, and a written plan for responding to infectious disease outbreaks. O. Reg. 79/10: General under the *Long-Term Care Homes Act, 2007*, SO 2007, C. 8 at ss. 229(8)(a) and 229(8)(b).

Recommendation #17: Create a supplementary funding stream that allows homes to respond to inspections, as will be discussed in greater detail below, inspections are a significant strain on a home's resources.

Recommendation #18: Create a supplementary funding stream for the development and creation of innovative ideas, greater efficiencies and technological advancements (an "Innovation Fund") that would allow a home to improve its infrastructure and provision of services.

Recommendation #19: Create a supplementary funding stream for capital projects.

Recommendation #20: Provide long-term care homes with funding for the installation and maintenance of cameras in all long-term care home hallways and medication rooms.

(B) INSPECTIONS

20. The current inspection and enforcement regime requires reform. The evidence before this Inquiry was that long-term care homes strive to comply with applicable legislation but encounter obstacles in understanding and attaining compliance.

21. In 1986, Woods Gordon conducted an independent review of Ontario's inspection and compliance system for nursing homes.[48] Over 30 years ago, Woods Gordon's review of the inspection regime identified the exact concerns that were voiced by many witnesses at the Inquiry. In particular, Woods Gordon's report found that "the combination of the regular inspection function with the enforcement (investigation and prosecution) function [had] produced an adversarial climate between the Branch and many of the nursing homes. In some cases, previous situations of goodwill and cooperation [had] been seriously eroded".[49] Notably, the report found:[50]

> ...The recent emphasis on enforcement has changed the relationship between the inspectors and many of the nursing homes. **Inspectors are now commonly seen**

[48] "Review of Inspection and Compliance in Ontario's Nursing Homes", July 8, 1986; Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit B.

[49] Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit B, p. 17.

[50] Exhibit 154, Affidavit of Karin Fairchild, sworn July 31, 2018, at exhibit B, p. 18.

> **as "policemen" in pursuit of evidence for citing violations and eventual prosecution**.... Changes to inspection procedures resulting from the need to improve the consistency of inspections may have added to this "policeman" perception, by creating the impression that all homes, regardless of their track record, are being treated as "problem" facilities.
>
> Nursing home owners and administrators informed us that the **current emphasis on prosecution is intimidating for management and staff, and that it has seriously affected morale in many homes.** Good staff are allegedly leaving the nursing homes in search of more professionally satisfying work, and **recruiting new staff is said to be getting more difficult**...
>
> **The recent emphasis on enforcement has led to a related de-emphasis of the advisory function.** Because of concerns about potential Ministry liability, the Branch has discouraged its inspectors from providing advice on how to achieve compliance with the regulations...Most owners and administrators, however, are left to determine on their own how they might change their operations to come into compliance with the regulations. **With little or no guidance from the Branch, they are not always able to meet its expectations.** From our questionnaires, 50% of administrators and owners agreed that a major reason for non-compliance may be lack of understanding on how to achieve compliance. **[Emphasis Added]**

22. After the Woods Gordon report but prior to July 1, 2010, long-term care homes were inspected by "Compliance Advisors". In addition to conducting inspections, "Compliance Advisors would also provide homes with advice about how to comply with standards and criteria..."[51] In July 2010, the inspection regime changed and Compliance Advisors became Inspectors. Inspectors are no longer permitted to provide advice to homes or assist homes in understanding how they can fulfill their legislative requirements. Additionally, under the tougher enforcement regime, Inspectors must take action against a home if they make a finding of non-compliance.[52] Inspectors do not have the discretion to issue warnings or negotiate next steps with a home and a home's due diligence cannot be considered.[53]

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[51] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018, at para. 19.

[52] An Inspector can issue: (i) Written Notifications; (ii) Voluntary Plans of Correction; (iii) Compliance Orders; (iv) Work and Activity Orders, or (v) Referrals to the Director.

[53] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018, at para. 63 and exhibit B, p. 47.

