IN THE MATTER OF A PUBLIC INQUIRY INTO:

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

WRITTEN CLOSING SUBMISSIONS OF THE ONTARIO NURSES' ASSOCIATION

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I. OVERVIEW

1. Elizabeth Wettlaufer's ("EW") crimes against residents of long-term care facilities and patients in home care is a shocking tragedy. All steps must be taken to try to understand the facts, root causes, and measures that can be implemented to prevent this from happening in the future. It is in this spirit that the Ontario Nurses' Association ("ONA") fully participated in this Public Inquiry and makes the instant submissions.

2. In Canada, there is known to have been two possible cases of health care serial murders.[1] It is a very rare phenomenon both in Canada and worldwide. It is notable and commendable that in both Canadian incidents of serial murder by a health care professional, large Public Inquiries have been held.[2] Despite its rarity, however, this is a serious problem.[3] How is it that someone can commit so many crimes in long term care and not be caught? On one hand, EW's complex psychiatric make up – which was not the subject matter of this Inquiry – may be such that, sadly, some or all of these crimes were neither predictable nor preventable. Notably, no one in EW's workplaces knew of her inner voices or urges and the reprehensible conduct she kept hidden.

3. On the other hand, the Inquiry heard much relevant evidence concerning several systemic issues facing the long term care sector as part of its mandate to uncover "circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices and

1 Over a period of approximately five decades, which is the period of time in which this phenomenon has been studied.

2 See the "Royal Commission of Inquiry into the Deaths at the Hospital for Sick Children and related matters" (known as the "Grange Inquiry") arising out of the suspicious deaths at the Hospital for Sick Children, the only other fact pattern of a possible Canadian serial killer referred to in the evidence by the expert Professor Beatrice Yorker. The Grange Inquiry in public hearings heard many days of evidence and produced the report authored by Commission Mr. Justice Grange in December 1984. As the Professor Yorker noted there was no nurse convictions arising out of the charges. RN Susan Nelles she was compensated financially after a civil suit of, *inter alia*, malicious prosecution and the recommendations of Mr. Justice Grange.

3 Professor Yorker cites the number of 1 in 2 million but agreed that it is even rarer, as her research was over a period of 48 years, worldwide. She testified that the fraction would be "a point zero something": Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p 8132. She further clarified that, though the tragedy should be addressed, the public must not lose its trust in the many other nurses in long-term, and agreed that the 'vast, vast, vast' majority of nurses are excellent nurses who should not be tainted by the small rare case of this serial killer: Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p 8135, ln 3-9.

accountability and oversight mechanisms". These systemic issues were undoubtedly contributing factors to EW's conduct, and the Inquiry is well positioned to implement several much-needed systemic changes as a result.

4. ONA submits that systemic change is required to address the following overarching issues:

(I) **Understaffing and Underfunding:** All witnesses were in agreement that long term care homes were staffed far too lean and the ratio of registered nurses to residents in nursing homes is far too low to allow adequate and safe care. Compounding this problem is the widespread recruitment and retention issues for the RNs in this sector, and the unsafe use of agencies that send in temporary staff who are not familiar with the homes or residents.

(II) **Leadership Problem**s: The evidence was that EW committed the majority of her crimes at three long term care workplaces. The employers at these facilities lack the necessary skills, training, and experience to hire, screen, staff, supervise and report to oversight bodies such as the College of Nurses ("CNO") and the Ministry of Health and Long Term Care ("MOHLTC"). Given the particular facts related to EW, these leaders are not to be personally faulted, however systemic change must occur to ensure that appropriate leadership is in place to avoid a recurrence; and

(III) **Medication Issues:** EW committed her crimes with the use of insulin, a readily available medication that has the power to kill and is difficult to detect. Workable, reasonable measures must be put in place to enhance oversight of insulin administration, increase education to recognize the dangers of non-narcotic, high alert medications such as insulin, and promote the assessment, detection, and treatment of its misuse.

5. In these submissions, ONA will review the relevant evidence that the Inquiry heard to assist in determining the circumstances and contributing factors that led to these tragic events. ONA will also outline the irrelevant, inaccurate, and misleading evidence that was heard in a number of areas outside of the Inquiry's mandate. ONA reviews this evidence to ensure that the Inquiry remains focused on its important mandate, and to ensure that these red herrings do not deflect from the real issues at hand.

6. In the second part of this submission, ONA provides both general and specific recommendations in order to assist the Inquiry in its fulfilling its mandate. ONA remains committed to providing both time and resources to assist the Commissioner in any way it can with Phase II of the Inquiry.

II. RELEVANT EVIDENCE HEARD BY INQUIRY

A. STAFFING ISSUES

7. ONA submits that the vast majority of evidence heard in this Inquiry establishes that the root systemic issue which permitted EW to go undetected for so many years is the severe understaffing that exists in the long-term care sector.

i. Residents are Increasingly Vulnerable and High Needs

8. Residents in today's homes are typically older and frailer, with higher acuity and more comorbidities, than the residents of the past. The data collected from the 2014 Resident Assessment Instrument – Minimum Data Set ("RAI MDS"), as well as a numerous reports to the MOHLTC, confirms that the average age of residents in long term care was 85 years. Of these residents: 78% required assistance (total or extensive) with the activities of daily living; 65% suffered from depression; almost half had aggressive behaviors for medical reasons; more than half were medically "unstable"; 69% had dementia/Alzheimer's disease; 50% had heart disease; and 26% had diabetes. Of the 71,000 residents in 2014, almost 23,000 were transferred to acute care hospitals.[4] These residents are not a medically stable patient population.

9. Similar patient challenges and demands are seen in the home care sector. As one witness noted, at companies like Saint Elizabeth, programs are run that are "literally [called] Hospital in the Home," where RNs provide "intensive services in the home" such as "giving chemotherapy in the home and advanced drugs in the home and providing […] end-of-life complex palliative care in the home".[5]

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4 Exhibit 169, Long-Term Care in Ontario - Sector Overview by the Health Analytic Branch, MOHLTC September 2015, p 20

5 Transcript of Carol Hepting, June 27, 2018, Day 26, p 3935, ln 11-22.

10. This results in an exceptionally vulnerable population in long term and home care. For an individual like EW, these patients are the perfect prey; she picked victims who could not 'self-report" or fight back[6].

ii. Crimes Were Committed At Night When No One There To Observe

11. A review of the evidence from EW's criminal proceedings indicates that all of her crimes were committed during night or evening shifts. The timing of these murders is relevant, because the staffing practices on these shifts allowed EW to conceal her crimes. Indeed, Professor Yorker confirmed that serial murders have a known pattern of committing their crimes in the night or evenings.[7]

12. The *Long Term Care Homes Act* requires only a minimum of one RN in the facility.[8] At all the facilities EW worked, she was the <u>only</u> RN in the building on a night shift. In a subset of these homes, she was the <u>only</u> nurse. EW therefore had free run of the facilities, with the reasonable expectation that no one would be around other than sleeping or bedridden residents.[9] The minimum staffing requirements are thus a contributing factor, as it created an environment in which EW could commit her crimes in total secrecy; there was no one around to observe, detect, and report her conduct.

iii. Chronic Understaffing

13. It was repeatedly confirmed that long term care is understaffed. This is directly related to the high acuity of residents and the resulting demands that are placed on staff. Unsurprisingly, reports, reviews and legal proceedings have been publicly stating this fact since at least 2001.[10] The numbers of nurses to residents however remains shocking, and staffing concerns remain unaddressed.

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6 Exhibit 5,Document 71420, Transcript of Interview with Elizabeth Wettlaufer, p 53.

7 Exhibit 163, Document 72861, Report of Professor Yorker, p. 14; See also Exhibit 128, Document 72834, Report by the CNO: Identifying Risks: Learning from the Literature on Health Care Serial Killers.

8 *Long Term Care Homes Act*, 2007, S.O. 2007, c. 8, section 8(3).

9 While there would also be a few PSWs in the home on evenings and nights, EW was their supervisor and the evidence was that she either befriended unregulated health care workers, distracting them from reporting her odd behavior, or she belittled and intimidated them.

10 See, for example: Exhibit 158, Price Waterhouse Coopers: Report of a Study to Review Levels of Service and Responses to Need in a sample of Ontario Long Term Care Facilities 2001; Smith Report – 2004 – Document 46531, appended to Exhibit 154, Affidavit of Karen Fairchild; Exhibit 135, Report on the inquest into the deaths

14. Despite the ever-increasing acuity of these residents, the ratio of RNs to residents was, at Caressant Care Woodstock ("CCW") for instance, one RN to 32 patients on days. On nights, the RN was assigned 99 patients and was also responsible for the entire facility of 163 residents.[11] This unacceptable staffing ratio is not limited to CCW; it is a systemic provincial problem, spanning the whole spectrum of shifts (day, evening, and night). Testimony of the nurse managers and nurses confirmed that a more appropriate ratio would be one nurse for every 10-20 residents.[12] There is simply not enough qualified staff in long-term care homes to perform the work that must be done. It is therefore not surprising that EW's conduct went unnoticed for so long; none of her colleagues had the time or capacity to properly observe her in practice.

15. While many homes do employ Registered Practical Nurses ("RPNs") and Personal Support Workers ("PSWs"), RPNs have a more limited scope of practice, and the high acuity of the residents in long term care homes means that, in accordance with CNO standards, RPNs may not be permissibly assigned unpredictable patients.[13] PSWs are not health care professionals and are neither trained nor permitted to administer medication or assess changes in resident conditions due to drug overdoses. These individuals lack the necessary training to properly observe nurses like EW, and cannot conduct health assessments.

iv. Workload is Untenable

16. The foregoing issues of under and short staffing result in a workload that is untenable for Ontario RNs. There are far too few RNs in this sector. As one RN at CCW wrote in a Professional Responsibility Workload form, she was responsible for approximately 164 patients as a result of short-staffing in the

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of Ezzeldine El Roubi and Pedro Lopez; Sharkley Report – 2008, Document 46745, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care; Donner Report – 2002, Document 61485, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care; and Geriatric LTC Review Committee – 2016, Document 61452, appended to Exhibit 9, Overview Report – MOHLTC.

11 Transcript of Brenda Van Quaetham, June 7, 2018, Day 3, p 562, ln 5-26; Transcript of Karen Routledge, June 13, 2018, Day 7, p 1433, ln 10-19.

12 Transcript of Brenda Van Quaethem, June 7, Day 3, p 454, ln 14-17; Transcript of Helen Crombez, June 12, 2081, p. 1147, ln 23-24; Transcript of Heather Nicholas, June 19, 2018, Day 10 , p 2288, ln 18-20.

13 Exhibit 31,Document 54989, CNO Practice Guideline - RN and RPN Practice: The Client, the Nurse and the Environment – 2014.

facility.[14] Each of the Professional Responsibility Workload Forms in evidence requested that the facility "adjust RN staffing" to accommodate the ever-increasing patient acuity and demands placed upon the RNs.[15] As Helen Crombez conceded, RNs were repeatedly advocating for more staff to address their workload concerns.[16]

17. Nurses are simply too busy to do anything but the necessities of their patients' care. At EW's facilities, nurses only saw each other for a short period at change of shift for report, or for discrete and short tasks such as a narcotic count.[17] Nurses who worked at the same facility with EW for years barely knew her, as they were like ships passing in the night.[18]

18. Moreover, staff at these facilities would often work double or triple shifts. At CCW, for example, these double and triple shifts would result in an RN working 16 and 24 hours straight.[19] This dangerous scheduling was the direct result of understaffing. EW's colleagues thus could not properly observe and assess her unusual behaviour or ascertain a change in one of her residents due to hypoglycemia, as there was not even enough staff in these facilities to cover the schedule.

