Family Statement to the Long Term Care Inquiry

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As the inquiry wraps up its public consultations, the Silcox family would like to thank Commissioner Gillese and all those involved for their tireless efforts over the summer. We would like to state that without radical changes to the collective attitude toward the Long Term Care system as represented by the Government of Ontario, we are not hopeful that the glaring problems unearthed by the inquiry will be solved.

The Inquiry into Long Term Care has offered an enormous amount of insight into the failure of the Province of Ontario to protect our most vulnerable.

These are the key revelations of the inquiry in our minds:

1. Under the current guidelines, Long Term Care facilities are very difficult to keep staffed at compliant levels, with quality nurses.

2. There is a systemic lack of internal quality control in nursing homes as seen in Caressant Care's fear of dealing with the union and its "wait and see" attitude that left residents at risk.

3. Medication controls, especially with insulin, are entirely inadequate, particularly given the nature of the population who lives in Long Term Care

4. Ontario Nurses' Association protected their member at all costs. Although protection of an employee's rights is a cornerstone of the union movement it should never put patient safety at risk.

5. Even though Caressant Care reported dismissing Ms. Wettlaufer to the Ontario College of Nurses, it took no follow up action on its concerns that she was not fit to safely practice elsewhere. This was because she was "no longer an employee". She had become someone else's problem.

6. The role of the coroner, Dr George, to detect death by other than natural causes proved worthless over the course of Ms. Wettlaufer's killing spree. Dr George's firm and unapologetic belief that he did the right thing in either not conducting a death investigation, or as in the death of our father, suggesting that an autopsy be conducted, despite requests from family members or peers, borders on negligence. In the case of Maureen Pickering, Dr George failed to perform an autopsy despite one having being recommended by Dr Urbanke. Dr Urbanke chose not to perform the autopsy herself as it would appear to be a conflict, since she had been Mrs. Pickering's attending physician at the ER at Woodstock General Hospital. Had the local coroner and the associated Coroner's Offices done their respective jobs, we strongly believe that further attacks by Ms. Wettlaufer could have been averted.

7. Ministry inspectors clearly admitted they are lacking in numbers and in process. It was made evident that Caressant Care Woodstock was not aware of its reporting obligations and the inspectors did not report that fact. No review of employee files was ever done regarding Wettlaufer. A quick review of the employee file could easily have revealed a problem.

8. The College of Nurses of Ontario knew about Wettlaufer's history of stealing narcotics from her employer, overdosing and having a problem with drugs and alcohol but was unable to make that information available to potential employers. It also has a year-long backlog of cases and some are even longer to resolve.

We see that there is a lack of clear direction at all levels when it comes to caring for our growing population of those needing full time care. Such direction comes only from strong leadership reflective of a collective will of all Ontarians to ensure security, dignity and respect for those in our LTC facilities. What is required is that all parties involved – facilities, staff, unions, coroners, the Ministry of Health and Long Term Care and lawmakers -- put patient-first policies in place, to ensure that resident care is not subject to poor management, substandard staffing and union bullying.

Over and above a fundamental policy of patient-first from our provincial government, in our view, the following immediate actions are needed to achieve an environment that better protects the vulnerable in our nursing homes:

- All private and public nursing homes should be inspected bi-annually by the ministry and annually internally. This internal inspection report must be sent to the ministry with corrective action included.
- Ensure staff know they are a valued, important part of a large care community and not just a nameless, faceless, voiceless employee.
- Make staff pay scale competitive with the same profession in other sectors.
- Overhaul the staffing requirements in LTC homes. Hire more front-line care staff (RNs, RPN's and PSWs) and limit overtime by hiring more part-time or casual staff to cover absences and vacations.
- Regulate PSWs and mandate a minimum number of in-service hours per year.
- Ensure staff are updated on new methods and requirements. Provide refreshers in areas identified as being a problem and in changes in residents' needs.
- Daily monitoring should be put in place to identify changes in work load in each area of the home so staffing can be adjusted accordingly.
- Review the need for 24/7 registered nursing presence. Increase RN presence and lower the staffing ratios significantly (i.e. lower resident to nurse ratio )
- Provide medication rooms that are secure and that have closed circuit TV as well as separation from other staff activities to ensure nurses can focus on the job at hand.
- Offer more training for staff at all levels to reinforce a culture of caring over politics.
- The Coroner's Office should audit all coroners every 5 years. Also, there should be regular retraining and in-service to keep them current and following the regulations.
- Invest in development of a simplified toxicology test for use in Long Term Care facilities, mandatory within hours of the death of a long-term care patient.

When the Government of Ontario introduced the Ministry of Health and Long Term Care, it was making a commitment. This commitment must be met. Those of us fortunate enough to live long lives and our loved ones need the Ontario Government to do the right thing. With the extensive knowledge acquired through the Inquiry it must provide leadership to develop a system with the funding, and checks and balances that ensure our senior population is properly taken care of with respect and dignity.

The news of the way in which our then helpless and ailing father died in a nursing home in which we had put our utmost trust was a shock and a horror we will never forget. We feel regret and even remorse at having placed him in Caressant Care even though no other choice existed. Thanks to the inquiry we now know that what went wrong, is systemic. We look to Ontario's government to make it right and, in the name of our father and the other victims, make Ontario's system a model for the rest of Canada.