23. A home's compliance history, whether it be composed of Written Notifications (which is the least severe enforcement mechanism) or Compliance Orders (which is the 2nd most severe enforcement mechanism), is used to place a home along a continuum of risk - a risk assessment framework.[54] The risk assessment framework is based upon the total number of findings of non-compliance and "...it does not distinguish between high and low risk findings". This means that a finding of abuse, for example, is weighted the same as a finding against the home because it failed to post the daily food menu.[55] Pursuant to the Ministry's risk assessment framework, a home is identified as being a Level 1, 2, 3 or 4 risk level home. Level 1 homes are "in good standing"; Level 2 homes are identified as having "improvement required"; Level 3 homes are identified as having "significant improvement required", and Level 4 homes have their license revoked.[56]

24. A home's placement on the risk assessment continuum can negatively affect its funding because, effective July 1, 2018, the funding that homes once received by way of accreditation is now tied to the risk levels.[57] In particular, "the accreditation premium has been replaced with the Quality Attainment Premium that is provided to accredited homes via the Other Accommodation funding envelope. Effective July 1, 2018, the Quality Attainment Premium of $0.36 will support accreditation and be provided to homes that are both accredited and have been assigned...a performance level of 1 ("in good standing") or 2 ("improvement required")."[58] If a home is accredited but is assessed as being a Level 3 home, then that home

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[54] In addition to the a home's compliance and inspection history, we note that the Risk Assessment Framework also includes RAI-MDS data and qualitative data.

[55] Exhibit 148, Affidavit of Phillip Moorman, sworn July 27, 2018 at para. 29.

[56] Exhibit 148, Affidavit of Phillip Moorman, sworn July 27, 2018 at para. 25.

[57] If a home completed the process to become an accredited long-term care home, that home used to receive a $0.33 accreditation premium.

[58] Exhibit 129, Affidavit of Karen Simpson, sworn July 25, 2018, at para. 40.

loses the entire premium of $0.36 and it will not receive the $0.33 that it once received for its accreditation.[59]

25. The evidence before this Inquiry was that this punitive enforcement regime has negatively impacted long-term care staff and the provision of care to long-term care residents. Helen Crombez was of the opinion that "...when the MHLTC's role prior to the implementation of the Long-Term Care Homes Act, 2007 was compliance inspectors/advisors, it was a much better system...I have always had a high regard for the MHLTC. I felt that we were working together as a team. In my experience there is now usually no advice given by the Inspectors."[60] Similarly, Dian Shannon's evidence was that "the compliance advisors would give [homes] advice such as what may be helpful with a particular family or what would be a good measure for us to take...now the inspectors don't provide that kind of advice. Since the legislation changed and advisors became inspectors, I have tried calling the MOHLTC for advice. I was told, 'look at the regulation and do what it says'. I wanted to understand something that was in the regulations. The person kept repeating 'just look in the regulations'. It was frustrating."[61] Michelle Cornelissen was also concerned about the impact of the Ministry's punitive regime and her evidence was that she was "...concerned that the current Ministry regulations and its penalties are so severe that people will fear entering into the long-term care industry".[62]

26. Further, inspections are always unannounced. Upon attendance at a home, the Inspectors will provide the staff with a list of requirements. "It is an exhausting process. The whole inspection process is overwhelming for the staff and the staff are often anxious and

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[59] Transcript of the Inquiry Day 28/Volume 28, dated July 31, 2018, testimony of Karen Simpson, p. 6410 at lines 1-8.

[60] Exhibit 16, Affidavit of Helen Crombez, sworn June 7, 2018 at paras. 16 and 17.

[61] Exhibit 81, Affidavit of Dian Shannon, sworn June 26, 2018, at paras. 28 and 29.

[62] Exhibit 85, Affidavit of Michelle Cornelissen, sworn June 26, 2018 at para. 48.

concerned that they may have made a mistake…It can be disruptive when the inspectors want to interview Registered staff in the middle of medication passes or when they are providing other care to residents."[63] The impact of the current enforcement regime was also apparent to the Ministry's witnesses. During cross-examination, Karin Fairchild recognized the demands of the current inspection regime:[64]

> Q.· ·And then you also spoke about
> the impact of the new legislation on the
> inspection regime, and as I understood you
> to say, the increased inspections -- and in
> fact, there are more inspections now that
> you have this new regime and that it was a
> demand on the Ministry's resources; is that
> fair?
> A.· ·Absolutely, yes.
> Q.· ·All right.· And I take it,
> then, you'd agree that it's also more of a
> demand on the staff at the homes in order to
> respond to these increased inspections?
> A.· ·Yes.
> Q.· ·And has the Ministry made
> any effort to try and quantify that, or do
> you have any sense as to how many hours are

[63] Exhibit 81, Affidavit of Dian Shannon, sworn June 26, 2018, at paras. 26 and 27.

