

Long-Term Care Homes Public Inquiry Makes 91 Recommendations to Address Systemic Failings

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As previewed in the July edition, the Honourable Eileen E. Gillese, Commissioner of the Long-Term Care Homes Public Inquiry (Inquiry), released her final Report and Recommendations (Report) on July 31, 2019, following the Public Inquiry into the Safety and Security of Residents in Ontario's Long-Term Care Homes System.

The principal findings of the Inquiry were as follows:

1. The criminal offences committed by Elizabeth Wettlaufer, the vast majority of which occurred in licensed and regulated long-term care homes, would not have been discovered had she not confessed;
2. These offences were the result of systemic issues for which no single actor is individually accountable (although that is not to say there were no individual shortcomings or that there is nothing the stakeholders can do individually to improve the safety and security of residents);
3. Although the long-term care system is strained, it is not broken.

These findings strongly suggest that, in order to prevent similar tragedies, individual stakeholders must work together to respond to failings in the long-term care homes system. Although the Inquiry identified significant gaps in the current regulatory regime, the Report proposes that it is possible to build on existing strengths in order to improve the safety of residents living in long-term care.

The Report includes a total of 91 recommendations. In line with the conclusion that collaboration between different stakeholders is necessary to achieve systemic change, the Report specifically directed its recommendations at different stakeholders, such as individual long-term care homes, home care service providers, the Ministry of Health and Long-term Care, Local Health Integration Networks, the College of Nurses, the Office of the Coroner and the Government of Ontario.

With respect to long-term care homes, the Report recommends that systemic issues be addressed at the frontline with a view to preventing future incidents of intentional harm by:

- Providing improved training for registered staff, administrators, and medical directors;
- Improving existing hiring and screening processes for prospective employees;
- Maintaining a complete discipline history record for each employee;
- Taking reasonable steps to limit the supply of insulin in homes;
- Taking steps to ensure that staff submit Institutional Patient Death Records (IPDRs);
- Minimizing the use of agency nurses when practicable, and ensuring that contracts with agencies build in more robust oversight over agency nurses.

While many of the recommendations comprise a call to action for long-term care homes and other services providers, the Report also identifies the need for increased government funding, regulatory changes and/or the implementation of improved policies in relation to a wide range of issues including, but not limited to, medication management, education, public awareness, inspection, reporting and investigation.

In making these recommendations, the Report dispelled a number of myths surrounding the nature of Wettlaufer's offences. First, the Inquiry concluded that the murders cannot be characterized as "mercy killings"; rather, the victims were enjoying their lives and their loved ones were still enjoying time with them when the offences took place. Second, the Report established that Wettlaufer's imprisonment does not eliminate the threat of harm to other residents in long-term care homes as "health-care serial killers" are an identified phenomenon and these individuals often go undetected. As such, it is imperative that the above-mentioned recommendations are followed in order to prevent the recurrence of these types of offences.

The Report's recommendations further suggest that risk management must become a top priority for long-term care homes. As such, homes must cultivate a culture of compliance that prioritizes the prevention of harm. Now that clear regulatory gaps have been identified, there is an expectation on homes to be extra vigilant with the hiring, screening, training and disciplining of staff. This requires the implementation of policies and procedures that focus on taking a proactive approach to mitigating risk of harm to residents in order to avoid similar tragedies and exposure to liability. Homes will also be expected to develop better practices for record keeping in order to monitor any issues with medication management, staff performance and resident deaths.

While primarily directed at long-term care homes, the Inquiry's final Report is an in-depth look at how a "health-care serial killer" operated covertly in a highly regulated health-care context. In this regard, the Report is a good read from a risk management perspective for all involved in owning and/or operating care homes that may not be strictly classified as long-term care homes.

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