Public Inquiry into the
Safety and Security of Residents
in the Long-Term Care Homes System

REPORT

The Honourable Eileen E. Gillese
Commissioner

Volume 1 – Executive Summary and Consolidated Recommendations

Volume 2 – A Systemic Inquiry into the Offences

Volume 3 – A Strategy for Safety

Volume 4 – The Inquiry Process

Ontario

The Long-Term Care Inquiry – IMPLEMENTING THE RECOMMENDATIONS

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TORONTO, ON

Implementing the Inquiry Recommendations

GOALS OF TODAY'S PRESENTATION

1. Highlight key Recommendations for Clinicians
2. Provide an easy approach to Recommendation implementation

TODAY'S TOPICS

I. WHY is there a need to deter and detect the healthcare serial killer (HCSK)?

II. WHAT insights does the LTCI offer?

III. HOW can <u>you</u> restore confidence in the LTC system?

Time permitting, I will address the OLTCC Board questions

But first,

CONTEXT

A. The Offences
B. The LTC system is strained NOT broken
C. A systemic approach is required

A. The Offences (vol 2, chp 2)

- 14 offences (2007-16)
  - 8 murders
  - 4 attempted murders
  - 2 aggravated assaults
- In 3 different LTC homes and 1 private home
- While working as an RN
  - Full-time employee
  - Agency nurse
  - Community nurse
- Using a combination of short and long-acting insulin

B. The LTC system is strained NOT broken (vol 3, chp 15)

LTC homes are under pressure

- Most highly regulated area of healthcare in Ontario
- Increasing resident acuity

BUT

- The existing regulatory regime is a solid foundation
  - Clear standards of care for residents and home
  - Rigorous compliance and enforcement regime
- Those who work in LTC have demonstrated leadership, commitment, openness to change, and a willingness to collaborate (vol 3, chp 15)

C. A Systemic Approach Is Required

- We know of the Offences only because Wettlaufer confessed (vol 2, chp 1)
- Systemic failings – not individual shortcomings – created the circumstances allowing the Offences to be committed (12 reasons described) (vol 2, chp 5)
- An effective systemic approach requires (vol 3, chp 15)
  - No finger-pointing
  - Stakeholders implementing the recommendations directed at them
  - Stakeholders working collaboratively with others in LTC system

Example: the redesigned IPDR

TOPICS

I. WHY is there a need to deter and detect the HCSK?

II. WHAT insights does the LTCI offer?

III. HOW can you restore confidence in the LTC system?

I. WHY is there a need to deter and detect the HCSK? (vol 3, chp 16)

HCSK → **Known risk**

→ With the **potential to seriously harm**

→ Obligation to **take reasonable steps** to limit the risk

HCSK phenomenon

- Longstanding
- Widespread
- Large #s of victims

90 convicted HCSKs since 1970

- 450 murders and 150 assaults
- But linked to 2600 suspicious deaths

Examples of HCSKs

Dr. Harold Shipman – British GP in private homes

- Convicted of 15 murders (2000)
- Inquiry found 215 additional murders

Niels Högel – German nurse – hospital ICUs

- Convicted of 2 murders (2015) + 85 further murders (2019)
- Ongoing investigations indicate up to 200 – 300 victims

Charles Cullen – American nurse – hospital cardiac and IC units

- Convicted of 29 murders (early 2000s)
- Experts say responsible for 400 murders

Key points on HCSK

- HCSK is NOT an LTC problem – it is a healthcare system problem
- HCSK is NOT limited to killing – it encompasses all intentionally caused resident/patient harm by a healthcare provider
- Recent Examples
  - Dr. Paul Shuen – OB/GYN in Toronto (2018)
    - Pills placed in women's vaginas to induce labour + delivery on weekends
  - Nicole Ruest – RN in Moncton (2019)
    - Oxytocin in women's IV bags to induce labour (**alleged**)
  - Dr. William Husel – Doctor in ICU in Cleveland, Ohio (2019)
    - Charged with 25 murders through fentanyl overdoses

II. WHAT insights does the LTCI offer?

A. Insights that shape the Recommendations
B. Recommendations for other stakeholders
    i. Ministry
    ii. Office of Chief Coroner and Ontario Forensic Pathology
    iii. College of Nurses of Ontario