19. As Carol Hepting noted, CCW had previously "allowed RNs to work many, many shifts in sequence, doubles, triples, etc, which weighed into a decision to not terminate another [nurse] previously due to med errors".[20] It was acknowledged that scheduling in this manner poses a safety risk to patients, as the individual who is working double and triple shifts will be less alert and less able to function at their

14 Exhibit 29, Professional Responsibility Workload Form of April 1, 2011.
15 See, for example: section 6 of Exhibits 28-30.
16 Transcript of Helen Crombez, June 12, 2018, Day 6, pp 1146-1147, ln 28-1.
17 Transcript of Helen Crombez, June 11, 2018, Day 5, p 1085, ln 10-15; p 1087, ln 1-4.
18 Transcript of Karen Routledge, June 13, 2018, Day 7, p 1445, ln 19-28.
19 Transcript of Carol Hepting, June 27, 2018, Day 16, p 3703, ln 10-22.
20 Transcript of Carol Hepting, June 27, 2018, Day 16, p 3683, ln 8-27. In reference to Document 72096.

full capacity.[21] Nonetheless, EW was repeatedly asked and indeed ordered to "step up and take some overtime".[22]

20. The need for EW to "step up" was said to arise from the facility's failure to have a sufficient number of nurses hired, and the MOHLTC's requirement for one RN in the facility at all times.[23] Karin Fairchild confirmed that, with respect to this requirement, the MOHLTC does not look at how a facility complies with the 24/7 requirement, but rather just the fact of compliance itself.[24] EW committed murders while working double shifts.[25]

21. It was sadly ironic, however, that at the same time CCW was forcing nurses to complete overtime and double or triple shifts, it was threatening staffing cuts in an attempt to increase its profit margin. In a memo distributed to registered staff at CCW on April 19, 2013, CCW stated the following: "a review of hours indicates we are over in hours for registered staff. This cannot continue as we will be unable to maintain budget and will result in a reduction of hours".[26] This is illogical. As RN Karen Routledge, who worked at CCW at the time testified, the normal hours could not have been reduced given the staffing patterns that existed.[27] Nurses in the sector are overworked while their "for profit" employers, discussed below, make countless cuts to increase their profit margins.

v. Staffing at "For Profit" Homes

22. In Ontario, there are both "for profit" homes – usually a chain of homes owned by a corporation or family – and "not for profit" homes, such as charitable or municipal homes. EW committed all of her murders at "for profit" homes. This is relevant, because funding and staffing problems in long term care are particularly pronounced in the "for profit" sector, though they exist in all aspects of healthcare.

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21 Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2296, ln 3-7. See also: Transcript of Carol Hepting, June 27, 2018, Day 16, p 3819, ln 11-17.
22 Document 16859, appended to Exhibit 11, Affidavit of Brenda Van Quaetham.
23 Transcript of Brenda Van Quaetham, June 7, 2018, Day 3, p 509, ln 10-20. s
24 Transcript of Karin Fairchild, August 8, 2018, Day 33, p 7622, ln 7-15.
25 See, for example: Exhibit 1, Agreed Statement of Facts, para 35.
26 Exhibit 27, CCW Memorandum of April 19, 2013.
27 Transcript of Karen Routledge, June 13, 2018, Day 7, p 1438, ln 19-29.

23. The Inquiry heard evidence that funding is distributed in what is referred to as four envelopes: Nursing and Personal Care ("NPC"), Program and Support Services, Raw Food and Other Accommodation ("OA"). Although all homes must use all of the funds earmarked for staffing in the NPC envelope, additional funds in the OA envelope can be used to supplement staffing[28] and are used regularly in "not for profit' homes for better staffing. In "for profit" homes, there is thus a disincentive to use OA funds to increase staffing levels, as that directly impacts the owner's profit levels. This exacerbates each of the other systemic issues discussed throughout these submissions.

vi. Recruitment and Retention Issues

24. There was consensus among the witnesses that the recruitment and retention of RNs remains a persistent challenge. It is a "constant battle to keep registered staff",[29] and "[t]here is currently, and has been for some time, a pronounced shortage of RNs in the long term care sector".[30] Both Ms. Van Quaethem and Wanda Sanginesi identified that it was particularly difficult to recruit for night and evening shifts, which were the very shifts that EW preferred to work.[31] This was echoed by Dian Shannon, who noted that many nurses did not want to work the night shift at Telfer Place because they would be working alone, with only one PSW to help with 45 residents.[32]

25. When asked to provide their opinion as to why recruitment and retention was so difficult in the long-term are sector, the witnesses consistently identified the same factors:

a. **Competition:** Nursing is a competitive industry and there is a shortage of nurses. The first choice for new graduate nurses tended to be the hospital sector;[33]

b. **Wage/Benefit Differentials**: the pay differential between for-profit long term care homes and hospitals and municipal not-for-profit homes makes it difficult to retain the

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28 Transcript of Carol Hepting, June 27, 2018, Day 16, p 3723, ln 11-18.
29 Transcript of Brenda Van Quaetham, June 6, 2018, Day 2, p 276, ln 9-10.
30 Exhibit 51, Affidavit of Wanda Sanginesi, appended as Exhibit "A", para 34.
31 Transcript of Brenda Van Quaetham, June 7, 2018, Day 3, p 458, ln 19-26; Transcript of Wanda Sanginesi, June 21, 2018, Day 12, p 2658, ln 18-23.
32 Transcript of Dian Shannon, June 26, 2018, Day 15, p 3526, ln 25-27.
33 Transcript of Brenda Van Quaetham, June 6, 2018, Day 2, p 276; Transcript of Helen Crombez, June 7, 2018, Day 3, p 655; Transcript of Heather Nicholas, June 19, 2018, Day 10, pp 2093-2094. Indeed, as Heather Nicholas noted, working in long term care is a speciality, and if it is not a good fit, nurses will leave the sector altogether.

scarce nurses who did want to work in long term care. Hospitals and municipal homes not only have better hourly wages, but better benefits.[34] As Karen Routledge testified, nurses are leaving these facilities, because hospitals pay more and the work load is much higher in the long term care sector;[35] and

c. **Workload**: the workload in long term care is physically and mentally taxing. The registered nurse-patient ratio is much larger than that found in other sectors, including the hospital.[36] As Dianne Beauregard testified, the work is so taxing that many new hires will actually attend for orientation and leave before it is completed, finding it was too busy and too physical a job.[37]

26. Expert reports, including the Donner Report on "Resident Care and Safety: An Action Plan to Address Abuse and Neglect in Long-Term Care Homes," discussed in detail below, validate the recruitment and retention challenges in this sector and have made recommendations for increased staffing and wages so as to make long-term care a more attractive career for nurses. To date, however, these recommendations have languished and recruitment and retention continue to be a problem.

27. The impact of this problem cannot be overstated: EW easily found work in long term care homes, because those homes were desperate for RNs – especially RNs who were willing to work at night. As Helen Crombez testified, at the time they hired Wettlaufer she believed that they were "lucky to have her come through the door".[38] Addressing the recruitment and retention issue will allow employers in this sector to conduct a more reasonable screening of the applications they receive.

vii. Recommendations to Address Staffing Issues Have Not Been Implemented

28. The staffing crisis in both long-term care homes and home care is not news to the provincial government or the long-term care sector. Since 2001, the provincial government has been provided with multiple expert reports, Inquests, and other reviews in long term care that each provide clear, strongly worded recommendations regarding an urgent need to increase staffing and funding in long-term care.

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34 Transcript of Helen Crombez, June 7, 2018, Day 3, p 655, ln 15-28; Transcript of Helen Crombez, June 11, 2018, Day 5, p 1075, ln 27-30.

35 Transcript of Karen Routledge, June 13, 2018, Day 7, p 1435, ln 22-27. See also: Transcript of Heidi Wilmot-Smith, June 13, 2018., Day 7, p 1574, ln 17-21; & Transcript of Dian Shannon, June 26, 2018, Day 15, ln 2-12.

36 Transcript of Brenda Van Quaetham, June 6, 2018, Day 2, p 276; Transcript of Helen Crombez, June 11, 2018, Day 5, p 1075, ln 1-6; Transcript of Karen Routledge, June 13, 2018, Day 7, p 1435.

37 Transcript of Dianne Beauregard, June 25, 2018, Day 14, p 3340, ln 21-27. See also: Transcript of Tracy Raney, June 25, 2018, Day 14, p 3392; Transcript of Sherri Toleff, June 26, 2018, Day 15, p 3603, ln 1-3; 10-12.

38 Transcript of Helen Crombez, June 8, 2018, Day 4, p 760, ln 13-14.

These documents expressly reference the relationship between low staffing and patient harm. Sadly, these recommendations have been largely not implemented. ONA submits that the implementation of these recommendations is key to preventing future harm. Respectfully, they have already done much of the 'heavy lifting', and their evidence-based findings should be respected and implemented. These documents were reviewed either in the Overview report for the facilities or in oral evidence (or both) and include the following:

a. Price Waterhouse Cooper on the Long Term Care Sector, 2001[39]

29. This widely circulated report compared the patient acuity and levels of service in Ontario long term care homes with those for similar residents in other Ontario, provincial, and international jurisdictions. The report found that Ontario LTC provided the fewest number of nursing hours per resident compared to other settings despite the fact that Ontario LTC residents are among the oldest, and have "more complex needs than residents in other jurisdictions".[40] Inexplicably, Ontario provides less funding for direct nursing care than other jurisdictions.[41] The acuity and complexity of Ontario LTC residents has only increased since this report was drafted.

b. "Commitment to Care: A Plan for Long-Term Care in Ontario," 2004[42]

30. In 2004, Monique Smith was asked by the MOHLTC to make recommended changes to long-term care facilities in the province. The report (the "Smith Report") stated that funding and staff shortages directly affect quality of care, and recommended the return to the 24-hour RN standard as a result. It also set out the need for strategic efforts to promote the long-term care sector as a desirable career option, as staffing shortages and pay inequities in long-term care are "constant challenges".[43] Karin

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39 Exhibit 158, Price Waterhouse Coopers: Report of a Study to Review Levels of Service and Responses to Need in a sample of Ontario Long Term Care Facilities and Selected Comparators, was commissioned by the OLTCA and the Ontario Association of Non-Profit Homes and Services for Seniors ("ONAHSS") dated January 11, 2001.

40 *Ibid* at p 69.

41 *Ibid* at p 65. See, in particular, Figure 16, which shows the total hours per resident, per day (RN, RPN and HCA) and illustrates how Ontario has significantly fewer RN hours than other Canadian, US, and other international jurisdictions. Indeed, Ontario is the lowest. See also: Figures 17 & 18 on pp 67-68.

42 Document 46531, appended to Exhibit 154, Affidavit of Karen Fairchild.

43 Document 46531, appended to Exhibit 154, Affidavit of Karen Fairchild, p 22.

Fairchild from the MOHLTC was just one of many witnesses who confirmed that pay inequities continue to be an issue, and nurses in "for-profit" homes are typically paid less than hospital nurses and those in "not-for-profit" homes.[44]

31. The Smith Report also recommended a public website to ensure public accountability – that would include information about a home's staffing profile (*i.e.* the number of RNs, RPNs, PSWs), staffing levels (staff to resident ratio, updated twice yearly) and employee retention rates[45] – and raised concerns about funding and the Case Mix Index ("CMI"), which was found to be problematic for a number of reasons, including the fact that facilities receive more funding for residents who are not well, with no commensurate incentive to promote wellness.[46] It concluded that it was essential to have and recruit more "full time, resident knowledgeable staff" who know the residents and are employed full time to avoid the increasing casualization of the nursing workforce.[47]

c. Casa Verde Inquest Recommendations, 2005[48]

32. On June 9, 2001, a long term care resident murdered two fellow residents. A Coroner's Inquest was held and in 2005, the jury issued 85 recommendations aimed at preventing deaths in similar circumstances. Many of their recommendations were directed towards revising the long-term care funding and staffing model, and are directly applicable to this Inquiry. They include recommending a new funding system, a study to determine appropriate staffing levels (and amounts of direct RN care required), funding to ensure parity in wages and benefits with hospital RNs, increases in the number of full time RN positions, and a reduction in the use of agency nurses. The jury recommended that staffing level standards be increased immediately to at least 1 RN hour per day, per resident, and that minimum staff hours be at least similar to other jurisdictions, as Ontario was, and remains, far behind Canada's other provinces.

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44 Transcript of Karen Fairchild, August 8, 2018, Day 33, p 7743, ln 4-21. See also: Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1574, ln 14-21.
45 Document 46531, appended to Exhibit 154, Affidavit of Karin Fairchild, pp.25-26.
46 Document 46531, appended to Exhibit 154, Affidavit of Karin Fairchild, pp 25-26.
47 Document 46531, appended to Exhibit 154, Affidavit of Karin Fairchild, p 26.
48 Exhibit 135, Report on the inquest into the deaths of Ezzeldine El Roubi and Pedro Lopez.

d. People Caring for People, 2008[49]

33. The MOHLTC commissioned "People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes: A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario" in 2008. The report was authored by Shirlee Sharkey (the "Sharkey Report"). Ms. Sharkey recommended that provincial guidelines be established to fund an average of up to four hours of care per resident per day, including up to an hour by licensed nurses. This recommendation was to be in place by 2012.[50] These recommendations have not been implemented.