[64] Transcript of the Inquiry Day 32/Volume 32, dated August 7, 2018, testimony of Karin Fairchild, pp. 7529-7530 at lines 16-32 and 1-6.

being spent by staff at the homes responding and assisting with the inspections?

A.· ·No.· Haven't attempted to do that.· We do hear from operators from time to time complaining about the length of the inspection.

27. While homes welcome inspections and the transparency that they provide, the Ministry's current inspection and enforcement regime has caused the system to revert back to the exact dynamic that was identified in 1986. Accordingly, the current inspection and enforcement regime requires systemic reform in order to foster an environment of collaboration and compliance while also enforcing compliance when necessary.

INSPECTION RECOMMENDATIONS

Recommendation #21: Strike section 144 of the *Long Term Care Homes Act, 2007*. Surprise inspections enforces the punitive nature of the process and the stress imposed on long term care home staff. If the intent of the inspection is to ensure compliance with the legislation, homes should be given notice and assistance in preparing for inspections. This would also allow for homes to ensure that they can provide proper staffing resources to manage the additional demands that an inspection requires.

Recommendation #22: Increase training for Inspectors so that they are adequately prepared to inspect all facets of the homes and to ensure standardization and consistency across the province.

Recommendation #23: Create a *de minimis* threshold for written notifications or, alternatively, revise the risk assessment framework so that it distinguishes between low and high risk findings.

Recommendation #24: Reintroduce the advisor role, or create a separate advisory branch within the Ministry, that would, *inter alia*: (i) work with the homes to enhance resident experiences; and (ii) provide guidance to, and coach homes, on how to improve their operations and ensure compliance. The dynamic should switch to one where the Ministry and the long-term care homes operate as allies working towards the provision of the best possible care for residents.

Recommendation #25: Eliminate the new Administrative Monetary Penalties and Re-Inspection Fees. There are already sufficient penalties and remedies within the *Long-Term Care Homes Act, 2007* to address violations and repeat offenders.

(C) EMPLOYMENT, RECRUITMENT AND RETENTION

28. The current employment, recruitment and retention systems in long-term care require reform. This Inquiry heard vast amounts of evidence on the significant staffing challenges that long-term care homes face on a regular basis. These challenges include, but are not limited to: (i) recruitment and retention; (ii) difficulty disciplining or terminating permanent staff members; and (iii) difficulty implementing staffing plans that align to the home's needs rather than the legislative requirements. The resulting high staff turnover, large numbers of vacancies, difficulty attracting new employees, and need to rely on agency nurses from time to time compromise the quality of care of long-term care home residents.

29. The evidence before this Inquiry was that long-term care homes face many human resource challenges. In 2012, the Long-Term Care Task Force on Resident Care and Safety published a report wherein they summarized some of long-term care homes' recruitment and retention challenges as follows:[65]

> Compensation: Pay rates are inconsistent within the sector (e.g., nursing) and are generally lower compared to other sectors (especially hospitals).
>
> Recruitment: Lack of confidence in the sector, shift work, lack of exposure to long-term care provides very little appeal for new and young workers.
>
> Retention: The main factors for leaving a long-term care job include perceptions about the long-term care system being out-of-date rather than responsive, and regulations being seen as being "more valued than expertise". Significant physical demands, lack of full time employment, shift work, limited advancement opportunities and the inaccessible location of some homes are also challenges.

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[65] Exhibit 9, Tab 59, "Long-Term Care Task Force on Resident Care and Safety, An Action Plan to Address Abuse and Neglect in Long-Term Care Homes" (May 2012), p. 21.

> Dissatisfaction of nurses: Long-term care nurses report feeling their work is not as valued or important as acute care work.

