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

The Honourable Eileen E. Gillese
Commissioner

Ontario

Commission d'enquête publique sur la sécurité des résidents des foyers de soins de longue durée

L'honorable Eileen E. Gillese
Commissaire

In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

Affidavit of Joanne Polkiewicz

I, Joanne Polkiewicz, in the Town of Sebringville, in the County of Perth East, MAKE OATH AND SAY:

1. I am a witness to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the "**Inquiry**.") I have firsthand knowledge of the matters to which I herein after depose. Where I do not have firsthand knowledge, I have identified the source of my information and belief, and believe it to be true.

BACKGROUND

2. I graduated from the University of Saskatchewan with a Bachelor of Science degree in Pharmacy in 1980. I have been a registered Pharmacist in Ontario since May 1983. I am also a Board Certified Geriatric Pharmacist and Certified Respiratory Educator.

3. I am employed by Medical Pharmacies Group Limited ("**MPGL**") as a Clinical Consultant Pharmacist. My role is to work in the home/facility with staff and residents to provide clinical expertise with respect to medications and

treatments, guidance on policies and procedures with respect to medication management, and education. MPGL is a company that provides pharmaceutical services to long-term care homes, retirement homes, and complex continuing care facilities. I began my employment with MPGL in September 2004 and I am still employed by them.

4. MPGL has been providing pharmaceutical services to Caressant Care homes since May 1996. The services MPGL provides include the provision of medications and clinical geriatric expertise specific to residents in long-term care homes. MPGL provides this service to Caressant Care Woodstock ("**Caressant Care**") from a community-based pharmacy located in Woodstock, Ontario (the "**Pharmacy.**")

5. I was the Clinical Consultant Pharmacist at Caressant Care from approximately 2006 to February 2013 ("**the Relevant Period**"). During that time, I also served as the Clinical Consultant Pharmacist for a number of long-term care homes and other facilities who received pharmaceutical services from MPGL.

6. As the pharmacy provider to Caressant Care, Caressant Care residents received all of their prescriptions from the Pharmacy, provided MPGL was able to supply them. Prior to July 1, 2010, Caressant Care residents could obtain and bring in over-the-counter medications, vitamins, and supplements from elsewhere if they wished.

7. I usually attended at Caressant Care one-two times/month during the Relevant Period.

8. In February 2013, MPGL assigned another Clinical Consultant Pharmacist to Caressant Care due to regional changes that required a reallocation of workload.

RESPONSIBILITIES AND DUTIES

Chart Reviews

9. Conducting resident medication chart reviews was the greater part of my Clinical Consultant Pharmacist role at Caressant Care.

10. In order to perform chart reviews, I would collaborate with the nurses to identify the effectiveness of the medication therapy and possible side effects or drug-related issues requiring a recommendation of a drug or dose change. I would also review the nurses' progress notes for signs and symptoms of adverse medication reactions or lack of effectiveness of therapy, the resident's lab work for appropriateness, the resident's Medication Administration Record ("**MAR**") for adherence to the medication regimen, and the physician's orders. The intent of a medication review by the Clinical Consultant Pharmacist is to improve and/or optimize medication therapy for the resident.

11. I would discuss any matters with the nursing staff that required clarification: for example, if a resident was getting medications for behaviours but no behaviours were charted in the progress notes, the need for the medication would be questioned.

12. I found that direct engagement with the nurses supplemented any gaps or unclear areas in the charting.

13. Generally speaking, medication chart reviews would be initiated by the nurses advising of a medication concern for a resident (e.g. constipation, not sleeping, or complaining of pain). In addition, I would independently review charts of residents who had changes in therapy and required follow-up.

14. I routinely coordinated my medication chart reviews with the residents' physician Quarterly Reviews, so that Dr. Richard Reddick, one of the Caressant

Care physicians who was also the Caressant Care Medical Director during the Relevant Period, had my comments in his Communication Binder prior to his review.