34. The Inquiry heard evidence that staffing in long-term care has not increased since 2008. At CCW for instance, given the 2007-2014 staffing pattern, Karen Routledge testified that RNs would only be able to devote, *at most*, the following portion of their shift to each resident:

a. **Day shift**, where there is an approximate ratio of 1 RN to 32 patients: *at most* 15 minutes per resident;[51] and

b. **Night shift**, where there is an approximate ratio of 1 RN to 99 patients: *at most* 4.5 minutes per resident.[52]

35. Ms. Routledge clarified that these *at most* estimates only apply in the unlikely – and indeed unheard of – event that there are no interruptions during the shift. This simply does not happen.[53] The reality is that, based on this staffing pattern, RNs have even less time to spend with each resident than even these surprisingly low estimates would allow. The recommendations of the Sharkey Report have been ignored.

e. Resident Care and Safety: An Action Plan to Address Abuse and Neglect in Long-Term Care Homes, 2012[54]

36. In 2012, Gail Donner chaired a report of the Long-Term Care Task Force that identified a number of familiar challenges in long-term care (the "Donner Report"). The Donner Report found that "the care

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49 Document 46745, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care.
50 Document 46745, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care, p 16.
51 Transcript of Karen Routledge, June 13, 2018, Day 7, p 1432, ln 13-26.
52 Transcript of Karen Routledge, June 13, 2018, Day 7, pp 1433-1434, ln 17-10.
53 Transcript of Karen Routledge, June 13, 2018, Day 7, pp 1434, ln 8-10.
54 Document 61485, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care.

needs of residents who live in long term care homes is becoming more complex and specialized" as older residents increasingly have "multiple co-morbidities".[55] These co-morbidities require not only more staffing in general, but staffing with RNs in particular, who have the scope of practice required for complex acute residents. The Donner Report also highlighted the human resource challenges impacting on the leadership and skill capacity in long term care, including wage disparity in the sector as compared to hospitals, and the serious issues of recruitment and retention and its impact on workload.[56]

37. With respect to the 2008 Sharkey Report, "although the Ministry accepted the recommendations in principle on June 17, 2008, the Task Force note[d] that there continue to be concerns about sufficient and appropriate staffing, training and workload in long term care homes to provide resident care".[57] It recommended that a sufficient number of direct care staff be required, and echoed the Sharkey Report's recommendation of four hours of direct care per resident per day, including up to one hour of care to be provided by licensed nurses.[58] Although the province accepted these recommendations, it did not implement it.

f. Geriatric and Long Term Care Review Committee Recommendations, 2016[59]

38. In 2016, the Geriatric and Long Term Care Review Committee issued recommendations following the homicide of a resident by another resident in a long-term care home. As above, the recommendation to protect residents from harm was to "increase staffing level requirements in long term care settings".[60]

39. Despite this series of reports – each containing an express finding that long-term care homes are insufficiently staffed to provide care and prevent harm to residents – the MOHLTC has yet to implement

55 Document 61485, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care, p 16.
56 Document 61485, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care, p 18.
57 Document 61485, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care, p 62
58 Document 61485, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care, pp 61-63.
59 Document 61452, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care.
60 Document 61452, appended to Exhibit 9, Overview Report – The Ministry of Health and Long-Term Care, p 4.

a reasonable registered nurse-resident ratio or mandate a set number of hours of care, per resident, each day. There remains insufficient funding and regulation to ensure adequate staffing that is capable of meeting the needs of patients in long term care facilities.

40. ONA's emphasis on staffing as a major systemic issue in the long-term care sector is supported by the evidence of the two experts who testified at the Inquiry. Each gave evidence that corroborates and confirms the foregoing recommendations. Professor Yorker, for example, was asked by Commission Counsel what steps have been taken internationally to assist in the prevention or detection of health care serial killers. She responded by highlighting various studies, including those of Linda Aiken,[61] which demonstrate that better nurse-patient ratios and the use of higher educated nurses results in better patient outcomes.[62] She confirmed that such measures serve the dual purpose of increasing patient outcomes generally, and "prevent[ing] patient harm due to intentional acts",[63] and increased staffing would assist in deterring nurses who might want to commit an intentional act and help with detection, as there would be other nurses present to act as the "eyes and ears" in the home.[64]

41. Professor Yorker was unable to provide much guidance as to what would be an appropriate ratio, however she agreed that ratios would vary depending on the acuity and comorbidities of the patient population, and the type of unit.[65] In any case, ratios would be nowhere near the type of ratios that the Inquiry heard exist in long term care homes.

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61 Although Professor Yorker testified that there was some new research looking at the ratios, she said that Linda Aiken's research, which found that every additional patient added to a nurses' workload results in increased mortality, was "very credible": Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p. 126 ln 24-26.

62 Exhibit 163, Document 72896, Report of Beatrice Crofts Yorker, p.15.

63 Ibid.

64 Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p. 173-175.

65 Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p. 177, ln 21-28.

42. Julie Greenall also provided evidence on the importance of staffing, confirming that a functional, safe medication system requires sufficient staffing,[66] and staffing is a systemic factor that impacts upon medication incidents and the response to those incidents.[67]

viii. Agencies Promote Unsafe Conditions Due to Lax Regulation

43. The use of agency staff is widespread across Ontario, and agency staff are used extensively in long-term care. This is evidenced by the findings of many MOHLTC inspections where agency staff are found to have been repeatedly used in many homes, in direct violation of s.8 of the *LTHCA* and its Regulation.[68] One of EW's crimes, the attempted murder of Sandra Towler, occurred while EW was working as an agency nurse at Telfer Place in Paris, Ontario.[69]

44. Lifeguard President Heidi Wilmot-Smith, referred to this use of agency nurses as a "necessary evil," because of the chronic staffing problems in the long term care sector.[70] She echoed ONA's submission that these long-term care facilities have chronic staffing needs, because they have difficulty recruiting registered staff due to the relatively lower pay and benefits that are provided in this sector.[71] Agency nurses are not just used for filling staffing holes on short notice. They are booked for longer periods of up to four weeks in advance.[72] EW, for instance, was placed in Telfer Place for forty shifts from January 2016 to April 2016.[73]

45. Agencies are a relevant and contributing factor, because they have little, if any, oversight and supervision. Lifeguard provided staff as a "subcontractor" to a number of other agencies.[74] Lifeguard was

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66 Transcript of Julie Greenall, September 13, 2018, Day 36, p. 8394 ln 22-26.
67 Transcript of Julie Greenall, September 13, 2018, Day 36, p. 8394-8395.
68 Exhibit 9, Overview Report-The Ministry of Health and Long Term Care, Vol. 5A, , para.36; Vol. 7A, para. 4; Vol 8A, para. 3(4); Vol. 9A, para. 4; Vol 10A, para. 3. Inspectors issued numerous written notifications with voluntary plans of correction to Telfer Place, Anson Place, Park Lane, Brierwood and Dover Cliffs.
69 Exhibit 1, Agreed Statement of Facts, para 1 (chart).
70 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1631, ln 6-10.
71 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1574, ln 14-21.
72 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1622, ln 6-15.
73 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, pp 1753-1754, ln 24-4.
74 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1576, ln 26-29.

not supervised, overseen, or vetted by either the MOHLTC or the LHINs.[75] There appears to be no Regulation that either forbids or supervises the use of agencies or, even worse, agency subcontractors. Neither the MOHLTC or the LHIN oversaw the agency's contract negotiations. These private entities thus engaged in contractual relations without adequate supervision to ensure that staffing remained compliant with MOHLTC requirements and in furtherance of proper patient care. This resulted in a placement of nurses that were poorly equipped to address the demands of the sector, as discussed in the next section.

46. Moreover, Employer Heidi Wilmot-Smith had no education or experience in the health care sector, let alone long-term care. She had no prior experience as an employer before starting Lifeguard in 2004. Her education was limited to a certificate in travel and tourism, and her experience was in sales in engineering in the US.[76] Her inexperience was problematic, because despite being an employer of registered nurses, she was not familiar with the *LTCHA* and its reporting requirements.[77] She admitted that she never received any information regarding whether or not any of the nurses she employed had received training or been trained on an annual basis in accordance with LTCHA.[78] As she noted, she was "not party to any communiqués directly" between any long term care home and the MOHLTC, nor had she ever read the *LTCHA*.[79] The direct implications of this lack of experience and training are discussed in this submission's section on "Leadership", however, relative to staffing, it raises significant cause for concern, as those in charge of these agencies are unaware of the staffing requirements in the long-term care sector.

ix. Agency Nurses Are Placed Without Regard for Patient Safety or Experience

47. As a corollary to this lack of regulation, agency nurses are drastically unprepared for the roles in which they are placed. Lifeguard did not provide direct supervision or training, nor did it provide or

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75 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, pp 1576-1577, ln 30-9.
76 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1571, ln 15-26; Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1774, ln 23-31; p 1795, ln 8-30.
77 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1628, ln 1-19.
78 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1630, ln 8-30.
79 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p. 1628, ln 16-19

ensure any orientation.[80] Though Ms. Wilmot-Smith referred to orientation as a "safety issue",[81] Lifeguard assumed its nurses were given appropriate orientation by the facilities, unless the nurse complained[82] and tried to negotiate some orientation but was far shorter than what a staff nurse would receive and what was necessary, had a cost to the disincentive to the employers and was not pushed very hard by her. As Ms. Wilmot-Smith conceded: "I am not familiar with the legislation [concerning the required amount of orientation]. I know that it is always a challenge to get any orientation".[83]

48. The agency is the "employer" of the agency nurses and other staff that they place in long-term care and private homes. Normally, an employer in the health sector is not only responsible for hiring, supervising, disciplining, and, if necessary, terminating an employee, but it also has responsibilities to both the MOHLTC and the CNO for mandatory reporting. The evidence concerning Lifeguard establishes that agencies have essentially bypassed these requirements, and created a system in which they operate virtually free of regulation. Compounding this problem is the fact that the assigned homes place blind trust in the agencies to provide available and qualified nurses for patient care.

49. Each party thus assumes the other is performing the necessary due diligence, without any obligation or duty to ensure this is the case. The use and poor regulation of agencies is therefore unsafe, as appropriate screening, orientation, investigation, and observation is not performed. As Ms. Wilmot-Smith's evidence demonstrates, where problems arise, the agencies feel no obligation – statutory or otherwise– act; a 'problem nurse' is simply assigned elsewhere. Requirements of the CNO and MOHLTC are ignored.

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80 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1797, ln 1-5.
81 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1625, ln 8-16.
82 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, pp 1720-1721, ln 20-20.
83 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, pp 1790-1791, ln 29-2.

B. LEADERSHIP PROBLEMS

i. Administrators, Managers, and Owners Lack Appropriate Education, Training, Qualifications, and Skills

50. The *LTCHA* and its Regulation establishes the required qualifications for both an Administrator and Director of Nursing.[84] These qualifications are mandated precisely so that the leaders of a long-term care home are able to meet their vital obligations to residents, families, and employees under applicable legislation.

51. At CCW, the Administrator was Brenda Van Quaethem. While well intentioned, she did not have the required qualifications; she was "grandparented" under the legislation, and allowed to continue working without meeting the required qualifications. This is unfortunate given the many serious responsibilities under the *LTCHA*, *Regulated Health Professions Act, Labour Relations Act*, and Human Rights Code. It was clear from her evidence that she was simply in above her head.

52. Similarly, Heidi Wilmot-Smith, owner of Lifeguard Inc., did not have any training whatsoever to prepare her to fulfill her obligations as a manager of nurses. As set out above she had no qualifications. She was also unfamiliar with the *LTCHA*, admitting that she still had not taken any steps to further educate herself about the environment of long-term care.[85] Like Ms. Van Quaethem, she was in above her head.

53. The demonstrated lack of appropriate education, training, qualifications and skills of the Administrators, Managers, and Owners who testified at the public hearing represents a failure to ensure accountability and oversight in the long-term care sector. Enhanced training is required to ensure that proper patient assignments occur at all times.

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84 O. Reg 79/10, ss. 212-213, under the *Long Term Care Homes Act*, 2007, S.O. 2007, c. 8.
85 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p.1833, ln 6-11.

ii. Insufficient Screening of Applicants

54. The evidence establishes that the screening and checking of references during hiring is misunderstood by those who are responsible for recruitment. Inexplicably, resumes were not scrutinized, and obvious gaps in EW's resume were not questioned. Hiring managers did little more than check the CNO's "Find a Nurse" database,' and perfunctory reference checks for individuals listed as references on her application form.

