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Long-Term Care Homes Public Inquiry Recommends Systemic Changes In Response to Wettlaufer Offences

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By

On July 31, 2019, the final report and recommendations of the Long-Term Care Homes Public Inquiry were released. The Inquiry, which had a two-year mandate, was charged with investigating the offences committed by Elizabeth Wettlaufer while she was working as a registered nurse in Ontario's long-term care system. This article summarizes the findings and recommendations of the Inquiry and comments on lessons applicable to all regulators, in light of certain recommendations of the final report.

In the report, Commissioner Eileen E. Gillese makes no individual findings of misconduct, but recommends several systemic changes to Ontario's long-term care system. In explaining why she concluded that individual findings of misconduct were not warranted, Commissioner Gillese stated:

Because it was systemic failings – not individual ones – that created the circumstances allowing the Offences to be committed, it would be unfair of me to embark on a personal attribution of responsibility. It would also be ineffective: assigning blame to individuals will not remedy systemic problems or guard against similar tragedies.

Moreover, given the need for those throughout the long-term care system to work collaboratively in resolving the systemic issues, assigning blame to individuals or organizations is counterproductive. Systemic issues are "best dealt with by encouraging people to go down a path where they can change the things that went wrong."[1]

By focusing on the systemic vulnerabilities in Ontario's long-term care system, the report issues a call to action to all those who work in that system – the government, regulators, employers, and staff. In total, the report contains 91 recommendations and is nearly 1500 pages long. The main themes of those recommendations are outlined below, as well as some of the lessons that regulators can take away from them.

BACKGROUND: THE OFFENCES

In September 2016, Elizabeth Wettlaufer abruptly resigned from her nursing job and checked herself into the Centre for Addiction and Mental Health in Toronto. While there, she told her treating psychiatrist that while working as a nurse in Ontario's long-term care system, she had intentionally killed several people in her care by giving them overdoses of insulin. She subsequently repeated these confessions to police.

Wettlaufer committed her offences over a period of 9 years, between 2007 and 2016. The first thirteen offences were committed while Wettlaufer was working as a registered nurse in various long-term care homes in Ontario, and the final offence was committed in the home care setting, when Wettlaufer was providing care in a patient's private home.

In June 2017, Wettlaufer pleaded guilty and was convicted of 14 offences: 8 murders, 4 attempted murders, and 2 aggravated

assaults. Until Wettlaufer turned herself in, she was not under any suspicion, and none of the deaths she had caused were under investigation. As the judge found during her criminal sentencing hearing, if Wettlaufer had not confessed, these crimes never would have been discovered.[2]

THE INQUIRY'S FINDINGS AND RECOMMENDATIONS

Like the sentencing judge, one of Commissioner Gillese's principle findings is that if it were not for Wettlaufer's confessions, her crimes would have gone undetected.[3] Commissioner Gillese emphasizes that this finding is particularly significant "because it tells us that to prevent similar tragedies in the future, we cannot continue to do the same things in the same ways in the long-term care system."[4] She goes on to find that while the long-term care system is strained – by the rising acuity of residents and limited resources – it is not broken. In her view, the regulatory regime that governs the long-term care system, combined with the dedicated people who work in it, provide a solid foundation on which to address the systemic issues identified by the Inquiry.[5]

While there are individual recommendations directed at particular stakeholders within the system, the bulk of the Inquiry's recommendations are connected to four systemic issues[6]:

The prevention of intentional harm by strengthening the long-term care system as a whole and encouraging excellence in resident care.[7] The report calls on the Ministry of Health and Long-Term Care[8] (the "**Ministry**", which regulates long-term care homes) to take a leadership role by:

- Providing assistance to homes that are struggling to achieve regulatory compliance;
- Providing bridging and laddering programs to increase the skills of those working in long-term care and provide opportunities for their advancement; and
- Encouraging innovations and the use of new technologies.

Creating awareness of the possibility that a healthcare worker may intentionally harm a resident or patient.[9] Because we cannot deter or detect something if we do not consider it a possibility, Commissioner Gillese emphasizes that everyone working in the healthcare system needs to be aware of the possibility of intentional harm by healthcare workers. Noting that "healthcare serial killing" is a rare but long-standing phenomenon,[10] she recommends that the Office of the Chief Coroner and Ontario Forensic Pathology Service take the lead in conducting ongoing research on this issue and disseminating key information to organizations and institutions (including regulators) that provide education and training to healthcare professionals. In turn, those organizations and institutions are to integrate this knowledge into their training and education programs by including it in broader discussions about topics such as professionalism, risk management, and medication incident analysis.