15. LTCI00014303 is an example of a resident medication review form and notes I left for Dr. Reddick. This is a "Pharmacist's Medication Review Form" that I filled out. The form was completed prior to the physician's quarterly review so that Dr. Reddick had my proactive comments prior to his review. Dr. Reddick would make his own comments in the chart and decide to change the drug therapy as necessary. Attached hereto and marked as **Exhibit "A"** is a copy of the Pharmacist's Medication Review Form (DocID LTCI00014303.)

16. I typically conducted the scheduled medication chart reviews over two sessions. I conducted all the medication chart reviews for the scheduled Quarterly Reviews for one side of Caressant Care on my first visit day of the month, and the remaining residents at Caressant Care for the scheduled quarter on my second visit day of the month.

MEDICATION MANAGEMENT SYSTEM

17. I would consult on quality improvements to the Medication Management System by suggesting changes both at Caressant Care and in the Pharmacy. I would make suggestions on policy and procedures for medication management system improvements and provide education and training to the nursing staff on these process changes.

PAC/PAT (PROFESSIONAL ADVISORY COMMITTEE)

18. One of my responsibilities was to attend Caressant Care's Professional Advisory Committee ("**PAC**") meetings. The PAC was comprised of Caressant

Care's Medical Director (Dr. Reddick), the Director of Care (the "**DOC**"), Assistant Director of Care, the Physiotherapist, Retirement Home Manager, Administrator, Activities Director, Dietician, Facility/Physical Plant Manager, and me. The PAC met every three months.

19. I would give a report on drug utilization metrics for Caressant Care. MPGL generates these metrics for the long-term care homes to which it provides pharmaceutical services, including Caressant Care. The report would include, for example, percentages on different therapeutic classes of medications and number of medications per resident. These were "benchmarked" to the LHIN average.

20. The number of medications per resident reporting was useful because it could provide Caressant Care with information on the amount of time it would take to conduct each medication pass and the prescribing habits of the Caressant Care physician(s) could be analyzed by reviewing the therapeutic classification report. The therapeutic classification report identified the number of residents that were prescribed insulin, as well as other drug classes. Attached hereto and marked as **Exhibits "B"** and **"C"** are copies of reports I provided at PAT (DocIDs LTCI00072256 and LTCI00072260.)

21. The Institute for Safe Medication Practice's (ISMP's) Medication Safety Self-Assessment for Long-Term Care was not done at Caressant Care during the Relevant Period.

INSULIN

22. Insulin is a "high-alert" medication; meaning that it is a drug that bears a heightened risk of causing significant patient harm if used in error.

23. My role in relation to insulin use at Caressant Care involved education sessions related to insulin use, administration instruction, recognizing and suggesting

treatments for hypoglycemia, and insulin types. I would also help monitor the resident outcomes/effectiveness of the insulin by checking the chart for blood glucose levels and lab values during resident my chart reviews.

24. The Drug Record Book at Caressant Care is a record of all medications (including the Emergency Starter Supply), including insulin, which were ordered and received from the Pharmacy. The tracking of the use of insulin would be recorded by the nursing staff on the MAR.

25. There are three different types of insulin:

ii. **Long-Acting:** this helps blood sugar stay at a constant low level. It is normally given at night but it can be given in the morning too. NPH has a peak to it; whereas Lantus has a more stable and flat effect. Levemir is another long-acting insulin but it has a shorter duration than Lantus. Long-acting insulin may be the first insulin prescribed for less severe diabetes, but some Caressant Care residents required a combination of long-acting and short-acting insulin. Long-acting insulin is given once or maybe twice a day and continues working for 12 to 24 hours.

iii. **Short-Acting**: the best way to describe this type of insulin is that it helps the body with a blood sugar increase after eating a meal. Short-acting insulin is typically given once diabetes has progressed. Often a diabetic will start with oral medication, followed by adding long-acting insulin, followed by adding short-acting insulin. Toronto is an example of a type of short-acting insulin that was used at Caressant Care. Its effect does not last long and must be given with each meal. It is typically dosed twice to three times a day.

iv. **Mixed**: this is a combination of short-acting and long-acting insulin; usually given at breakfast and supper. A benefit of mixed is that there are fewer injections required.