55. For example, Helen Crombez, who testified about hiring EW at CCW in 2007, stated that she interviewed EW and then phoned Christian Horizons and received a positive oral reference. She accepted this reference at face value, notwithstanding the fact that, though EW had been licensed by the CNO in 1995, she had been working as a support worker – a less responsible position at a much lower pay – at Christian Horizons. She testified that no flags were raised,[86] and felt "lucky to have [EW] come through the door".[87]

56. Heather Nicholas was the hiring manager at Meadow Park. Jarlette had the most sophisticated hiring process: it provided managers with a handbook on hiring, required group and individual interviews and reference checks.[88] Despite this process, Heather Nicholas did not question the gaps in EW's resume, even though the Jarlette hiring guide specifies such gaps as a concern worthy of investigation.[89] Ms. Nicholas did not ask why EW had not worked as a nurse prior to 2007 and testified that this was not a concern for her.[90]

57. EW's dismissal from her employment at CCW was similarly not an issue for Ms. Nicholas. EW described the medication error involving insulin, and claimed that she wasn't getting along with her

86 Transcript of Helen Crombez, June 11, 2018, Day 5, p 1071, ln 11-17.
87 Transcript of Helen Crombez, June 8, 2018, Day 4, p 760, ln 13-14.
88 Document 72015, Hiring the Jarlette Way, appended as Exhibit "C" to Exhibit 43, Affidavit of Heather Nicholas.
89 Document 72015-Hiring the Jarlette Way, appended as Exhibit C to Exhibit 43, Affidavit of Heather Nicholas
90 Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2118, ln 7-10.

coworkers.[91] Despite this advisement, Ms. Nicholas did not dig deeper. She did not contact Helen Crombez or Brenda Van Quaethem.[92] Instead, she simply called the references provided by EW: David Petkau from Christian Horizons, who had not worked with her in seven years, and Sandra Fluttert, a supervisor at CCW who confirmed she was terminated, referring vaguely to a "a personality conflict"[93]. The reason for this was clear: she was in desperate need of nurses.[94]

58. Heidi Wilmot-Smith also failed to appropriately scrutinize EW's application. On the face of EW's application, there were holes and inconsistencies, however no attempts were made to seek clarification. Ms. Wilmot-Smith admitted that she "clearly" didn't question the fact that EW didn't have 18 years working as a nurse, as claimed in her cover letter and resume.[95] When asked why she did not contact anyone at Meadow Park, Ms. Wilmot-Smith said that she did not make a habit of contacting their current employers because it would compromise "their human right to privacy"[96] – a human right that does not exist. She does not appear to have questioned why a nurse with a full-time position would want to work as an agency nurse and be paid significantly less than she was making at Meadow Park.

59. Lifeguard appears to have just been content to find a nurse who wanted to work in long term care at wages which were lower than even typical long term care rates. As Ms. Wilmot-Smith conceded, Lifeguard charges the RN out to the LTC home at, on average, $65 an hour, yet only pays the RN $36 an hour. This results in a profit by Lifeguard of $29 an hour.[97] A reasonable review by a competent employer should have required that these gaps and inconsistencies be questioned and followed up on.[98]

91 Document 17519, Interview Notes appended as Exhibit "L" to Exhibit 43, Affidavit of Heather Nicholas. See also: Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2116, ln 14-19.
92 Transcript of Heather Nicholas, June 19, 2018, Day 10, p. 2136 ln 20-29.
93 Transcript of Heather Nicholas, June 19, 2018, Day 10, p.2134, ln 32.
94 Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2297, ln 2-4.
95 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1807, ln 29.
96 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1602, ln 22-25.
97 Transcript of Heidi Wilmot-Smith, Dated June 14, 2018, Day 8, pp 1802-1803, ln 26-15.
98 Document 72015-Hiring the Jarlette Way, appended as Exhibit C to Exhibit 43, Affidavit of Heather Nicholas.

60. Lifeguard's review of EW's references was similarly inadequate. She spoke to a CCW manager, Sandra Fluttert, who provided a reference described as "glowing",[99] even though she knew EW was terminated for cause. She did not probe the termination with the reference or EW. Even when she was told by CCW's VP Carol Hepting that they were not interested in having "that person" back, she did not inquire further.[100] Moreover, this advisement came as a result of Ms. Wilmot-Smith seeking new clients; it was not part of Ms. Wilmot-Smith's screening process.[101] She testified that she thought it was odd, but did not follow up as she dismissed it as EW "lock[ing] horns with senior management".[102] Though she spoke briefly to David Petkau at Christian Horizon[103] she does not appear to have asked any probing questions as to why EW was an RN working as a "Support Worker". Mr. Petkau was aware of EW's previous history with the CNO, as he was given a copy of the Fitness to practice decision at the CNO.[104]

61. The hiring process at St. Elizabeth was also deficient in its examination of EW's candidacy for a position as a nurse in home care. EW first applied to St. Elizabeth's in 2014, but her application was rejected in part because Tamara Condy, the hiring manager, had heard rumours that there had been issues with EW at CCW.[105] Two years later, however, when EW again applied, her application was treated differently. She made it through the pre-screening process, was interviewed and her references were checked via an online process. Ms. Condy testified that EW was upfront in the interview about being let go by CCW. Instead of this leading to additional scrutiny, Ms. Condy left it at that and "respected the fact that she was willing" to admit to the termination.[106] Ms. Condy did not contact anyone directly at CCW to ask questions about what had happened, nor did she contact Lifeguard or Meadow Park.[107]

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99 Exhibit 38, Affidavit of Heidi Wilmot-Smith, para 33.
100 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1607, ln 9-13.
101 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p.1607, ln 1-8.
102 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1607, ln 19-24.
103 Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, pp 1600-1601, ln 14-6.
104 Exhibit 6, Overview Report – the Facilities and Agencies, Volume 4, p 21, s 8: "Petkau receives a copy of the Decision of the Fitness to Practice Committee of the CNO dated May 9, 1997". See also: Document 36808.
105 Transcript of Tamara Condy, June 27, 2018, Day 16, p.3839-3840, ln 5-2.
106 Transcript of Tamara Condy, June 27, 2018, Day 16, p.3860 ln 18-20.
107 Transcript of Tamara Condy, June 27, 2018, Day 16, p. 3862, ln 4-13.

62. The lax screening processes, exhibited by all hiring managers, meant that it was very easy for EW to find employment in long-term care and home care.

iii. Administrators, Managers, and Owners Lack Knowledge of Duties and Responsibilities as an Employer

63. All four Employers, including the Administrators and Director of Nursing/Care consistently demonstrated gaps in their understanding of their duties as employers. The Inquiry heard much evidence concerning EW's employment history at CCW, including Ms. Van Quathem and Ms. Crombez's unsuccessful attempts to manage EW's misconduct. ONA does not intend to repeat the fulsome review of the approximately 49 incidents heard in testimony. This thorough review of the incidents, however, demonstrated a puzzling reluctance and inability on the part of Ms. Van Quaethem and Ms. Crombez to appropriately investigate and supervise EW.

64. For instance, CCW received dozens of complaints and concerns regarding EW while she was working on night and evening shifts, yet they never moved her to the day shift for proper observation, never set up a monitor, and never sent EW for remediation. Both testified about progressive discipline, yet clearly did not have a thorough understanding of what exactly that concept entails. When deciding what level of discipline to levy, neither reviewed her full personnel file.[108] Indeed, Ms. Van Quaethem and Ms. Crombez had no idea that the "sunset" clause in the CCW Collective Agreement was 18-months (instead of 12).[109] EW never had an 18-month period free of discipline, so each incident should have been reflected in her record. This was obviously not done, however, as they did not track her discipline in any systematic way. Each struggled with the most basic of supervisory duties, such as taking comprehensive notes during investigation meetings and keeping all notes in a personnel file.

65. Ms. Van Quaethem and Ms. Crombez also did not know how to deal with EW's disclosure of health and medication issues, which EW claimed had led her to fail to assess a resident. EW's self-disclosure of these issues was ignored. Ms. Van Quaethem confirmed that she did not follow up on this

108 Transcript of Brenda Van Quathem, June 7, 2018, Day 3, p. 526, ln 26-29.
109 Transcript of Brenda Van Quaethem, June 7, 2018, Day 3, p.542, ln 11-19.

disclosure and instead permitted EW to continue to work without investigation.[110] Neither sought any advice from Human Resources in the corporate office until later in 2013-14, and neither contacted the CNO for advice.[111]

66. Management at CCW also failed to prioritize training and orientation as required under the *LTCHA*. Sandra Fluttert, who was hired in 2013 as the Resident Care Coordinator and then was promoted into the Assistant Director of Nursing ("ADON") position in November 2015, advised Rhonda Kukoly during the MOHLTC inspections following EW's confession, that she did not receive any orientation when she started at CCW.[112] She also advised that required annual training was not provided until she became the ADON which meant that staff did not receive training on prevention of abuse, whistleblowing, mandatory reporting, the home's complaint process and the Resident's Bill of Rights.[113]

67. Heidi Wilmot-Smith also had no clue as to her obligations as an employer, as discussed above. When she was provided with information about bizarre behaviour from several homes – including that EW had made inappropriate sexual and vulgar comments at Telfer Place, and that a physician had indicated that he was not confident in her abilities to assess residents and questioned her ability to carry out basic nursing duties – she failed to follow up in any meaningful way. After meeting with EW to discuss the complaint, she provided solace to her by saying that other homes liked her.[114] Instead of investigating further, she opted to place EW in other facilities.

68. Ms. Wilmot-Smith provided much testimony that demonstrated her lack of understanding of her duties and responsibility as an employer. She was uninformed and confused about what she could ask regarding self-identified health problems, such as when EW advised as a defence for her failure to report to work that she had been drinking and she was a "recovering alcoholic". Ms. Wilmot-Smith did not meet with EW in person upon being advised of EW's drinking. She was under the impression that any question

110 Transcript of Brenda Van Quaethem, June 6, 2018, Day 2, p 375, ln 14-20.
111 Transcript of Helen Crombez, June 8, 2018, Day 4, p 856, ln 1-15.
112 Document 71590, p. 1 appended to Exhibit 141, Affidavit of Rhonda Kukoly.
113 Document 71590, p. 1, appended to Exhibit 141, Affidavit of Rhonda Kukoly.
114 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 12, p.1665-1671.

about this advisement would be considered "harassment".[115] Even though EW raised the drinking herself, Ms. Wilmot-Smith inexplicably claimed she “had had not a hint, not a rumour, not an innuendo” that there was a problem.[116] Instead of getting legal advice or advice from the CNO, which has a health program specifically for nurses, she guessed at what her duties were as an employer. She guessed wrong.

69. These employers were unaware of their duties and obligations and, as a direct result, EW's misconduct and troublesome conduct was minimized or ignored altogether.

iv. Employers' Lack of Knowledge of the CNO's Reporting Obligations

70. The employers demonstrated a clear deficiency with respect to their understanding of their obligations to report to the CNO and, in the case of Ms. Van Quathem, how to file such a report altogether.

71. The leaders at Meadow Park failed to report EW to the CNO when they ought to have done so. Heather Nicholas, the Director of Care at Meadow Park, testified that she did not contact the CNO to report her suspicions that EW had stolen missing hydromorphone from the Home or to report the addiction health problems she of which she was advised.[117] This was despite the fact that she suspected EW was responsible and was aware that EW had been hospitalized for an overdose the same weekend that the narcotic went missing.[118] Ms. Nicholas testified that as she did not know at the specific time of EW’s resignation that she was addicted that she did not believe she had an obligation to report.[119] Ms. Nicholas testified that she did not look at the CNO website to see if she should be reporting the events.[120] Most perplexingly, she still appeared to take the position during the hearing, even after reading the definition of incapacity, that she would not have reported her.[121]

115 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 12, p.1745-1746, ln 29-3.
116 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 12, p. 1651, ln 2-24.
117 Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2260, ln 6-7.
118 Transcript of Heather Nicholas, June 19, 2018, Day 10, pp 2173-2174, ln 28-9.
119 Transcript of Heather Nicholas, June 19, 2018, Day 10, pp 2260-2261, 21-2.
120 Transcript of Heather Nicholas, June 19, 2018, Day 10, pp 2264, ln 6-11.
121 Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2178, ln 1-27.