30. Similarly, an inquest in 2006[66] highlighted the fact that long-term care homes face staffing challenges and made recommendations to assist with improving the working conditions in the long-term care sector. In particular, the inquest's report noted that, "in order to attract and retain sustainable Registered Nurses' [sic] to provide the skilled continuity of care required, the MOHLTC should take immediate steps to enhance the working conditions in LTC facilities including: (i) immediately change the funding system to ensure parity in wages and benefits with Ontario hospital Registered Nurses..."[67]

31. In her evidence, Helen Crombez's addressed long-term care's human resource challenges and noted that:[68]

> The sector was short of Registered staff, RN and RPN, as of 2007. There was, and still is, a nursing shortage, especially Registered Nurses. There are still peaks and valleys. It was hard to find replacements. It was hard to staff the Home when there were maternity leaves, surgeries, etc.
>
> I believe that the nursing shortage is as a result of the nature of the job in long-term care. It is very difficult looking after so many people. When I did my training, it was done in the hospital setting. In the hospital setting I had 6 - 8 patients. If I was working in the delivery room, I would have 1 - 2 patients.
>
> It is hard for a hospital nurse to work in long-term care if they have never had any exposure to working with 25 to 34 residents at a time. It is a very busy and demanding job. I also believe that at that time the County Home offered more money. Caressant Care would hire staff, train them and when a spot opened up at the County Home some would go there...

32. In discussing the sector's recruitment and staffing issues, Dian Shannon's evidence identified a direct relationship between a home's inability to hire registered staff and its

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[66] Exhibit 135, "Report on the Inquest into the Deaths of Ezzeldine El Roubi and Pedro Lopez", July 2006.

[67] Exhibit 135, "Report on the Inquest into the Deaths of Ezzeldine El Roubi and Pedro Lopez", July 2006, p. 14.

[68] Exhibit 16, Affidavit of Helen Crombez, sworn June 7, 2018 at paras. 20-22.

need to rely on agency staff. "Agency staff" are staff who work at the long-term care home pursuant to a contract between a home and an employment agency or other third party.[69] In 2015 and 2016, EW worked several shifts at Telfer Place as an agency nurse. EW's employer at the time was Lifeguard Homecare Inc.[70] Ms. Shannon's evidence was that:[71]

> In 2015 and 2016, Telfer Place was using Agency staff. We did a lot of work trying to recruit Registered staff. Telfer Place had difficulties attracting Registered staff because of the workload, the pay, and the location. Registered Nurses who came into long-term care at the end of their nursing career were often surprised at the significant workload in long-term care. Those at the start of their career were also not particularly interested in geriatric nursing because it isn't as appealing as acute care. Long-term care work is very challenging. People would come in and try long-term care but they would not stay.

33. Although the use of temporary/contract staff from external agencies can temporarily increase the number of staff available for resident care, the use of agency staff is not preferred because: (i) it disrupts the continuity of care; (ii) agency staff are often unfamiliar with the residents; and (iii) agency staff are often unfamiliar with the home's policies, practices and staff. In addition, private agencies exist in a relatively unregulated space. In particular, agencies have no obligation to comply, ensure that their nurses comply, or even be familiar with the provisions of the *Long-Term Care Homes Act, 2007*. On cross-examination, Heidi Wilmot-Smith's evidence highlighted this legislative gap in control and supervision:[72]

> Q. Okay. Have you ever read the
>
> Long-Term Care Homes Act?
>
> A. No.

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[69] *Long-Term Care Homes Act, 2007*, SO 2007, c. 8, s. 74(2).

[70] Exhibit 38, Affidavit of Heidi-Wilmot Smith, sworn June 12, 2018 at para. 2.

[71] Exhibit 81, Affidavit of Dian Shannon, sworn June 26, 2018, at para. 30.

[72] Transcript of the Inquiry Day 8/Volume 8, dated June 14, 2018, testimony of Heidi Wilmot-Smith, pp. 1822-1824 at lines 24-32 and 1-5.

Q. Have you ever read the
regulations under the Long-Term Care Homes Act?
A. No.
Q. And you ever had any training
under the Long-Term Care Homes Act?
A. No.
Q. Did you ever provide any
training to your staff, either Personal Support
Workers, RPNs, or nurses, about duties and
under the Long-Term Care Homes Act?
A. No.

