Long Term Care (LTC) Public Inquiry Overview

Concerned Friends of Ontario Citizens in Care Facilities

Annual General Meeting

November 6, 2019

Background

Commissioner Eileen Gillese and Counsel team

Public Inquiry into the safety and security of residents in the Long-Term Care (LTC) Homes System

- Commissioner's Remarks on the Public Release of the Inquiry Report July 31, 2019 (18 pages)
- Volume 1 – Executive Summary and Consolidated Recommendations (56 pages)
- Volume 2 – A Systemic Inquiry into the Offences (998 pages)
- Volume 3 – A Strategy for Safety (197 pages)
- Volume 4 – The Inquiry Process (240 pages)

The Inquiry Process

- Commission counsel conducted thorough system-wide investigations into the offences (Chapter 3-14 of volume 2)
- Conducted research, advice of experts, and extensive consultations with those who work in the LTC system (Volume 4)

Debunking Myths

- The offences were mercy killings **NOT TRUE**
- LTC issues are a baby-boomer problem **NOT TRUE**
- Wettlaufer is in jail so the threat she poses has passed **NOT TRUE**
- The harm caused by the offences is limited to the victims and their loved ones **NOT TRUE**

The 91 Recommendations

Four Strategies – PADD – **Prevention, Awareness, Deterrence** and **Detection** (Chapter 15-18 of Volume 3)

Each strategy:

- Addresses a systematic vulnerability
- Requires a systemic response
- Multiple stakeholders in the LTC system must engage in implementation

Prevention

The best way to prevent similar tragedies in the future is to strengthen the LTC system and encourage excellence in resident care.

- Systemic **Recommendation 62** calls for the Ministry of Long Term Care (MOLTC) to play an expanded leadership role by establishing a dedicated unit to do three things:
  - Support LTC homes in achieving regulatory compliance and spread best practices
  - Provide bridging and laddering programs in LTC homes to increase the skills of those who work in them and offer opportunities for advancement to build HR capacity and address the long-standing problem of a shortage of registered staff
  - Encourage innovations and the use of new technologies in the long-term care system
- Recommendation 62 calls for the work of the new unit to be done collaboratively, with stakeholders throughout the long-term care system, drawing on existing partnerships and forging new ones

Prevention (continued)

Recommendations to long-term care homes that they:

- Strengthen their training and education requirements (**Recommendations 3, 4, 5**); and
- Limit and improve the use of agency nurses (**Recommendations 11, 12** and **13**).

Prevention (continued)

Recommendations to the Ministry that it:

- Expand the funding parameters of the nursing and personal care envelope (**Recommendation 19**);
- Recognize and reward LTC homes that have made demonstrated improvements in the wellness and quality of life of their residents (**Recommendation 20**);
- Create a new, permanent funding envelope to fund training and education in LTC homes (**Recommendation 21**);
- Strengthen the education requirements relating to medical directors and nurse practitioners (**Recommendation 22**);
- Refine the LQIP (LTC Home Quality Inspection Program) Performance Assessment to better identify homes struggling to provide a safe and secure environment for residents and use the LQIP data when establishing inspection priorities (**Recommendations 25 - 27**);
- Identify LTC homes who have fallen below level 1 performance for two consecutive quarters and assist the homes to return to the level 1 classification (**Recommendation 28**); and
- Where a licensee fails to report reasonable suspicions of negligence and abuse, as required by section 24(1) of the LTC Homes Act, 2007, ensure that the next RQI (resident quality inspection) conducted in the home is the intensive RQI, regardless of the performance level assigned to the home (**Recommendation 29**).

Awareness

It is not possible to deter or detect something unless you are aware that it exists

Systemic **Recommendations 64 – 73** provide a roadmap for building, developing, and maintaining this awareness in a positive way. I recommend that the:

- Office of the Chief Coroner and the Ontario Forensic Pathology Service lead this initiative, beginning with the creation of a strategic plan.
  - conduct ongoing research to keep up-to-date on the healthcare serial killer phenomenon in other jurisdictions.
  - provide standardized key information and support to the 11 organizations and institutions that deliver education and training to healthcare and allied service providers.
  - provide guidance to the relevant organizations and institutions on how to develop the necessary awareness without creating a climate of fear and mistrust.

Awareness (continued)

Recommendations that the College of Nurses:

- Educate its membership and staff on the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care (**Recommendation 40**);
- Strengthen its intake investigation process by, among other things, training its intake investigators on the healthcare serial killer phenomenon and how to conduct their inquiries in light of it (**Recommendation 41**);
- Review and revise its policies and procedures to reflect the possibility that a nurse or other healthcare provider might intentionally harm those for whom they provide care (**Recommendation 42**);
- Share its research on the healthcare serial killer phenomenon with other healthcare regulators in Canada, the United States, and internationally (**Recommendation 44**); and
- Review its approved nursing programs to ensure they include adequate education and training on the possibility that a healthcare provider might intentionally harm patients/residents, and work with post-secondary institutions offering approved nursing programs to assist with this (**Recommendations 44 and 45**).