72. After receiving a resignation letter from EW stating that she was "no longer able to work as a registered nurse", Heidi Wilmot-Smith testified that although she thought the wording was strange, she did not contact the CNO.[122] Neither she nor anyone else at Lifeguard made any inquiries of EW, as she "likely had bigger fish to fry that day."[123]

73. Brenda Van Quaethem, in filing a report to the CNO following EW's termination, testified that she did not list all the issues with EW in her report, because she ran out of space on the form.[124] She apparently did not consider attaching additional pages to the document. As Ms. Van Quaethem was not a nurse, it is possible she did not understand the implications of filing an incomplete report. She also did not share the report with the Director of Nursing, Helen Crombez, who was listed as the contact person on the form. This meant that when the CNO contacted Ms. Crombez to discuss the report, Ms. Crombez had never seen it.[125]

74. Each employer thus failed to appreciate the CNO's role in investigating and monitoring the health or fitness to practice of its members. A proper understanding of the CNO's role could have resulted in its intervention at an earlier juncture, and perhaps prevented some of the reprehensible crimes that EW went on to commit.

v. Employers' Lack of Knowledge of the MOHLTC's Reporting Obligations

75. The evidence was replete with examples demonstrating substantial gaps in the employers' understanding of mandatory reporting requirements to the MOHLTC. These requirements were put in place to ensure that long term care homes are compliant with their considerable obligations under the *LTCHA* to provide safe and quality resident care. The Ministry was circumvented in its ability to oversee the homes due to this failure of the homes' leadership to identify and fulfill their reporting obligations.

122 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p 1818, ln 6-11, 28-30.
123 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p.1706, ln 17-27.
124 Transcript of Brenda Van Quaetham, June 7, 2018, Day 3, p 568, ln 4-14.
125 Transcript of Helen Crombez, June 11, 2018, Day 5, p. 1093, ln 4-21.

76. As just one example, Ms. Crombez testified that when she received a complaint from a resident that EW had slapped her, she decided to investigate *first*, before filing a Critical Incident Report with the Ministry.[126] This was clearly not the appropriate way to proceed.

77. Ms. Crombez also admitted that CCW didn't file a report when she received a complaint that EW had finished her break before attending to a resident in pain. When asked why this wasn't reported as abuse she confessed that she "just didn't think of it".[127] Similarly, when asked why she didn't consider reporting EW's failure to assess a bleeding finger, she stated: "You know, I don't know if I had a mental block about neglect, but I really didn't think of it, as far as I can, you know, recall".[128] This is less than appropriate in the circumstances.

78. Ms. Van Quathem also did not understand her reporting obligations. She testified that even though a PSW, Dawn Pike, had filed a report indicating that she thought EW's conduct was neglectful when she failed to assess a resident who was having difficulty breathing for three days, a Critical Incident Report was not filed with the Ministry.[129] She also didn't give any consideration as to whether the complaints filed by Wendy Macknott – which said that EW had used unsterile scissors to "pop" a hematoma and had not assessed or treated a bleeding finger –would meet the threshold for abuse or neglect and thus be reportable.[130]

79. Similarly, no one at Meadow Park reported the incident with Mr. Horvath being found "tied to the bed rails by his drawstring".[131]

80. Perhaps most astoundingly, when CCW was contacted and advised that EW had confessed to murdering residents at the Home, the facility operator failed to immediately notify the Ministry. Instead,

126 Transcript of Helen Crombez, June 8, 2018, Day 4, p.823, ln 5-7.
127 Transcript of Helen Crombez, June 8, 2018, Day 4, p 833, ln 27-31.
128 Transcript of Helen Crombez, June 8, 2018, Day 4, p 843, ln 3-6.
129 Transcript of Brenda Van Quaethem, June 6, 2018, Day 2, p 350, ln 1-12.
130 Transcript of Brenda Van Quaethem, June 6, 2018, Day 2, p 357, ln 16-21.
131 Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2158, ln 8-12.

he hired a PR firm, contacted the OLTCA and then, after being contacted by the Ministry, filed a report.[132]

81. These examples demonstrate the employers' repeat failure to consider the MOHLTC's regulatory role in the long term care sector. As with the CNO, the MOHLTC was deprived an opportunity to appropriately intervene, and we will never know what effect, if any, it could have had on preventing the harm that was caused.

C. MEDICATION ISSUES

82. EW committed her crimes with insulin, a medication that is readily accessible in long-term care and must continue to be so, given the large number of residents with diabetes. It is also readily accessible to anyone walking into an Ontario drug store, as no prescription is needed. EW could have bought it and brought it, in; her only deterrent was cost. However, the reality is she did not have purchase this medication as there were untracked boxes of it sitting in the medication rooms where she worked that she could access. Pens for injection could be borrowed without suspicion.

83. The Inquiry heard detailed and thoughtful evidence from the medication administration expert, Julie Greenall regarding the challenges of tracking and controlling insulin given its ubiquitous use and the large and changing doses that are required for residents in long term care.[133] Julie Greenall confirmed that measures taken to restrict access may be circumvented because other methods of access exist.[134]

84. Moreover, both the pharmacist at CCW, Joanne Polkiewicz, and the pharmacist for MP, Jonathan Lu, testified that tracking insulin would be extremely challenging.[135]

85. Ms. Greenall was of the view that it would be not possible to prevent the use of insulin as a means to inflict intentional harm. This is the disappointing reality of this high alert yet common

132 Transcript of Karen Simpson, July 31, 2018, Day 28, p 6360, 4-32.
133 Exhibit 166, Expert Report of Julie Greenall, p.26.
134 Exhibit 166, Expert Report of Ms. Julie Greenall, p 26.
135 Exhibit 68, Affidavit of Joanne Polkiewicz, para 70; Transcript of Jonathan Lu, June 25, 2018, Day 14, p 3290, ln 5-23.

medication. Nonetheless, she made a number of recommendations that could be taken to reduce the potential for intentional harm from insulin misuse.[136]

86. ONA generally agrees with these recommendations, with the exception of one (discussed below). Specifically, ONA agrees that the following steps could be effective to deter intentional harm:

a. Limit supply of insulin per resident to a current pen and a spare pen, or a maximum 10-day supply based on usage.

b. Implement a central supply process for replacement insulin pens in LTC homes.

c. Develop standard audit processes to check the drug record book for unusual patterns of use.

87. ONA believes that these recommendations should be further addressed in the consultation phase of this Inquiry, and submits that any measure must be both reasonable and workable. There is no point in implementing costly or labour intensive measures that are easily circumvented by a health care provider who is intentionally using insulin as a weapon.

88. For instance, some homes have reverted to previous practice of having two nurses involved in the administration of insulin. This practice was in place to avoid inadvertent errors at a time when insulin was drawn up from central sources, as opposed to dial up pen cartridges. Double checks are labour intensive. As nurse Agatha Krawczyk testified, they create more work: she has to find a nurse before administering insulin, they have to check the EMAR and the dose together, and then watch while the insulin is administered. If the nurse doesn't watch her administer the medication, then it would be easy to simply dial and change the dose prior to injection. This means that a second nurse has to be on shift and must be able to leave her own patients to come and perform the double check.[137]

89. In addition to adding to the already overburdened workload of nurses, the practical reality is that this does not work to deter someone with ill intent from taking insulin and giving it to a resident. EW was injecting the residents outside the insulin rounds and would never have asked for a double check when

136 Exhibit 166, Expert Report of Ms. Julie Greenall, p 26.
137 Transcript of Agatha Krawczyk, June 14, 2018, Day 8, pp 1861-1862, ln 2-32.

she was intent on committing murder. Julie Greenall agreed that the independent double checks would in no way prevent intentional misuse of insulin, which is the very problem that this Inquiry is looking into.[138] ONA submits that there is little point in implementing this change across the long term health care sector, as it would not address the problem and in any event is not even workable given the staffing and workload crises, as detailed above.

90. In addition to deterrence, there is the issue of detection. Ms. Greenall provided certain recommendations to enhance detection of whether a patient was intentionally harmed by the misuse of insulin. Specifically, these included the following:

a. Evaluation of sudden changes in resident condition, specifically hypoglycemia. This includes prompt evaluation and investigation of possible causes in order to mitigate harm and protocols to routinely check blood sugar when a resident is found with a decreased level of consciousness or other signs of hypoglycemia. When looking at possible causes, it is important to consider the possibility of a medication error;[139] and

b. Review the use of rescue medications, specifically glucagon.[140]

91. ONA wholeheartedly supports these measures, which should lead to a culture change in how hypoglycemia is viewed and how health care providers turn their minds to possible insulin problems, including intentional misuse.

92. In order to support these changes, however, education needs to be provided to all staff, physicians, coroners and nurse managers, and appropriate staffing must be implemented. Unexpected hypoglycemia can only be picked up by health care providers trained in assessing unexpected changes; for nursing this is the RN, not RPN.[141]

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138 Transcript of Julie Greenall, September 13, 2018, Day 36, p. 8390, ln 21-31.
139 Exhibit 166, Document 72897, Report of Julie Greenall, p.29; See also ISMP Bulletin: Unexpected Hypoglycemia: Considering Medical Error in the Differential Diagnosis, p. 50-52 of Exhibit 166
140 Exhibit 166, Document 72897, Report of Julie Greenall, pp. 29-30.
141 Exhibit 31, Practice Guideline - RN and RPN Practice: The Client, the Nurse and the Environment – 2014.

93. As Julie Greenall and others testified, it is crucial that the "Just Culture" philosophy, which was implemented after the landmark 1999 study "To Err is Human", not be dismantled in any way.[142] It is imperative that a "no blame, no shame" response to reported medication errors be maintained, as it encourages reporting by not only the individual but colleagues as well, in furtherance of patient safety. Such a response encourages reporting of errors at the first opportunity, which in turn permits employers to assess the reasons for such errors, including whether it was an individual error (or intentional act) and whether there was a systemic or recurring problem.[143] Departing from this important cultural attitude concerning medication errors would drive reporting underground.

D. COLLEGE OF NURSES OF ONTARIO

i. RHPA and CNO Public Registrar/Website

94. The applicable legislation – the *RHPA* – has been amended several times, including in 2017 with the passage of the *Protecting Patients Act,* 2017.[144] Several changes have been made to both the legislation and the CNO's procedures, policies, and practices since EW was reported for the first and second time. It is ONA's position that, as a result of these changes, the *RHPA*'s present requirements with respect to mandatory reporting and a member's fitness to practice are rigorous and there is no need for an amendment.

95. With respect to the CNO Public Registrar, more information is found on it as a result of the 2017 amendments, and, today, if nurse receives even a "caution" or a remedial plan from the CNO – neither of which follow any finding by the CNO – it is on the public registrar with no process to remove it from a nurse's profile.

96. There have been suggestions at the hearing that additional information should be added to the CNO website, such as the entire employment history of a nurse. ONA takes no position on this in these

142 Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, pp 8032-8033, ln 6-5.
143 Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, pp 8033-8034, ln 11-9; Transcript of Julie Greenall, September 13, 2018, Day 36, pp 8292-8295.
144 Exhibit 126, Document 72870; also see FD 00005 page 1894.

submissions, except to say that it was troubling to hear of the employers' reliance on the CNO's "Find a Nurse" database as a substitute to their obligation to conduct appropriate screenings of prospective employees. The CNO is not an employment agency; the purpose of the "Find a Nurse" database is to advise of the status and history of their registration.

97. As set out elsewhere in these submissions, there was troubling evidence of the hiring processes engaged in by all of EW's employers. As EW said herself, it was bit of a sham and she felt like her job interview with CCW was more like an orientation.[145] She was hired by simply walking in the door as a direct result of the staffing shortages that exist in this sector. EW's employers did not follow best practices for hiring, and failed to exercise due diligence to protect their residents. This may be due to a lack of skills, knowledge, and experience among the facilities and agencies (as well as their respective administrators). It is also directly related to the current nursing shortage.

98. An expanded CNO database would not have changed these practices. Accordingly, none of the issues which resulted in EW's being hired would be remedied by simply forcing the CNO to add employment history to their website.

ii. Fitness to Practice and the New Nurse Health Program

99. The Inquiry heard evidence of EW's health history in the documents regarding the CNO's Fitness to Practice process in 1995 and the CAMH documents. The exact nature and depth of her health problems remain unclear, however it is undisputed that she had highly complex psychiatric history problems. As Anne Coghlan and the expert Professor Yorker testified, many nurses, like all Canadians, have mental health issues, including addiction, and may be rehabilitated to practice safely and be excellent nurses.[146] We must be careful not to overreact and treat all health professionals with mental health issues as potential serial killers.

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145 Exhibit 5, Document 71420, p. 32-33.

146 Transcript of Anne Coghlan, July 26, 2018, Day 25, p. 5743, lns 8-23; Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p.182, ln 8-11.