34. Even though long-term care homes face significant challenges recruiting and retaining registered staff, a home faces additional human resourcing challenges as a result of the difficulty disciplining and terminating its permanent staff members and its inability to implement staffing plans that align to the home's needs rather than the legislative requirements. Brenda Van Quaethem addressed these challenges in her evidence. In particular, Ms. Van Quaethem's evidence was that "there is a shortage of nurses, and in particular Registered Nurses, in long-term care…It was a struggle to recruit and retain Registered Nurses. Many new graduates want jobs in hospitals…Competitive wages could also be a factor for nurses when they were seeking employment. The wages for Registered staff at Caressant Care were set through negotiations with the Ontario Nurses Association ("ONA"). Although they leveled out by approximately years 5-7, the starting wages and the wages over the first few years would be lower typically than

what a hospital would pay so we weren't always viewed as first choice for employment. Finally, as I said before, the workload is heavy in long-term care."[73]

35. In addition to wages being set pursuant to collective bargaining agreements, unions also affect a home's ability to discipline and terminate permanent staff members. Ms. Van Quaethem highlighted this issue in her evidence. Specifically, Ms. Van Quaethem's evidence was that Caressant Care was always "...aware of the fact that the Union, and in the case of Registered staff, ONA, may fight the discipline...Sometimes we would go back down or repeat a step (i.e. from a written warning to a verbal warning, or two verbal warnings), to resolve a situation or to avoid a grievance. We would avoid skipping a step, (i.e. from a verbal warning to a 1 day suspension) knowing that it would more than likely be grieved."[74]

36. Lastly, long-term care homes' authority to make their own staffing decisions is further eroded by the staffing provisions of *Long-Term Care Homes Act, 2007*. While the 24-hour RN requirement was addressed throughout the Inquiry, it is important to note that the *Long-Term Care Homes Act, 2007* also requires homes to have, *inter alia*, a designated lead for the recreational and social activities program,[75] a nutrition manager,[76] a designated lead for each of the housekeeping, laundry services and maintenance service programs,[77] and an administrator.[78]

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[73] Exhibit 10, Affidavit of Brenda Van Quaethem, sworn June 4, 2018, at paras. 21-22.

[74] Exhibit 10, Affidavit of Brenda Van Quaethem, sworn June 4, 2018, at para. 35.

[75] O. Reg. 79/10, s. 66: The designated lead must have, (a) a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; and (b) at least one year of experience in a health care setting.

[76] O. Reg. 79/10, s. 75: The nutrition manager must be an active member of the Canadian Society of Nutrition Management or a registered dietitian.

[77] O. Reg. 79/10, s. 92: The designated lead must have, (a) a post-secondary degree or diploma; (b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and (c) a minimum of two years experience in a managerial or supervisory capacity.

[78] O. Reg. 79/10, s. 212: The home's Administrator must have, (a) a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; (b) has at least three years working experience, (i) in a managerial

37. The evidence that was heard by this Inquiry demonstrates that there are significant employment, recruitment and retention issues that require systemic reforms in order to protect residents' safety and well-being.

EMPLOYMENT, RECRUITMENT AND RETENTION RECOMMENDATIONS

Recommendation #26: Recognize the increased acuity of the residents in long term care homes and demands placed on nurses working in long term care and increase the per diem funding for nurses to make it comparable to nurses in acute care.

Recommendation #27: In order to encourage promotion opportunities from within the sector, strike out section 92(2)(c) of O. Reg. 79/10, which requires a minimum of two years of experience in a managerial or supervisory capacity prior to appointment as a designated lead, as it is often not possible for employees to act in a supervisory capacity in housekeeping, laundry or maintenance prior to becoming a designated lead.

Recommendation #28: With respect to those hired into the position of Director of Nursing and Personal Care, allow time supervising RPNs and PSWs to count as experience working "in a managerial or supervisory capacity" for the purposes of section 213(4)(b) of O. Reg. 79/10, and remove the requirement for a minimum of three years of experience working in "a managerial or supervisory capacity".

Recommendation #29: Revise *Long-Term Care Homes Act, 2007* to enforce zero tolerance for abuse by mandating termination for any staff member found through a Ministry inspection to have committed abuse as defined in section 2 of O. Reg. 79/10, or at a minimum, "financial abuse", "sexual abuse" or "physical abuse" as defined in section 2 of O. Reg. 79/10..

Recommendation #30: Revise the *Long-Term Care Homes Act, 2007* to include the regulation of agencies supplying staff to long term care homes, including:

> 75 (1) Every licensee of a long-term care home **and every agency supplying agency staff to a licensee** shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers.
>
> 76 (1) Every licensee of a long-term care home **and every agency supplying agency staff to a licensee** shall ensure that all staff at the home have received training as required by this section.