Deterrence

LTC homes must make changes to the medication management system to deter staff from diverting medications and make it more likely that they will be caught if they do.

Systemic **Recommendations 74 – 85** set out a three-pronged approach for deterring wrongdoers from intentionally harming residents through the use of medication.

- strengthen the medication management system in LTC homes
- improve medication incident analysis in LTC homes, including by establishing specific strategies for incidents relating to possible insulin overdoses
- increase the number of registered staff in LTC homes.

Deterrence (continued)

Recommendations that long-term care homes:

- Adopt a hiring/screening process that includes robust reference and background checking where there are gaps in a resume or the candidate's previous employment was terminated, and close supervision in the probationary period (**Recommendation 6**); and
- Require the Director of Nursing to conduct unannounced spot checks on evening and night shifts, including on weekends (**Recommendation 7**);
- Take reasonable steps to limit the supply of insulin (**Recommendation 10**);

Detection

Steps must be taken to strengthen Ontario's death investigation process, as it relates to residents in LTC homes, so that it is better equipped to detect intentionally caused resident deaths.

- Systemic **Recommendations 86 – 89** are a blueprint for the Office of the Chief Coroner and Ontario Forensic Pathology Service to meaningfully increase the number of death investigations of residents using information from a redesigned Institutional Patient Death Record (IPDR) and the Ministry of Health's data analytics model. The IPDR is the form that LTC homes must complete and submit to the Office of the Chief Coroner for every resident death.

Detection (continued)

Recommendations that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- Redesign the IPDR so it is evidence-based; contains more and better information about a resident's death, is reviewed by other healthcare providers; and completed by registered staff who are familiar with the resident and trained on the completion of the redesigned IPDR (**Recommendations 50, 51, and 54**);
- Ensure that the redesigned IPDRs are submitted electronically so the information in them can be aggregated and used to look for trends, spikes, and clusters of deaths (**Recommendation 52**);
- Require that a redesigned IPDR be submitted for a resident who dies in hospital within 30 days of being transferred to the hospital from a LTC home (**Recommendation 53**);
- Establish as a best practice that, at the preliminary consultation stage, coroners speak with the deceased's family about the resident's death and advise the family what they can do if the decision is made that no death investigation will be undertaken (**Recommendation 55**);
- Prepare written materials on the death reporting and investigation process and provide the materials to LTC homes for distribution, at appropriate times, to families of residents (**Recommendation 56**);
- Strengthen the processes around the decision not to conduct a death investigation; develop protocols and policies on the involvement of forensic pathologists in the death investigation process; and develop a standardized protocol for autopsies performed on the elderly (**Recommendations 57- 59**);
- Maintain and strengthen the cadre of specially trained coroners who will, among other things, help fulfill m any of the foregoing recommendations (**Recommendations 60 and 61**).

Detection (continued)

Recommendations that the Ministry:

- Ensure that inspections involving either missing narcotics or allegations of staff-to-resident abuse are preceded by reviews of previous critical incident reports involving the same staff member (**Recommendation 30**);
- Establish a formal communications policy and process to ensure that Ministry inspectors share relevant information with the College of Nurses of Ontario about members of the College who may pose a risk of harm to residents (**Recommendation 31**).

Detection (continued)

Recommendations that long-term care homes:

- Electronically submit the IPDR and the redesigned IPDR, when it becomes available, to the Office of the Chief Coroner and Ontario Forensic Pathology Service (**Recommendation 9**).

Detection (continued)

Recommendations that the College of Nurses of Ontario:

- Take specified steps to improve reporting by long-term care home employers and facility operators on their mandatory reporting obligation relating to termination reports and reports relating to incompetence and incapacity (**Recommendations 46 - 48**); and
- Institute a program to educate its members on their reporting obligations relating to suspected abuse and neglect of patients and residents by nurses (**Recommendation 49**).

Role of LTC Homes

Recommendation 3

Licensees must provide management and registered staff with the following training:

a. Administrators and directors of nursing should receive training:

- on best practices in the screening, hiring, and management and discipline of registered staff;
- on conducting workplace investigations;
- as recommended elsewhere in this Report, such training to be provided by the Ministry of Health and Long-Term Care, the College of Nurses of Ontario, and the Office of the Chief Coroner / Ontario Forensic Pathology Service; and
- on their reporting obligations to the Ministry and the College.

Role of LTC Homes (continued)

Recommendation 3

b. Registered staff must receive comprehensive ongoing training on:

- the requirements of the *Long-Term Care Homes Act, 2007* (LTCHA), relating to the prevention of resident abuse and neglect, and their reporting obligations under section 24(1) of the LTCHA;
- the home's medication administration system, and the identification and reporting of medication incidents; and
- the redesigned Institutional Patient Death Record, once it is created, such training to be provided by the Office of the Chief Coroner / Ontario Forensic Pathology Service.