100. The CNO's Fitness to Practice process has changed significantly since EW went through it in the 1990s, and we heard evidence that at the present the CNO is setting up a new program called the Nurse Health Program (NHP), hopefully similar to the comprehensive Professions Health Program ("PHP") presently in place for doctors and certain other regulated health professionals.[147]

101. ONA is not making any recommendations on the CNO at this stage of the Inquiry. We submit that the *Regulated Health Professions Act*, 1991, and the CNO 's professional misconduct, incompetence, and fitness to practice processes are comprehensive and, in any event, have been updated since the time that EW worked as an RN. ONA reserves its right to respond to any recommendations that other Participants may raise in relation to the CNO.

E. HOME CARE

102. While the evidence on home care was not as extensive as that of long term care, it is clear that there are similar problems of staffing, funding, recruitment and retention, and proper screening and supervision.

103. Tamara Condy testified that recruitment and retention of nurses in this sector was challenging. She described home care nursing as a hard job, with nurses in and out of their car, toting supplies and working in a less controlled, sometimes unsavoury, environment. The job is physically demanding, stressful, and does not pay as well as other sectors.[148]

104. The recruitment challenges were illustrated as the evidence regarding EW's history with St. Elizabeth’s unfolded. Although Ms. Condy had initially rejected EW as a candidate in 2014 due to her experience at CCW, she ultimately hired her two years later basically because there was not a better candidate.[149]

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147 Exhibit 127, Document 72871.
148 Transcript of Tamara Condy, June 27, 2018, Day 16, pp 3841-3842.
149 Transcript of Tamara Condy, June 27, 2018, Day 16, p. 3843, ln 18-26.

105. Ms. Condy also attributed a high turnover rate in the sector to the fact that many new graduates work in home care to obtain nursing experience and then move to an acute care hospital, as the hospital sector is more stable and better paid.[150] Just as in long term care, RNs are simply not paid enough in home care to attract and retain experienced staff. The dearth of qualified nurses applying to work in home care helped create the conditions in which a nurse like EW could find work.

106. The Homecare sector has significant systemic problems beyond those that were heard about in the limited evidence at this Inquiry. The employers in this area are often contracted by the LHINs and subject to constant change. They are selected in part by how cheaply they can provide services. They are permitted to enter into subcontracts with other providers, including agencies like Lifeguard. The LHIN does not provide much oversight to those subcontractors, who have no reporting obligations to the LHIN. Instead, the LHIN relies on the home care agency with which they have a contract to provide the supervision.[151] The systemic problems in this area are beyond the scope of this Inquiry but require serious attention and change.

F. FUNDING

107. The Inquiry did not hear substantial evidence on funding in long term care. ONA submits that it is very difficult to address some of the overarching problems, particularly those involving staffing, in the absence of an overhaul to the existing funding regime.

108. The Inquiry did hear evidence from Karen Simpson confirming that a home with a higher CMI will in theory get more funding than a home with a lower CMI and that there is a time lag between actually gathering the information and the release of funding.[152] She further agreed that the CMI is

150 Transcript of Tamara Condy, June 27, 2018, Day 16, p. 3842-3843, ln 31-1.
151 Transcript of Steven Carswell, August 9, 2018, Day 34, p. 7866-7867.
152 Transcript of Karen Simpson, July 31, 2018, Day 28, p.6528, ln 16-20.

indexed and that it does not increase the actual funding, but rather the proportion of the overall “pie” that is received by any given home.[153]

109. Karin Fairchild confirmed that when she was involved in drafting provisions in the *LTCHA* in response to the Smith Report, funding was not considered. Instead, staffing regulations were created in isolation from funding considerations.

110. ONA submits that this is not an effective way to proceed. Staffing and funding go hand in hand. The Casa Verde Recommendations speak to funding so as to set standards to increasing staffing levels and ensure wage parity.[154] The Sharkey Report recommends that guidelines be established to support funding to provide up to four hours of care per resident per day.[155] The Donner Report strongly recommends that the Sharkey Report be implemented, again drawing the connection between funding and staffing.[156] Put simply, it is impossible to address the staffing issues that were identified as leading contributors to abuse and neglect in long term care without also properly funding long term care.

III. IRRELEVANT EVIDENCE HEARD BY INQUIRY

111. Although unions in the workplace were repeatedly raised as a "problem" by some counsel, there was no evidence of any pattern linking unionized workplaces with any problem in deterring or detecting intentional harm committed by nurses. ONA notes that only two of the five workplaces in which EW committed her crimes were unionized with ONA. Nurses at Lifeguard Inc and St. Elizabeth Health Care, for example, were not unionized.

112. It is notable that the only other Canadian case of possible serial murder – the Hospital for Sick Children case, which was analyzed in the Grange Inquiry and referred to by Professor. Yorker in evidence – was at a hospital where the nurses were <u>not</u> unionized by any union. The Hospital for Sick Children is

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153 Transcript of Karen Simpson, July 31, 2018, Day 28, p.6530, ln 22-31
154 Exhibit 135, Report on the inquest into the deaths of Ezzeldine El Roubi and Pedro Lopez, Recommendations 29 and 34.
155 Document 46745, appended to Exhibit 9, Overview Report – The MOHLTC, p. 16.
156 Document 61485, appended to Exhibit 9, Overview Report – The MOHLTC, p. 63.

one of the few hospitals in Ontario that has never had a union for nurses. Professor Yorker's study and report do not link serial killers to unionized workplaces; indeed the ratio is higher in the US where there is a significantly lower rate of unions in the health sector.

113. Notwithstanding the irrelevance of unionization, there was extensive questioning related to ONA having grieved and settled matters for EW in 1995 and 2013/2014. The grieving or settlement of these matters, including any negotiated references for EW, had nothing to do with her being hired elsewhere and nothing to do with her criminal conduct. ONA submits, both on the facts and due to the Inquiry's mandate, that these issues are simply red herrings and unfair attempts by other parties to find or shift blame for the conduct that no one, least of all ONA, knew anything about.

114. Indeed, there was much fuss made by certain participants of references and reference letters that former employers of EW had provided leading to wrong facts being reported in the public media. The evidence is clear that no such references were ever seen or relied on by any of EW's employers when they made their hiring decisions. Rather, EW kept being rehired due to the extreme shortage of nurses willing to work in long term care. Each of the employers who hired her were desperate for nurses, and considered themselves “lucky to have her come through the door”.[157]

A. Geraldton District Hospital Grievance

115. The "reference" negotiated by Geraldton District Hospital and ONA in 1995 was not much of a reference at all. Pursuant to Minutes of Settlement, the Hospital had simply agreed that any person contacting the Hospital for employment references would be advised by the Human Resources Department that Beth Parker, as she then was, had resigned her employment for health reasons.[158]

116. This was part of an agreement to resolve a grievance after EW’s employment was terminated on October 13, 1995, after she had physically collapsed at work on one of her first shifts after obtaining her

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157 Transcript of Helen Crombez, June 8, 2018, Day 4, p 760, ln 13-14.
158 Document 54872, appended to Exhibit 6, Overview Report – the Facilities and Agencies.

nursing license.[159] Whether she took the drugs at work due to addiction, stress, or as a suicide attempt is unclear. However, it is clearly established that she was a new RN who had a health issue, and her termination in relation to this health issue was appropriately reported to the CNO. The CNO dealt with this health issue under its "Fitness to Practice" process under the *Regulated Health Professions Act, 1991* as set out in the CNO overview report and the affidavit of Anne Coghlan.[160]

117. It was not unreasonable for the Hospital as part of its settlement of a grievance to convert a termination to a resignation for health reasons and give a "reference" stating that she left for health reasons. The Hospital was dealing with a brand new nurse and the CNO was dealing with the health matter.

118. The Geraldton 'reference', in any event, is a non-issue as no one who subsequently hired EW was ever aware that she had worked at the Hospital. It was not on her resume or applications for CCW, MP, Lifeguard or St. Elizabeth's.[161] Respectfully, it would not have made an iota of difference whether her termination was grieved, whether her record said she was terminated, or whether she had a reference or reference letter. Not one of EW's employers relied on the 'reference'; she was hired because the facilities needed nurses.

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159 Exhibit 6, Overview Report – the Facilities and Agencies, Volume 1. EW began to work as an RN the week of September 11, 1995. She collapsed at work on September 13, 1995. She had previously worked at the Hospital as a student nurse (since approximately June 12, 1995).

160 See, in particular: Exhibit 121, Affidavit of Anne Coghlan, paras 129-130.

161 See Documents 57083 & 57094, Cover Letter and Resume for CCW, appended to Exhibit 6, Overview Report – Facilities and Agencies. See also:

- Exhibit 16, Affidavit of Helen Crombez, para 76, where Ms. Crombez confirms she did not receive a Geraldton reference;
- Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2117, ln 5-15 & p 2307, ln 16-24, where Ms. Nicholas confirms that she never knew that EW had worked for the Hospital nor did she rely on any reference from it;
- Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1588, ln 27-31 & June 13, 2018, Day 8, p 1813, ln 14-23, where Ms. Wilmot-Smith confirms she had no information that EW had previously worked at the Hospital; and
- Transcript of Tamara Condy, June 27, 2018, Day 16, p 3932, ln 3-15, where Ms. Condy confirms that she did not receive any reference letters with EW's application; and
- Exhibits 91 & 92, Resumes of EW, where she did not reference the Hospital.

119. To the extent it is at all relevant, ONA's motivations were of course rational. It had no reason to suspect that this incident was anything other than what it appeared to be: a young nurse experiencing depression, who subsequently received appropriate review by the regulator's incapacity experts. ONA negotiated this brief settlement a year after her termination, following EW's referral to the CNO's Fitness to Practice process. As several witnesses noted, many nurses experience mental health illnesses and still go on to have a successful and safe career in nursing. In Prof. Yorker's view, "they all deserve the chance".[162] There was no indication at that time of the problems to come.

120. Moreover, EW omitted that brief employment relationship from her resume, which Prof Yorker does not fault her for doing.[163] Instead, she only cited her work with Christian Horizons as a "Support Worker", not a nurse, for eight years, and a very brief stint at Victoria Rest Home (which we heard nothing about as no witnesses were called from there)[164]. The Inquiry did not hear oral evidence from David Petkau, the manager at Christian Horizons, who had signed the CNO documents as a supervisor under their Fitness to Practice Program.[165] Mr. Petkau was clearly aware of her health issues and recommended her nonetheless.[166] There was no indication at that time that EW was a serial killer in waiting.

B. Reference Letter and Settlement from CCW Not Relied On

121. The reference letter from CCW was never relied on by any of EW's hiring managers following her termination at CCW. In fact, EW was honest about her termination when she was hired at MP and St. Elizabeth, having advised that her employment at CCW had been terminated due to a medication error involving insulin. Despite knowing this information, they hired her without contacting the Director of Nursing, Administrator or Human Resources at CCW.

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162 Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, p 8127, ln 3-11.
163 Transcript of Beatrice Crofts Yorker, September 12, 2018, Day 35, pp 8079-8080, ln 16-3.
164 Exhibits 91 & 92, Resumes of EW.
165 Document 37062, Letter from David Petkau to Tracy Raso (CNO), dated June 19, 1997, appended to Exhibit 6, Overview Report – The Facilities and Agencies.
166 See, for example: Transcript of Heidi Wilmot-Smith, June 13, 2018, Day 7, p 1600, ln 12-30; Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2132, ln 10-20;

i. Meadow Park (Owned by Jarlette Chain of Homes)

122. It is not in dispute that EW was hired and began working at MP as of April 21/22, 2014.[167] The reference letter from CCW was not even finalized until June 4, 2014. Accordingly, it could not have been relied on and any suggestion to that effect is implausible. This was confirmed by MP's Director of Nurses in her affidavit and oral evidence.[168] Heather Nicholas testified that EW provided her with a copy of the reference letter after she had been working for approximately one month, sometime in mid-June 2014. Her manager simply filed the document and did nothing more.[169]

123. MP was also told by EW herself that she was "dismissed," and her supervisor's name, Helen Crombez, was given on the application.[170] Sandra Fluttert, the Assistant Director of Care, was provided as a reference and this CCW manager readily gave EW a positive reference. The settlement between CCW and ONA and the letter drafted by Wanda Sanginesi as part of the settlement was thus irrelevant as it was never referred to by Ms. Fluttert. It is noteworthy that the negotiated settlement in no way restricted CCW from being honest or from giving any oral reference as desired. Instead, for reasons we will never know, as Ms. Fluttert was not called as a witness, a good reference was given, making the much-weaker reference letter irrelevant.