Recommendation #31: Revise O. Reg. 79/10 to add the following:

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or supervisory capacity in the health or social services sector, or (ii) n another managerial or supervisory capacity, if he or she has already successfully completed a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

215(9) The requirements of subsection 75 (1) and 75 (2) of the Act and of subsections (1) to (5) of this section must be maintained by any agency providing agency staff to a licensee and must be supplied to the licensee upon request by the licensee.

Recommendation #32: Allow long-term care homes to staff with RPNs or agency staff. In that regard, O. Reg. 79/10 should be revised as follows:

45. (1) The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

1. For homes with a licensed bed capacity of 64 beds or fewer,

i. a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,

~~ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,~~

ii. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or

iii. a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

~~i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,~~

~~ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or~~

~~agreement between the licensee and an employment agency or other third party may be used if,~~

i. a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used, or

ii. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, **and** a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

(D) ACCESS TO INFORMATION/TRANSPARENCY

38. Regardless of whether information concerns nurses, personal support workers or even the residents themselves, long-term care homes require greater access to information in order to protect the safety and well-being of residents and staff. The evidence before this Inquiry demonstrates that long-term care homes want to be better positioned to understand and to be familiar with those they are hiring and those they are admitting into their homes.

39. EW became a registered nurse in 1997. At that time, the CNO made the following information publicly available: a member's name, business address and telephone number, class of registration, any specialist status, and any terms, conditions and limitations on his or her certificate of resignation (inclusive of the results of any disciplinary or incapacity proceeding completed within six months before the time the register was updated).[79] Since 2009, this information has been made publicly available on the CNO's "Find a Nurse" website. The list of publicly available information has expanded since 1997, however, "absent a specific Order of the Fitness to Practice Committee, past and current findings of incapacity are not

[79] Exhibit 121, Affidavit of Anne Coghlan, sworn July 3, 2018 at para. 52.

contained on the Public Register."[80] The CNO posts allegations against a nurse that are referred to the Discipline Committee. If the Discipline Committee does not make a finding of professional misconduct or incompetence, the outcome is only on the Register for 90 days.[81]

40. While the CNO and the Ministry are making strides towards providing the public and the industry with greater access to information, the current data available for RNs, RPNs, PSWs, and residents themselves does not sufficiently equip the homes to protect the safety and well-being of all residents. In the result, the current regime requires further reform so as to ensure that long-term care homes are positioned to make the best possible decisions in support of resident care.

ACCESS TO INFORMATION/TRANSPARENCY RECOMMENDATIONS

Recommendation #33: Expand the scope of information available to licensees from the CNO such that, upon consent of the member, a licensee can access information concerning whether a member is currently under investigation or has received written complaints about his/her practice, or has been the subject of past discipline of fitness to practise proceedings.

Recommendation #34: Should a licensee report a member for incapacity, professional misconduct or incompetence, the CNO should be required to notify the licensee of any previous findings of incapacity, professional misconduct or incompetence if it would be in the interest of public safety to do so.

Recommendation #35: Amend section 22 of the *Long-Term Care Homes Act, 2007* to read:

> **22** (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.
>
> **22 (1.1) If the written complaint concerns a staff member that is regulated under the *Regulated Health Professional Act*, the home shall also immediately forward a copy of the written complaint to the licensing body of that staff member.**

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[80] Exhibit 121, Affidavit of Anne Coghlan, sworn July 3, 2018 at para. 58.

[81] Exhibit 121, Affidavit of Anne Coghlan, sworn July 3, 2018 at exhibit B, p. 9.

Recommendation #36: The CNO should establish a public registry which would indicate a member's past work history, including the name of past employers, the time spent in each position and the role or position in which the member was employed.

Recommendation #37: Establish a reliable and timely system that allows homes to know whether a resident seeking admission to a long-term care home has severe mental health issues, a criminal record, or any condition that may result in safety concerns for other residents or staff in order to allow homes to assess whether they can provide proper care and/or whether additional staffing or supports may be needed.