A. Insights that shape the Recommendations

- No “front end” fix – profiling does NOT work (vol 3, chps 16 and 19)
- No “back end” fix – intentional insulin overdoses are virtually undetectable (vol 3, chp 19)
- Healthcare worker awareness of HCSK phenomenon is critical (vol 3, chp 16)
- Technology and data are key tools (vol 3, chps 16, 17 and 18)
- Systemic issues require systemic responses, which depend on collaboration, communication and co-operation among stakeholders (vol 3, chp 15)
- Recommendations lead to improved resident care and outcomes (vol 3, chp 17)
- Need to build capacity in leadership team in homes (vol 3, chp 15)
- Greater role for pharmacists (vol 3, chp 17)

B. Recommendations for other stakeholders

i. Ministry

- Inject additional funding and more flexibility in use of funds
- Expand Ministry vision and role
    - Retain minimum standards focus
    - Lead the excellence movement in resident care
    - Create new unit to support LTC homes
    - Help build capacity in LTC homes
    - Encourage innovation and use of new technologies

B. Recommendations for other stakeholders (continued)

ii. Office of Chief Coroner and Ontario Forensic Pathology Service

- Overall responsibility for building awareness of HCSK phenomenon (vol 3, chp 16)
- Redesign the IPDR (vol 2, chp 14)
  - Dedicated coroners to provide training
- Increase number of resident death investigations using (vol 3, chp 18)
  - Redesigned IPDR
  - Ministry data on higher than expected numbers of deaths in a home
  - Internal aggregated data
- Develop specialized protocol for autopsies of elderly

B. Recommendations for other stakeholders (continued)

iii. College of Nurses of Ontario (vol 2, chp 13)

- Redesign practices, procedures, and policies to reflect the HCSK phenomenon
- Influence content in nursing programs
- Implement changes related to reporting obligations by homes/employers

III. HOW can you restore confidence in the LTC system?

STEP 1: Lead the way

STEP 2: Follow the money

STEP 3: Determine what Recommendations to implement, create an implementation strategy, and communicate

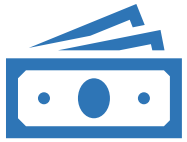
STEP 4: Recommendations on which to focus

Clinicians play an important leadership role in LTC.

Your attitudes and responses to the Report and Recommendations are of profound importance in restoring confidence in the LTC system.

STEP 1: Lead the way in using the Report and implementing the Recommendations

- Print and read the summary of Recommendations (pages 21-44 of volume 1) (available on the Inquiry website)
- Do not use the word “Wettlaufer” when discussing the Report or Recommendations
- Treat the Report and Recommendations as a question of risk-management



STEP 2: Follow the money

- Enlist the aid of the OLTCC?
- See Recommendations 19-21, 62, 76 – 77 and 85

STEP 3: Determine which Recommendations to implement, create an implementation strategy, and communicate

STEP 4: Recommendations on which to focus

1. The redesigned IPDR (Recommendations 50-56)
2. Recommendations in chp 17 (Recommendations 74-85)

Recommendations in chp 17 (recommendations 74-85)

1. Strengthen the medication management system in LTC homes
   - Update homes:
     - Insert glass doors, windows and walls in medication rooms and other rooms in which medications are stored
     - Install security cameras in medication rooms, common areas, entrances and exits
   - Use technology
     - Integrated automated dispensing cabinets and/or barcode-assisted medication administration system
   - Expand the role of pharmacists and/or pharmacy technicians

2. Improve medication incident analysis in LTC homes
   - Use an incident analysis framework that includes screening for the potential of intentional harm

3. Increase the number of registered staff in LTC homes

THANK YOU

OLTCC Board Questions

1. If a physician feels that a colleague, nurse or other healthcare professional may be a threat to resident care, how should the doctor express the concern?
2. LTC is increasingly interdisciplinary. Based on your observation of the system, how can accountability be identified?
3. Physicians attend to about 15,000 deaths in Ontario's LTC each year. These deaths are usually expected. Do you have suggestions on how families can be better prepared for an expected death?
4. What are your suggestions for responding to any questions that loved ones have at the time of death of a resident?
5. How do regulations and inspections protect residents in LTC?
6. Can you advise of the prevention, awareness, detection and deterrence of the HCSK? Could the risk be even greater outside of the LTC system? (recommendations 32 to 39)