124. There is no basis to the outrage that was heaped upon Jill Allingham, the ONA labour Relations Officer. She had a statutory obligation under the *Labour Relations Act* to represent all of her members, including EW.[171] She of course had no idea that EW was committing intentional harm. She had an obligation to file the grievance within the ten days required under the CCW collective agreement.[172] Moreover, even Wanda Sanginesi agreed that it was not surprising the union would have grieved the

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167 Document 72618, Email from EW to Jill Allingham re: New Job, appended as Exhibit P to Exhibit 58, Affidavit of Jill Allingham; Exhibit 6, Overview Report – The Facilities and Agencies, Volume 6: Meadow Park Chronology, 27, April 22, 2014 – Orientation day one for EW at Meadow Park.

168 Exhibit 43, Affidavit of Heather Nicholas, para 61; Transcript of Heather Nicholas, June 19, 2018, Day 10, p 2247, ln 17-23.

169 Transcript of Heather Nicholas, June 19, 2018, Day 10, p. 2247, ln 21-27.

170 Document 72015-Hiring the Jarlette Way, appended as Exhibit C to Exhibit 43, Affidavit of Heather Nicholas.

171 *Labour Relations Act*, 1995, SO 1995, c 1, Sch A, s. 74.

172 Exhibit 12, Full Collective Agreement Between CCW and ONA, s. 8.08(b).

letter, as the letter itself contained blatant errors and referred to suspensions that had not actually taken place.[173] Even if one could put together the pieces of how troubled EW was from the many complaints about her this could only be done by CCW, this information was not provided to ONA or Ms. Allingham.[174] When Jill Allingham asked for the discipline record from the employer she was not provided it for over a month – after the grievance step meeting had occurred – and what she was sent was a fraction of EW's record[175]

125. Moreover, there was no pressure on the employer to settle; the claim that they were scared of the grievance was laughable. They freely decided to negotiate a settlement that was far from generous given the conduct that ONA knew about from the limited disclosure it had received.[176] The settlement was what Wanda Sanginesi called a "nuisance" amount, and she agreed that it was very low in the scheme of things. Moreover, this reference letter was entirely written by Wanda Sanginesi; not one word was written or changed by the Union.[177]

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173 Transcript of Wanda Sanginesi, June 21, 2018, Day 12, p 2753, ln 2-8.

174 See, for instance: Transcript of Jill Allingham, June 21, 2018, Day 12, pp 2831-2836, where Ms. Allingham confirms that, though she had requested EW's entire patient file, she only received a small portion of it. The 'file' she received was missing crucial information and did not reference the majority of EW's prior misconduct and inappropriate behaviour. As Jill later stated (p 2965, ln 22-29), "I had no facts".

175 Transcript of Wanda Sanginesi, June 21, 2018, Day 12, p 2738, ln 13-22.

176 Wanda Sanginesi and Ms. Allingham both testified about the negotiations that led to the resolution of the two outstanding grievances. To the extent that their evidence conflicts, ONA submits that Ms. Allingham's evidence is more reliable as she took notes at the time of the conversations. At no time did Ms. Allingham ever ask the Employer to provide any information on the reference letter that was not true: Document 72557, J. Allingham's email to W. Sanginesi, appended as Exhibit O to Exhibit 58, Affidavit of Jill Allingham, p 47; ment 72557, J. Allingham's email to W. Sanginesi, appended as Exhibit P to Exhibit 58, Affidavit of Jill Allingham, p 10. Rather, it was Ms. Sanginesi who indicated that the Employer was willing to pay $2000 and to provide a reference letter. Ms. Allingham immediately replied and asked Ms. Sanginesi to provide a draft reference letter to review. Ms. Sanginesi forwarded a draft of the reference letter to Ms. Allingham on May 22, 2014. It remains unclear who provided the information contained in the reference letter. Ms. Sanginesi indicated that Brenda Van Quaethem provided her with the information by taking it from Elizabeth Wettlaufer's last performance appraisal, however Ms. Van Quaethem testified that no one had discussed the contents of the letter with her (Transcript of Brenda Van Quaethem, June 7, 2018, Day 3, pp 551-552, 28-2). Regardless, there is no dispute that the content of the letter was drafted solely by the Employer. Ms. Allingham reviewed the letter, but did not propose any changes. The final version of the reference letter was identical to the draft.

177 Transcript of Jill Allingham, June 21, 2018, Day 12, p 2849, ln 9-12.

ii. Lifeguard Inc

126. The grievances and the 'reference' letters are also irrelevant to the hiring of EW by Lifeguard. EW did not reference the Hospital in her resume,[178] nor did she provide a copy of the CCW reference letter when she applied to Lifeguard. Heidi Wilmot-Smith testified that she never saw the reference letter.[179] In any event, Ms. Wilmot-Smith spoke to a CCW manager, Sandra Fluttert, who provided a reference she deemed "glowing",[180] making whatever came out of the grievance process irrelevant.

iii. St. Elizabeth's Home Care

127. Similarly, the grievances and settlements are irrelevant to EW's hiring at St. Elizabeth Health Care. There was no reference to the Geraldton District Hospital on either the 2014 or 2016 resumes submitted by EW to St. Elizabeth Health Care.[181] Tamara Condy testified that they did not receive any reference letters at all.[182]

128. It is ONA's position that the settlement of the 2014 grievances also had no impact whatsoever on EW's ability to find work as a nurse following her termination from CCW. Instead, EW was able to find work because long term care homes were desperate for nursing staff. As an experienced long term care nurse, in a sector that is underfunded, overworked, and underpaid, any nurse was extremely marketable.

C. Criticism of the Grievance Arbitration Process is Unfounded and Misinformed

129. As with the reference letters, ONA submits that the criticism of ONA – and all unions and labour arbitrators – was not based in fact and was an attempt to deflect criticism from an employer who employed EW for 7 of the years she committed murders.[183] We trust that the Inquiry will not give any

178 Document 17387 appended to Exhibit 38 (Tab B), Affidavit of Heidi Wilmot-Smith.
179 Transcript of Heidi Wilmot-Smith, June 14, 2018, Day 8, p. 1811-ln 30-32.
180 Exhibit 38, Affidavit of Heidi Wilmot-Smith, para 33.
181 Exhibit 91, Document 65409 and Exhibit 92, Document 65427
182 Transcript of Tamara Condy, June 27, 2018, Day 16, p.3932 ln 3-8
183 We submit that this strategy (ie a best defence is an offence strategy) is consistent with having hired a PR firm, which we heard evidence that CCW did, before they even contacted the MOHLTC: Transcript of Karen Simpson, July 31, 2018, Day 28, p 6360, 4-32.

weight to these baseless criticisms, however given the amount of time spent on it in the Inquiry, and the resulting media attention, ONA provides the following clarifications.[184]

i. "Fears" of the Union

130. Brenda Van Quaethem and Helen Crombez said they did not impose more severe discipline on EW at times because they were afraid of the union and the grievances it might file.[185] Ms. Van Quaethem testified that she did not impose a suspension at one point and instead gave a written warning because “if it is fought by the union and it is pushed back” it might be reduced to a written warning in the end.[186] Wanda Sanginesi painted ONA as “aggressive” in representing its members.[187] This is a *post hoc*, unfair claim to justify these individuals' lack of appropriate supervision, and the anticipated criticism of their delay in terminating EW's employment.

131. In actual fact, notwithstanding EW's extensive disciplinary record – including several disciplinary suspension and counselling incidents for which ONA was not made aware – ONA only grieved three times. One was withdrawn and the second two – EW's five-day suspension of January 30, 2014, and her March 31, 2014 termination – were grieved. Any settlement was modest and finalized well before any knowledge of EW's crimes came to light. As Wanda Sanginesi testified, grieving an employee's termination is standard given the unions' statutory duties to represent their members.[188] Moreover, a union filing a grievance does not automatically result in an arbitration, as is clear from the fact that the five-day suspension of April 12, 2013 was withdrawn by ONA and never went to arbitration.

ii. Union Does Not Have An Investigative Duty; the Employer Does

132. Given collective agreement timelines and the jurisprudence regarding what happens when they are missed, unions must grieve to preserve *potential* rights in the future. In the case of the CCW-ONA

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184 We submit that issues around labour relations, despite suggestions from other Participants in earlier submissions, are outside the scope of the inquiry mandate, however if the Commissioner thinks this is not the case, ONA suggests a consultation with the Ontario Arbitrators Association as a neutral body that can provide information on the *Labour Relations Act*, the grievance arbitration process, and labour law jurisprudence.

185 Exhibit 16, Affidavit of Helen Crombez, paras. 202 and 205; Exhibit 10, Affidavit of Brenda Van Quaethem, para. 36.

186 Transcript of Brenda Van Quaethem, June 6, 2018, Day 2, p. 368, ln 21-30.

187 Exhibit 51, Affidavit of Wanda Sanginesi, para. 110.

188 Exhibit 51, Affidavit of Wanda Sanginesi, para. 50.

Collective Agreement, this timeline was within ten days of the discipline.[189] A grievance is the only way for a unionized employee to challenge termination since they have no access to the courts for wrongful dismissal.[190] Jill Allingham, ONA's Labour Relations Officer acted properly and in accordance with the statutory obligations of a union.[191]

133. Ms. Allingham was vigorously cross-examined, however, and had it put to her that she or ONA should have "investigated" EW. This is absurd and in direct contrast to the statutory regime. It is the exclusive responsibility of an <u>employer</u>, as set out under the Collective Agreement (and governing legislation), to investigate and discipline.[192] By contrast, a union's statutory duty is to fairly represent its members by, *inter alia*, filing timely grievances.

134. Ms. Allingham and ONA would not have access to all the information required to conduct an investigation. They did not have access to confidential patient records or the facts to assess the merits. They were not given disclosure before the timeline to file the grievance, as conceded by Wanda Sanginesi.[193] Accordingly, Ms. Allingham did not and could not have access to EW's discipline record, and could not conduct a preliminary assessment of the merits of the termination. When she did get the record, it was sparse and incomplete, containing only a fraction of EW's disciplinary record and the complaints made against her. As it turns out, even Ms. Sanginesi was not given the whole disciplinary record from the home's administrator Brenda Van Quaethem. Like the union, she was only given bits and pieces of information that was held by the on-site managers at CCW.[194] ONA did not have all the pieces to this puzzle.

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189 Exhibit 12, Document 70956, CCW-ONA Collective agreement, Article 8.08. Furthermore, at all times ONA was acting in accordance with its duty under s.74 of the *Labour Relations Act, 2005*

190 *Weber v. Ontario Hydro*, [1995] 2 S.C.R. 929.

191 Section 74 of the *Labour Relations Act, 1995*, which provides that a trade union "shall not act in a manner that is arbitrary, discriminatory or in bad faith in the representation of any of the employees in the unit."

192 Exhibit 12, Document 70956, CCW-ONA Collective Agreement, Article 3. See also Transcript of Brenda Van Quaethem, June 7, 2018, Day 3, p.489-490.

193 Transcript of Wanda Sanginesi, June 21, 2018, Day 12, p 2738, ln 13-22.

194 Transcript of Wanda Sanginesi, Days 11 and 12. See for example, p. 2651 lines 24-32 when Ms. Sanginesi testified that she had not been advised that EW had claimed to be OCD and bipolar and p.2684, lines 16-32

135. During her cross-examination, it was repeatedly put to Ms. Allingham that the information in the personnel file disclosed serious issues resulting in harm to residents. However, as Ms. Allingham pointed out in re-examination, the level of discipline imposed by the Employer did not reflect the level of seriousness that was being suggested by counsel. As she stated, the written warnings and counselling sessions would not indicate that the employer thought these were serious issues.[195] The Director of Nursing, Helen Crombez, was a nurse, and was in the best position to assess the seriousness of the incident and to impose a sanction commensurate with that assessment. She failed to do so, despite being in possession of all the relevant information. That was her error. The strategy of this employer at the Inquiry to try and unfairly shift blame onto Jill Allingham and the union is simply inappropriate.

iii. No evidence that Settlement funds came Out of the Nursing Envelope

136. It was suggested that the settlement of EW's grievance came out of the nursing care envelope, causing public outcry at the thought of a serial murderer being paid out of funds that should have been directed to residents care. As it turned out, this claim was never proven in evidence. Each witness, including the Administrator, the Director of Nursing, and the VP of Human Resources at CCW, testified that they did not know where the funds for this modest "nuisance" settlement came from. We do know that the employer had a funding envelope called "OA" where the funds could have been paid out of; however, this would have resulted in less profit for the owner of CCW.