26. As far as "red flags" to watch for with diabetics taking insulin, blood sugars need to be monitored, to a certain extent, but this depends on the type of insulin a resident is receiving, how frail they are, and how steady their sugars are.

27. "HbAIC" is a lab test that provides the average of blood sugar level over three months. Because it is an average, a diabetic taking insulin could have very high blood sugars and very low blood sugars (lots of up and down), but still present with "perfect" HbA1C. HbA1Cs are a useful tool, provided they are interpreted properly. It is also necessary to do blood sugar testing where HbA1Cs are used. Attached hereto and marked as **Exhibit "D"** is a copy of lab work for Ms. Helen Young, which includes Hemoglobin A1C (DocID LTCI00014696.)

28. Low blood sugars can be caused by a lot of things, such as certain types of medication, or even illnesses.

29. Insulin comes with five cartridges in a box. One cartridge is 300 units, which is 3 ml. The cartridges are colour-coded. Each type of insulin labelling/packaging is a different colour. For example, NPH is green. Each cartridge is sealed within a foil packet.

30. The outside of the box of insulin has the resident's name, the type of insulin, the directions for use, the date dispensed, the date expired, and the lot number.

31. The cartridge just has the name of the insulin on it.

32. The insulin cartridge is labelled by the manufacturer and has the name of the insulin on it.

33. The insulin pen delivery device has the resident's name on them. There is a separate insulin pen device for each of the resident's insulins – e.g. one insulin pen device for long-acting and one insulin pen device for short-acting.

34. Each resident also has their own glucometer to test blood sugars. Glucometers have memories but the readings are not linked to the resident's name, so would not be reliable. Glucometer results are documented on the resident's MAR and/or their blood glucose monitoring record.

35. The strips for the glucometers used at Caressant Care came in a box of 100. The resident's finger is poked with a sterile lancet and a blood drop is placed on the glucometer strip, which is then inserted into the glucometer. The glucometer displays the blood glucose value for the nurse to read and document in the resident's records.

36. How often a resident's blood glucose is measured depends on their prescription and how well their blood glucose is controlled.

37. The resident's physician prescribes the glucometer if needed and orders how often blood sugar tests are to be taken.

MEDICATION ADMINISTRATION

38. The standard procedure for a medication pass ("**med pass**") is generally as follows:

    a. There are standard hours of administration for the med pass. When the nurse prepares to administer medications to a resident, the nurse uses the MAR (electronic or paper) to determine the medications for each resident (when I first became the Clinical Consultant Pharmacist at Caressant Care, they used a paper MAR, but switched to eMAR during the Relevant Period). The nurse obtains medication from the resident's bin in the medication cart and if the resident is to receive an oral solid medication, checks the MAR for which medications are to be administered at that time, removes the pills from the strip pack, and puts them in a little cup. If the resident is to receive an injection, the injection is prepared. If an inhaler or liquid is to be

administered, the nurse will know because all medications are identified on the MAR for the med pass time that they are to be administered. The nurse is to perform the standard "rights" of medication administration: the right medication, the right client, the right dose, the right time, the right route, the right reason, and the right documentation.

b. If the resident is to receive a controlled substance, there are a number of additional inventory checks. The checks include the MAR, the count, the drug, and the packaging/label. These medications are stored separately and double locked in the medication cart in the dedicated area for controlled substances. The nurse documents administration on the MAR and also documents on the narcotic count in the Narcotic Binder (located with the medication cart) that she has removed inventory from the narcotic supply. The nurse then checks that the Narcotic Binder record is accurate to the medication that has been removed.