Role of LTC Homes (continued)

Recommendation 4

Licensees should amend their contracts with medical directors to require them to complete:

- the training required under section 76(7) of the *Long-Term Care Homes Act, 2007*; and
- the Ontario Long Term Care Clinicians' Medical Director course within two years of assuming the role of medical director.

Role of LTC Homes (continued)

- **Recommendation 5** To ensure management and registered staff can regularly attend training, licensees must pay for the costs of the training, cover staff salaries during the training, and backfill shifts as necessary.
- **Recommendation 6** Licensees should adopt a hiring / screening process that includes robust reference checking, background checks when there are gaps in a resumé or if the candidate was terminated from previous employment, and close supervision of the candidate during the probationary period.
- **Recommendation 7** Licensees should require directors of nursing to conduct unannounced spot checks on evening and night shifts, including weekends.

Role of LTC Homes (continued)

- **Recommendation 8** Licensees must maintain a complete discipline history for each employee so management can easily review it when making discipline decisions.
- **Recommendation 9** Management in homes must ensure staff submit the Institutional Patient Death Record electronically to the Office of the Chief Coroner / Ontario Forensic Pathology Service.
- **Recommendation 10** Licensees should take reasonable steps to limit the supply of insulin in long-term care homes.

Agency Nurses in LTC Homes

- **Recommendation 11** Licensees should minimize the use of agency nurses. To achieve this, they should develop proactive strategies such as maintaining a roster of casual employees who are members of the regular nursing staff and can cover shifts in the case of an unexpected absence.
- **Recommendation 12** If agency nurses must be used, licensees should thoroughly vet agencies before entering into contracts with them to ensure that the agency's management and staff have the knowledge, skills, and experience required to provide services effectively and safely to the home's residents, including on the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations.

Agency Nurses in LTC Homes (continued)

Recommendation 13 Licensees should ensure that their contracts with agencies:

- require the agency to, at all times, have a roster of nurses who have been oriented to the licensee's home and meet the requirements of the *Long-Term Care Homes Act, 2007*, and its regulations;
- set out clear responsibilities and expectations for the agency in terms of its hiring, screening, and training of registered staff; and
- set out a clear process for reporting performance concerns from the licensee to the agency.

Role of Ministry of Health and LTC

Recommendation 19 to 31

- Funding
- Education
- Inspection Program

Role of College of Nurses of Ontario (CNO)

Recommendation 40 to 49

- Increase awareness
- Education
- Mandatory reporting
- Reporting obligations

Building Capacity and Excellence in the Long-Term Care System

Recommendation 62 The Ministry of Health and Long-Term Care (Ministry) must play an expanded leadership role in the long-term care system by: establishing a dedicated unit within the Long-Term Care Homes Division to:

- support LTC homes in achieving regulatory compliance; and
- identify, recognize, and share best practices leading to excellence in the provision of care in LTC homes;
- providing bridging and laddering programs in LTC homes; and
- encouraging innovation and the use of new technologies in the long-term care system.

Both the Ministry and the dedicated unit should work collaboratively with stakeholders throughout the LTC sector, drawing on existing partnerships and forging new ones.

Building Awareness of the Healthcare Serial Killer Phenomenon

Recommendations 64 to 73

Educating and training the groups that make up the healthcare system must be responsible for the delivery of education and training on the possibility that healthcare providers may intentionally harm those in their care.

- colleges and universities;
- regulators, including the College of Nurses of Ontario and the Ontario College of Pharmacists;
- the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians;
- the Long-Term Care Homes Division in the Ministry of Health and Long-Term Care;
- Local Health Integration Networks or any successor organization;
- licensees of long-term care homes;
- the Office of the Chief Coroner and the Ontario Forensic Pathology Service;
- the Ontario Association of Residents' Councils;
- Residents' councils;
- Family Councils Ontario; and
- Family councils.

Deterrence Through Improved Medication Management

Recommendations 74 to 84

A three-pronged approach should be taken to deter wrongdoers from intentionally harming residents through the use of medication:

- strengthen the medication management system in long-term care (LTC) homes;
- improve medication incident analysis in LTC homes; and
- increase the number of registered staff in LTC homes.

Increase the Number of Registered Staff in LTC Homes

Recommendation 85

The Ministry of Health and Long-Term Care should conduct a study to determine adequate levels of registered staff in long-term care (LTC) homes on each of the day, evening, and night shifts. The Minister of Health and Long-Term Care should table the study in the legislature by July 31, 2020. If the study shows that additional staffing is required for resident safety, LTC homes should receive a higher level of funding overall, with the additional funds to be placed in the nursing and personal care envelope.

Principal Findings

- No knowledge of the offences without Wettlaufer's confession. Offences committed over nine year period from 2007-2016.

Fundamental changes must be made – changes that are directed at:

- Prevention (chapter 15 of volume 3)
- Awareness (chapter 16 of volume 3)
- Deterrence (chapter 17 of volume 3) and
- Detection (chapter 18 of volume 3)

- No findings of individual misconduct
- The LTC System is STRAINED but not BROKEN