D. Conclusion on Irrelevant Evidence

137. ONA submits that there was nothing improper about filing the grievances or entering into the settlements it did. It had a statutory obligation to conduct itself in this regard. Moreover, given the information that was within its knowledge at the time, its actions were objectively reasonable. The union had far less information than the employer, and it is disingenuous to suggest that the union should have taken on the employer's responsibility to investigate. It is especially absurd to suggest, as was aggressively done during Ms. Allingham's cross-examination by the employer, that the union should, in

when Ms. Sanginesi stated that it would have been helpful if she had been given the information about the non-disciplinary letter issued by Brenda Van Quaethem in December 2013.

195 Transcript of Jill Allingham, June 21, 2018, Day 12, p 2967, ln 6-9; p 2969, ln 4-10.

the ten day time period it had to grieve, somehow conduct an investigation into EW's seven or so years of misconduct (which the employer had theretofore failed to do). The union was dependent on the employer to provide it with disclosure of the facts and relevant documents. Full disclosure was never received.

138. ONA does not have any recommendations regarding the grievances, settlements, or processes in which they were concluded. The evidence does not reveal any need in this area. If a participant raises any recommendations in this area, ONA reserves its right to respond. However, ONA respectfully submits that this area is beyond the mandate and scope of the Inquiry. Labour relations is a complex matter involving many statutes. If the Inquiry has an inclination in this area, we submit that it must necessarily consult with labour arbitrator associations, as third party arbitrators would be well-suited to provide the Inquiry with neutral and knowledgeable information in this area.

IV. RECOMMENDATIONS

139. ONA submits that the unique facts concerning EW, especially given her unknown deeply troubled mental state, may mean that this tragedy could not at the time be detected or prevented. The Inquiry, however, has shed a light on a number of very serious systemic problems in the Ontario long-term care sector that require significant change. The following is a list of both specific and general recommendations from ONA, provided in support of the Inquiry's mandate to prevent similar deaths in the future.

140. ONA will also participate in the consultation stage to provide additional information on any recommendations that the Inquiry wishes to explore further and to respond to any recommendations that may be raised by other parties.

A. STAFFING AND FUNDING

141. ONA submits that enhanced staffing lies at the heart of the question before the Inquiry, which is how to prevent and detect the intentional infliction of harm by health care providers. Staffing in long term care has been a chronic problem for decades, however it is now a crisis situation that will only worsen

with Ontario's aging population. Virtually every witness, including the experts, said staffing is key to the provision of safe care, including the detection and deterrence of intentional harm.

142. Widespread changes and sufficient funding must be implemented, as these changes require additional staff – particularly RNs, due to resident acuity and the CNO's guidelines regarding a nurse's scope of practice. One RN assessing and providing caring for 30 - 160 frail and unstable residents is both shocking and unsafe. Such lean staffing allows intentional harm to go undetected. ONA therefore recommends:

a. **The MOHLTC immediately increase the funding to long-term care homes to reflect the growing care needs of the increasingly aging and high acuity patient population.**

b. **Funding should be assessed and re-assessed in relation to current statistics. It must be based on accurate data that is reflective of the actual resident populations in long-term care settings. Funding must not be indexed or capped in any artificial way to meet a fixed budget or based on data that lags in time (such as by 12 to 18 months).**

c. **To ensure all public funding to long term care homes is provided directly to resident care, the MOHLTC should develop a plan to ensure that all "for profit" long term care homes are eliminated and/or that "for-profit" homes are replaced by a "non-for-profit" home within five (5) years. In the alternative, any newly funded long term care beds should only be provided to "not-for-profit" homes.**

d. **The MOHLTC should direct homes to address staffing shortages with funding from the Other Accommodation ("OA") envelope funding. Licensees, Administrators, and DONs should be educated to ensure they are aware that OA funding can be used for increased staffing.**

e. **Managerial positions, including the DON and ADON, should not be funded from the NPC envelope.**

f. **The MOHLTC should immediately increase the funding per home to ensure there is an average hours of RN care that is equivalent to at least one (1) RN for every 20 residents, each twenty four (24) hour day. In addition, though there was not time to explore this in the public hearing, there should be at least (1) NP for every 120 residents given the present acuity of Ontario residents. This should be a legislated, enforceable minimum, which would require a change to Section 8 of the *Long Term Care Homes Act* (LTCHA) and any applicable or new regulations.**

g. **Every long term care home should have sufficient RNs and RPNs on each shift to ensure medication administration is timely, legislatively compliant, and follows best practices. This will minimize medication administration errors and provide time for appropriate tracking and charting of all medication, including narcotics and high alert medications, and allow the effects of the medication to be appropriately monitored such that conditions like unexpected hypoglycemia are detected.**

h. **Section 8 of the *LTCHA* presently provides for minimum RN staffing; this should be amended to increase the minimum number of RNs and to clarify that "a member of the regular nursing staff" does not, at any time, include managerial staffing.**

i. **Increased transparency of staffing is necessary; every licensee should disclose the required staffing plan to residents, families, employees and the union. The staffing plan should be posted in the Home or through other means easily accessible to the public.**

j. **Agency use should be eliminated for nursing staff at all times in long term care homes and homecare. Agency use is not a safe practice. Ontario hospitals are taking steps to eliminate the use of agency nurses; long term care should do the same. The lack of oversight in these agencies compounds the problems discussed in this submission. There is a reason that section 8 of the *LTCHA* states that the minimum RN must be "both an employee of the licensee and a member of the regular nursing staff of the home". In the alternative, or in the interim while agencies are phased out, there should be MOHLTC oversight of agencies.**

B. RETENTION AND RECRUITMENT

143. Immediate measures for addressing recruitment and retention problems for nurses in long term care are required. EW was hired by each employer (or placed by an employer agency at a facility) with little or no screening, because they were desperate for nurses. The Inquiry heard that Registered Nurses, particularly new graduates, did not apply or stay working in LTC homes, especially "for profit" homes, as the salary and benefits were higher in other sectors and the workload in the long term care facilities untenable. ONA recommends the following:

a. **The MOHLTC provide funding incentives to long term care homes so that they may put in place appropriate measures to recruit and retain RNs.**

b. **A key recruitment and retention measure is parity with hospitals and municipal homes in salary, benefits, pension, and working conditions. The MOHLTC therefore must base staff funding to long**

term care homes on remuneration rates that are comparable to similar roles in these other MOHLTC funded health care workplaces. It must ensured that any homes in receipt of such funds are using the funding for staffing and *not* the remuneration of administrators, managers, or for profit.

c. **The Inquiry heard that new graduate nurses have a preference for the hospital sector, and there is a perception that long term care does not offer challenging and/or high-quality learning and working opportunities. Ontario's colleges and universities must ensure senior care, gerontology and long term care practice is a mandatory part of the nursing curriculum in nursing educational programs and must place a greater emphasis on promoting clinical placement opportunities in long term care.**

d. **In order to retain nurses in long term care, working conditions must be addressed. Staffing/resident ratios should be put in place to ensure appropriate numbers of all types of staff—Registered Nurses, Nurse Practitioners, Registered Practical Nurses, and Personal Support Workers.**

e. **All nurses working in long term care facilities, no matter their employment status, should be provided with appropriate paid orientation and training to the facility and to long term care. This should include training before being given a resident assignment to the home's medication administration systems, including administering high alert medications, as well as to policies and statutory provisions on abuse and neglect, reporting mechanisms, and whistleblowing protections. New hires should be assigned peer mentors who will work with management to ensure the new hire has the requisite skills, competencies, and abilities to work independently in the home before working any evening and night shifts.**

B. LEADERSHIP

144. As highlighted in this submissions, the evidence indicated serious and significant concerns about gaps in the knowledge and expertise of many of the leaders (especially Administrators, Directors of Nursing, and Assistant Directors of Nursing.) EW was not appropriately screened or monitored or supervised appropriately, and concerns about her were not properly investigated or addressed. Managers were woefully uninformed about how to manage health issues, how to discipline or provide remedial plans, and how to report to oversight bodies such as the CNO and Ministry inspectors. The *LTCHA* has provisions that aim to ensure appropriate qualifications for DONs (hired after July 1, 2010), however it is silent on ADONs. ONA makes the following recommendations to ensure that those in charge of a home

have the expertise required to fulfill their numerous obligations under various legislative regimes, including the *LTCHA*, the *RHPA*, the *LRA*, the *ESA*, the *Human Rights Code*:

a. **The *LTCHA* and its regulation 79/10, ss. 212-213 regarding administrative and leadership skills, education, experience and qualifications for Administrators and Directors of Nursing should be enhanced and the grand-parenting provision that allows homes to bypass appropriate qualifications of Administrators and DONs be removed. Similar provisions should be added for ADONs to ensure they are RNs with appropriate skills, education, experience and qualifications.**[196]

b. **The MOHLTC should ensure compliance with DON, ADON and Administrator leadership skills, training, and education, as set out in the *LTCHA* and amended Regulation.**

c. **Licensees, DONs, ADONs, and Administrators must have mandatory training regarding the CNO requirements for reporting, detecting, and monitoring Fitness to Practice issues, the *Human Rights Code*, employer obligations, and privacy legislation regarding health information, in order to appropriately screen, hire, supervise, and manage the professional and health issues of their staff.**

C. FUNDING/ CLASSIFICATION SYSTEM

145. The present funding of LTC is based on the CMI/RAI RUGS III MDS. Unfortunately the Ministry witnesses that gave evidence did not work in this area or areas that could speak to funding issues in any detail. The Inquiry did hear that there are problems and disincentives to the current funding model; for instance if a home improves resident care, the CMI drops, which results in a reduction in funding. The funding is inappropriately indexed and artificially capped with inappropriate lag times. ONA recommends that this information be explored during the next phase of the Inquiry, and to that end, makes the following recommendation:

a. **Within two (2) years, the current resident classification system (RAI RUGS III MDS) should be amended and/or replaced with a system that measures the real resident acuity by home. Long term care homes will then be funded to the staffing level that is required, based on resident acuity. At no time should there be less than the updated minimum staffing (see above).**

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196 O. Reg 79/10, ss. 212-213, under the Long Term Care Homes Act, 2007, S.O. 2007, c. 8.

D. DATA COLLECTION AND TRACKING

146. Enforcement of staffing minimums and the mandatory staffing plans required under the *LTCHA* is difficult without data collection and tracking. ONA echoes the recommendations contained in the Smith Report and the Casa Verde Inquest regarding the need to publicly track data on staffing in long term care. ONA therefore recommends:

a. **To accurately understand the current nursing and personal care workforce in long term care, the MOHLTC should collect and maintain up-to-date, province-wide data on NPs, RNs, RPNs, and PSWs in the sector. This data should be made accessible to the public, and include: (i) staffing ratios; (ii) paid worked hours; (iii) a breakdown of FT, PT, and casual positions per staffing type; (iv) a number of resident days; (v) paid worked hours of care per resident day; and (vi) assessed care needs of long term care residents (not indexed for funding).**

E. WHISTLEBLOWING

147. To detect problems such as inappropriate medication administration practices or other issues that may be indicators of possible intentional harm, reports must be encouraged and reporters must be assured that they are protected when they make the reports. Staff and others may be reluctant to file reports or, as the Inquiry repeatedly heard, unclear as to how to file any reports, concerns, or complaints. ONA recommends:

a. **A review of the "whistleblower" protections that are currently in place, and an enhancement of protections for whistleblowers under the *LTCHA*.**

b. **Ensure education is provided to all long term care staff on the protections available to encourage the reporting of all concerns.**

F. HOME CARE

148. Although the evidence on home care was less extensive than that on long term care, similar concerns regarding staffing, funding, agency use, and leadership skills were raised. Accordingly ONA makes the following recommendations:

a. **Staff should be appropriately screened and educated prior to commencing care with patients, and no agency nurses should be used in the sector.**

b. **The MOHLTC should fund home care to enable the sector to to attract and retain nurses, and should introduce remuneration rates (*i.e.* salaries, benefits, and working conditions) that are comparable to similar roles in other sectors, particularly acute care providers in the hospital sector.**

c. **All supervising managers and administrators should be Registered Nurses with appropriate skills, education, experience and qualifications set out by regulation.**

G. MEDICATION ADMINISTRATION

149. ONA endorses the recommendations of the Inquiry expert, Julie Greenall, as set out in our submissions, with the exception of the suggestion to have two nurses administer insulin as this will not address intentional harm in any way. If it is recommended, it must be accompanied by additional staffing provisions.

150. ONA remains committed and is looking forward to participating in the next phase of the Inquiry, and will make itself available to provide both clarification of these recommendations and consultation on any other recommendations that may be considered.

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