c. For both controlled and non-controlled medications, when the nurse leaves the medication cart he/she closes the resident's eMAR screen (if using the electronic MAR), locks the cart, administers the medication, and then documents on the MAR to mark that is has been administered, held, refused, etc. The resident's individual narcotic count book ("**Narcotic Record**"), if relevant, is also initialed, as an additional checking step.

d. Sometimes residents will refuse medication because they don't want it (which is their right to refuse, if they are capable, they believe they don't need it, etc.), or sometimes if they have cognitive impairment. If this occurs, the nurse should put the resident's medication in a paper cup in the resident's bin and complete the rounds. The nurse will try re-approaching the resident later during the med pass.

e. If the medication is refused after a re-approach, it is put in the disposal bin on the medication cart for destruction and marked as "refused" on the MAR. It is also marked as refused on the resident's Narcotic Record, if it is a controlled substance.

39. For controlled medications that are refused, I encouraged the nursing staff to follow this process: put the refused medication back into the narcotic card, tape it up, and mark "Refused" on it with a marker or pen. That way, when the count is done at the end of the week, it is easier to do the count because when the weekly narcotic card gets counted for destruction, the refused medication is right there.

40. At the end of the week, the narcotic card and the resident's Narcotic Record go into the destruction bin. Two nurses sign for this. They also sign the destruction bin's separate log, kept with the bin.

41. To administer insulin, you load a cartridge into the insulin pen device, add a pen needle, dial up two units of insulin to prime the needle, check the MAR that you have the right drug, note what dose to give, then dial up the dosage amount as prescribed (e.g. eight units), double-check again before administering the dose by injection, and administer it in an appropriate site for insulin. It is recommended for the nurse to double-check the insulin dosage before administering and hold the needle to the skin for 10 seconds to ensure proper absorption.

42. The nurse will use the insulin from the cartridge for each administration, until it's empty. If it looks like the cartridge is getting low and there is not enough insulin for the dose required, then it is recommended that nursing staff use a new cartridge to begin with, to avoid giving the resident two injections. The cartridge to be disposed would be put into the drug destruction container. The nurse is to view the cartridge of insulin to ensure he/she has enough insulin

liquid to administer the dose required when preparing the injection. Another cartridge would need to be removed from the fridge in advance of administration of the insulin so the nurse would have what is required for this medication pass and for the insulin to reach room temperature before injecting. Insulin pen devices are refillable and an insulin cartridge is loaded into the insulin pen device for administration purposes.

43. The insulin pen devices dial to a maximum number of units; I believe it is around 60. It is not possible to dial all the way to 300 units. The nurse can dial back the amount of insulin too, if too much is dialed up the first time.

44. Insulin pen devices with new cartridges need to be primed as per manufacturer recommendations to ensure the insulin plunger is in the right place and all the air has been removed. In doing so, some insulin is wasted (usually two units, but this can be more.) The presence of an air bubble will change the dose. The amount of insulin "wasted" by priming isn't tracked.

45. There are prefilled disposable insulin pen devices available for certain insulins, but I do not believe that they were used at Caressant Care during the Relevant Period. Disposable insulin pen devices are used until the cartridge is empty, and then they are thrown out in the drug destruction container. Needles are placed into the sharps container.

46. Vials and syringes have not been used in a long time.

47. Most diabetic residents taking insulin get a set dosage at set times during the day.

48. Due to sliding scale orders there is also sliding scale insulin which is administered after a blood glucose test is obtained and insulin is dosed at a

specific amount according to the blood sugar results of the resident. This type of insulin regimen is used much less frequently in long-term care settings.

49. It is typical for there to be interruptions by residents, families, and staff during the med pass. For example, if a resident falls it will result in a pause in the administration of medications while nursing staff attend to that resident, before returning to the med pass. The nurse is interrupted with questions and often distracted during a med pass as he/she is also responsible for managing the floor during this time.