Implementing measures to deter those who may seek to intentionally harm residents or patients.[11] Commissioner Gillese recommends three broad strategies to deter potential wrongdoers:

- Strengthen the medication management system in long-term care homes. The report provides several options for homes to choose from, including the installation of glass doors and windows in medication rooms; the use of security cameras in common areas, medication rooms, and entrances/exits; the use of technologies such as automated dispensing cabinets and barcode-assisted medication administration; and increasing the role of pharmacists and pharmacy technicians in long-term care homes. The report recommends that the Ministry provide monetary grants to each home for this purpose.
- Improve medication incident analysis in long-term care homes, including by establishing specific strategies for incidents related to possible insulin overdoses; establishing a climate that encourages the reporting of medication errors; and using an incident analysis framework that includes a consideration of the possibility of intentional harm.
- Increase the number of registered staff in long-term care homes. The report recommends that the Ministry conduct a study to determine adequate levels of registered staff on each shift, with the results of the study to be tabled by July 31, 2020, and

with additional funding to be given to homes if the study shows that higher staffing levels are needed.

Detecting intentional harm when it occurs.[12] The report recommends that the number of investigations into the deaths of residents in long-term care be increased. This is to be done in a meaningful way, based on a redesigned, evidence-based form submitted by long-term care homes when residents die, and also based on data gathered by the Ministry about deaths in long-term care homes.

LESSONS FOR REGULATORS

The emphasis Commissioner Gillese puts on systemic vulnerabilities in the long-term care system – and on the need for all stakeholders to work together – is a reminder for all regulators to consider their own role in the fields they regulate, as well as their relationships to other organizations within those systems. There are several broader lessons for regulators based on the Inquiry's final report and recommendations.

The importance of setting clear regulatory requirements. Several of the Inquiry's recommendations are directed at clarifying regulatory requirements. To give just two of many examples, there are recommendations that:

- The Ministry establish a new unit to provide guidance to homes that are struggling to achieve compliance. In arriving at this recommendation, the report notes that when the *Long-Term Care Homes Act, 2007*[13] was enacted, Ministry inspectors were no longer permitted to give homes advice about how to achieve compliance (which had previously been permitted). As a result, when homes were found in non-compliance, they could not get advice from the Ministry – the regulator – about what was required to comply with the regulatory requirements.[14]
- The College of Nurses of Ontario ("**CNO**") take steps to ensure nurses, employers and facility operators understand their reporting requirements. The report notes that there appeared to be confusion about when a report was required to the CNO. In particular, it was not clear when a facility operator or employer was required to report to the CNO if an issue had already been reported to the Director under the *Long-Term Care Homes Act, 2007*. In a similar vein, the report also recommends that the CNO clarify when a nurse is required to report to it about suspected abuse and neglect by other nurses.[15]

As these recommendations allude to, regulatory requirements are only effective if those at whom they are directed understand what is expected of them and how to achieve it. It is a good reminder to all regulators to look at areas of frequent non-compliance and consider whether additional clarity or guidance will help remedy the issue. By the same token, regulators rely on proper reporting to carry out their duties. It is worth considering whether additional clarity around reporting requirements is needed – particularly in areas where the legislation does not provide an explicit mandatory reporting obligation – to ensure that regulators are learning about all issues of concern.

Effective ongoing education and training is key, particularly in areas of risk. Several of the recommendations in the report are focused on additional training and education in areas related to patient safety. They indicate that regulators should look at areas where more training or education is needed both for those whom they regulate and for their own staff.[16]

Of particular note are certain recommendations that the bodies responsible for regulating and overseeing long-term care and home care (specifically, the Ministry and the Local Health Integration Networks) take steps to educate members of the public. To that end, Commissioner Gillese recommends that the Ministry create a public awareness campaign to alert the public to the need to report suspected abuse or neglect in a long-term care home.[17] It also recommends that the Local Health Integration Networks prepare written materials to educate home care patients about the signs and symptoms of toxicity, to aid them in recognizing and addressing an overdose (accidental or otherwise) if it occurs.[18] These recommendations are a reminder that in some cases, it may be desirable for regulators to engage directly with clients their members serve, so that they have the information they need to advocate for themselves.

Processes and procedures must be tailored to areas of risk. Commissioner Gillese makes it clear that to protect against risk, processes must be designed with known dangers in mind. As mentioned, one of the Inquiry's primary recommendations focuses on ensuring those in the long-term care system are aware that intentional harm is a possibility – because without that awareness, there is no way to guard against it. In light of this, several recommendations focus on ensuring there are appropriate processes in place. For example, the CNO is directed to review and revise its policies as appropriate – including those applicable to intake and investigations – to account for the possibility of intentional harm.[19] Another significant recommendation relates to the improvement of medication incident analysis in long-term care homes, in particular, by using an incident analysis framework that recognizes intentional harm as a possibility.[20] Because regulators often play an important role in disseminating best practices and guidelines, these recommendations suggest that regulators may want to consider whether there are certain practices it wants to encourage its members or employers to adopt to address areas of risk.