(E) MEDICATION MANAGEMENT

41. This Inquiry was presented with a significant amount of information regarding the handling and use of medications, and in particular insulin, in long-term care homes. "Insulin is available without a prescription from any community pharmacy in Ontario to facilitate access to this life-saving medication. Insulin is stored 'behind the counter'; however, no documentation or identification is required to access it."[82] There is no standard dosage for insulin and residents can receive "...as little as 4 units of insulin per day, while others may require over 300 units per day".[83] Some residents may require one dose once per day, while others may require four doses of insulin each day. In addition, the prescribing techniques for insulin vary from physician to physician and some residents may receive a "sliding scale" of insulin (i.e. a varied dose of insulin depending upon their sugar levels).[84] Since each resident's insulin dosage can vary so drastically, so too does the speed at which a pen is used.[85]

42. Currently, insulin is administered through insulin pens. The pens consist of a syringe and a needle. The RN will "dial up" the dose of insulin pursuant to a resident's

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[82] Expert Report of Julie Greenall, Director of Projects and Education, ISMP Canada; dated June 1, 2018, p. 12.

[83] Expert Report of Julie Greenall, Director of Projects and Education, ISMP Canada; dated June 1, 2018, p. 12.

[84] Exhibit 77, Affidavit of Tracey Raney, sworn June 25, 2018, at para. 44.

[85] Expert Report of Julie Greenall, Director of Projects and Education, ISMP Canada; dated June 1, 2018, p. 14.

prescription.[86] Some insulin is wasted every time insulin is administered because the needle must be primed.[87] Additionally, some nurses may dispose of an insulin pen if it does not contain a full dose. An RN will dispose an insulin pen in that circumstance because it is preferable to avoid having to inject a resident twice.[88] "The ubiquitous use of, and requirement for, insulin in a variety of dosage forms constrains opportunities within existing medication distribution systems...to mitigate the potential for international harm from insulin misuse."[89]

43. This Inquiry should not advance a recommendation that insulin be treated as a narcotic or controlled drug because of the very fact that it is life sustaining and must, therefore, be readily available. Moreover, "narcotics and controlled drugs must be counted each shift."[90] If RNs were required to count insulin in addition to narcotics, assuming one were to devise a method through which the home could track insulin wastage, then one might expect that the RNs would be required to spend an additional 5 to 20 minutes conducting an insulin count each shift. As stated in the Funding section of these submissions, the more the system requires RNs to complete administrative tasks (such as narcotic counts or documenting clinical data), the less time RNs have to provide direct care to the residents. It is respectfully submitted that this Inquiry should not ignore the reality and challenges associated with the use of insulin and must instead advance recommendations that are practical, feasible and optimize drug therapy outcomes for residents. Even if insulin was treated like a controlled drug or narcotic, that would be no guarantee that it could not still be used as it was by EW, or that an individual who was intent on harming patients would not simply use alternative means.

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[86] Expert Report of Julie Greenall, Director of Projects and Education, ISMP Canada; dated June 1, 2018, p. 12.
[87] Exhibit 77, Affidavit of Tracey Raney, sworn June 25, 2018, at para. 45.
[88] Exhibit 76, Affidavit of Dianne Beauregard, sworn June 25, 2018, at para. 21(p).
[89] Expert Report of Julie Greenall, Director of Projects and Education, ISMP Canada; dated June 1, 2018, p. 26.
[90] Expert Report of Julie Greenall, Director of Projects and Education, ISMP Canada; dated June 1, 2018, p. 20.

MEDICATION MANAGEMENT RECOMMENDATIONS

Recommendation #38: Emphasize the need for greater communication and collaboration between physicians, pharmacists and nursing staff on the prescription of insulin, taking into account workload and medication management.

Recommendation #39: Require the Ministry to investigate the potential implementation of Automated Medication Dispensing machines in long-term care homes, and the cost/funding associated therewith.

Recommendation #40: Limit the amount of insulin that is delivered to a long term care home at one time so as to reduce the amount of insulin on site. For example, the home could receive a one or two week supply, rather than one month supply, of insulin for each resident. Ensure that the Ontario Drug Benefit (ODB) Program will cover the cost of supplying insulin this frequently.

Recommendation #41: Create a funding stream to employ a nurse or pharmacy technician who is dedicated to medication management in each home. This individual could support the administrative work that must be completed in long-term care homes, examine medication reconciliation, and review possible medication compression in order to simplify medication passes. This recommendation would allow the home's other staff to focus on direct resident care.

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

Jennifer McAleer

per **Rachel Laurion**