50. There are four main med passes daily; however, medications are also administered to residents throughout the day.

51. While it makes sense to have a double-check or two sets of eyes at every stage of administration, it would require a lot of nursing staff to do this.

52. There are some new insulin pen devices that will record how much insulin has been administered, at the end of the insulin pen device. For example, if you administer five units, then the number five will flash at the end of the pen.

MEDICATION ORDERING

53. For new orders, usually the physician writes the order in the resident's chart and flags it. The nurse would copy the order into the Drug Record Book and onto the paper MAR, when that was used. These are both then faxed into the Pharmacy. With eMar, the Pharmacy schedules the order into the electronic system as well as the Pharmacy system. Usually on the next shift, a second nurse checks the MAR (paper or eMar) against the physician's order sheet. When the medication comes in, the medication and its label is checked against the resident's chart and the MAR entry and recorded in Drug Record Book.

54. The physician can also write the order using a digital pen, which is a method of directly transmitting prescription orders from Caressant Care to the Pharmacy. The nurse can also use the digital pen to write the order if the physician is not present at Caressant Care and she/he, for example, takes a telephone order from the physician.

55. For insulin, one box was ordered at a time. When there was only one cartridge left (i.e. 300 units) the nurse would need to reorder the insulin from the Pharmacy.

56. I cannot recall any issues with respect to ordering insulin at Caressant Care.

57. For emergency stock in the Emergency Starter Supply, the Pharmacy would monitor the inventory by completing audits of the correct usage and completing the "monitoring form" of the contents. The contents of the Emergency Starter Supply is decided at the PAC meeting and agreed upon by the DOC, Medical Director, and the Clinical Consultant Pharmacist. Glucagon and insulin are included in the Emergency Starter Supply. Each month, the Emergency Starter Supply gets checked to make sure everything is "in date" and to confirm what has been used. If something is used from the Emergency Starter Supply, the nurse is supposed to record it in the Drug Record Book. The Emergency Starter Supply is kept in a cupboard in the locked medication room.

58. If an insulin pen device and cartridge were missing from the Emergency Starter Supply, I would notice it when I completed the monthly monitoring form. The monthly monitoring included quantity on hand and expiry dates, for the Emergency Starter Supply. The documentation of use and/or removal from Emergency Starter Supply is done in the dedicated drug record book and communicated to the Pharmacy by fax upon removal. When new Emergency Starter Supply was replaced by the Pharmacy, the nurse would need to sign it in the drug record book and add it to the Emergency Starter Supply.

MEDICATION DELIVERY

59. I was not involved in the delivery of medication, so I am not able to comment on this in a definitive manner. However, my general understanding is that the insulin would leave the Pharmacy in a bag with the other non-controlled medications. The controlled medications are in a separate bag. The bags are stapled closed and labelled, with the long-term care home's name and the Unit Number on the bags. I do not know if the driver would have to sign that he or she received the bags. The nurse would sign at the home what he/she received which would match what was ordered. If there were any discrepancies, MPGL's policy was for the nurse to notify the Pharmacy immediately via MPGL's 24/7 phone line.

60. The driver takes the bags directly to the unit in the long-term care home and gives them to the nurse on duty, at the main desk, and obtains a signature on the delivery manifest. The nurse signs for them, indicating the package was received, and then takes them to the units. It is my understanding that the order may not be checked as soon as it arrives, especially if the driver arrives during the med pass. The nurse would sign for it on the unit and then put in the medication room or the fridge, accordingly, to be counted later and checked against the Drug Record Book.

61. I believe that delivered medications are checked when it is less busy; often at night.

62. I do not recall any issues with delivery of medications to Caressant Care during the Relevant Period.

63. If the long-term home is using eMAR, then the order can be scanned in to populate the electronic drug record book. The eMAR displays the order as pending, until the prescription is delivered and successfully scanned in the

electronic drug record book. There are bar codes on the product label that are scanned to populate the electronic drug record book.