Partnerships and information-sharing between those in the health care system are important tools for patient safety. Several recommendations emphasize the important role that regulators play in establishing partnerships and sharing information with others in the system. For example, the report recommends that the Ministry establish formal policies and processes to ensure its inspectors share relevant information with the CNO when it becomes aware of a nurse that may pose a risk of harm to residents.[21] The report also recommends that the CNO share the research it has conducted on "healthcare serial killers" with other health regulators around the world, with the goal of leading a larger discussion in the regulatory community about how to prevent, deter, and detect healthcare professionals who may seek to intentionally harm patients.[22] Both of these recommendations are an implicit recognition of the vital role information-sharing plays in protecting patients, and the importance of regulators taking proactive steps to address risks, in collaboration with others in the system.

The goal for regulators should be to promote excellence – not simply achieve compliance with minimum standards. On a more aspirational level, the report also explicitly recognizes that regulators can – and should – work collaboratively with other organizations to transform the healthcare system for the better. As mentioned, the recommendations aimed at "preventing intentional harm" focus on strengthening the long-term care system – and give the Ministry a leadership role in achieving this. However, significantly, these recommendations make it clear that the Ministry must not work in isolation: they explicitly direct the Ministry to work collaboratively with stakeholders across the sector to identify existing areas of excellence, spread those lessons across the sector, and to encourage the development of new innovations. Commissioner Gillese emphasizes that while compliance with the regulatory scheme is necessary, the goal should be a move to "consistent excellence in the provision of resident care" – and the Ministry is in a position to provide the necessary leadership.[23]

CONCLUSION

Although it remains to be seen how many of the Inquiry's recommendations will ultimately be adopted, its recommendations provide an opportunity for all regulators to assess their own roles within the fields they regulate, and the way they collaborate with other organizations. The Long-Term Care Inquiry's report and recommendations are a reminder about the importance of ensuring regulatory standards are clear; focusing processes, education, and training on areas of risk; and building effective partnerships between regulators and other actors in the sector.

Lara Kinkartz ***served as Associate Commission Counsel to the Long-Term Care Homes Public Inquiry. This article provides an overview of information contained in the Inquiry's final report and recommendations. To the extent it contains additional analysis, the opinions are those of the author and should not be attributed to the Inquiry.***

situations, the reader should seek professional advice.

[1] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Vol. 1, p. 13 [citations omitted].

[2] *R. v. Wettlaufer*, 2017 ONSC 4347, p. 10.

[3] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Vol. 1, pp. 12-13.

[4] Commissioner Eileen Gillese, *Commissioner's Remarks on the Public Release of the Inquiry Report*, July 31, 2019, at p. 5, available at < http://longtermcareinquiry.ca/wp-content/uploads/20190730_Commissioners-Remarks-on-Report-Release-EN.pdf>.

[5] Commissioner Eileen Gillese, *Commissioner's Remarks on the Public Release of the Inquiry Report*, July 31, 2019, at p. 7, available at < http://longtermcareinquiry.ca/wp-content/uploads/20190730_Commissioners-Remarks-on-Report-Release-EN.pdf>.

[6] The Inquiry's systemic recommendations are all contained in Vol. 3 of the report, with the individual stakeholder recommendations contained in Vol. 2.

[7] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Vol. 3, Ch. 15.

[8] As it was known at the time of the writing of the Inquiry's report. It has since been split into two separate ministries: the Ministry of Health, and the Ministry of Long-Term Care.

[9] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Vol. 3, Ch. 16.

[10] The Inquiry heard expert evidence about "healthcare serial killers", which is discussed in Chapter 16 of the Report. This expert report, along with the other exhibits, are available online at < https://longtermcareinquiry.ca/en/exhibits/>.

[11] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Vol. 3, Ch. 17.

[12] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Vol. 3, Ch.18.

[13] S.O. 2007, c. 8.

[14] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendations 28 & 62 and accompanying text (Vol. 2, pp. 397, 425; Vol. 3, pp. 16, 21-23).

[15] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendations 46-47, 49 and accompanying text (Vol. 2, pp. 592-97; 651-52, 654).

[16] For example, it is recommended that those in long-term care homes (depending on their role) receive training on hiring and screening of staff, workplace investigations, reporting requirements, and the reporting of medication errors (see e.g. Recommendations 3-5, Vol. 2, pp. 119-21; Recommendations 21-22, Vol. 2, pp. 420-21). The report also recommends that the CNO's intake investigators receive training on how to conduct their inquiries in light of the "healthcare serial killer phenomenon" (see e.g. Recommendation 41, Vol. 2, pp. 648-49).

[17] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendation 23 (Vol. 2, p. 422).

[18] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendation 35 (Vol. 2, p. 559).

[19] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendations 41-42 (Vol. 2, pp. 648-49).

[20] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendation 79 and accompanying test (Vol. 3, pp. 113, 127).

[21] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendation 31 (Vol. 2, p. 426).

[22] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendation 43 (Vol. 2, p. 649).

[23] *Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, Recommendation 62 (Vol. 3, pp. 21-23).

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