64. Controlled medication is supplied in a 31-blister card for prn "as needed" orders and a seven-day card for regularly dosed oral solid forms (e.g. 14 tablets in a seven-day card if the drug was needed twice a day) (the seven-day card is the current packaging. I cannot recall if this packaging was also used during the Relevant Period). A separate sheet called the "Monitored Medication Count" is sent with each card of controlled medications and this gets signed each time one dose is administered to a resident to track the inventory used and still on hand. It is not usual to order more than one 31-day card at one time; however it is done at certain times. For example, the nurses might bulk up their orders at Christmas time to ensure adequate supply over the holidays.

65. Non-controlled regularly-dosed oral medications are sent in seven-day supplies packaged in multidose strip packaging. Other non-oral tablets or capsules are ordered "as needed" when the supply is low (i.e. treatments, inhalers, eye drops, patches, liquids, and injectables; such as insulin).

66. It is possible to order more than one narcotic card at one time (e.g. a larger supply), but it's not usual. The dosing for the drug dictates how much will be used and how soon the card will run low. For example, if a resident is becoming palliative and requires a narcotic every two hours then more than one card might be ordered at once. It is a priority to have enough medication over a weekend. During the week there is daily delivery.

MEDICATION STORAGE

67. The Emergency Starter Supply was kept in a locked medication room, to which the nurse on duty had a key. Inside each locked medication room at Caressant Care was also the dedicated medication fridge, which is where the insulin was

kept. The fridge was not locked. The medication cart was also kept inside the medication room when not in use. The medication cart was kept locked and a separate drawer at the bottom had a bin dedicated for narcotic and controlled medications which was also locked. The medication cart was to be locked whenever there was not a nurse present using it. Sometimes it would be kept unlocked while stored in the locked medication room.

68. Insulin was stored in the fridge in the locked medication room. This was for new insulin cartridges, not yet opened. If a cartridge was in use, it was kept in the locked medication cart. Most insulin is stable for 28 days at room temperature.

69. Checks were done on safe storage as part of the audits. All medications are locked in the medication room and/or medication cart. Other things were audited too: the fridge temperatures, that medications were stored and locked in the right place, the medication cart was locked, etc. Access to medications was monitored through the quarterly auditing that was done by the Pharmacy. Other audits completed by the Pharmacy included: accurate MAR/TAR and Medication Review documentation, proper medication administration, resident safety and medication reconciliation, narcotic requirements, medication disposal, proper insulin use, Emergency Starter Supply inventory, and proper Drug Record Book use.

70. The Pharmacy provided education materials to Caressant Care, including a DVD on orientation to the medical management system to use for staff. The Clinical Consultant Pharmacist would not provide live orientation for each new staff. However, one of the quarterly staff education sessions provided by the Pharmacy could be designated as an orientation to the medication system to support policies and procedures. The DVD is now replaced by online medication management orientation videos.

71. The amount of insulin stored in Caressant Care was not tracked or counted as a controlled substance; as non-controlled medications are not counted at the time of nursing shift change. An audit would not disclose misuse. Concerns would only be raised if it was re-ordered too soon based on dosage variations. If ordered too soon, the Pharmacy would be notified in its system through the interaction with the Ontario Drug Benefit adjudication that the days' supply was too early.

72. I do not believe that there is a way to track insulin misuse in a long-term care home. For example, if there was trouble priming insulin, then more would be used/wasted. If the cartridge was dropped and cracked or broken, then a new cartridge would be taken from the supply and used.

73. I do not recall any reports of medications being accessed at Caressant Care during the Relevant Period that shouldn't have been.

MEDICATION INCIDENTS AND REPORTING

74. I don't recall specific medication errors occurring at Caressant Care.

75. I do not recall any medication incidents with Elizabeth Wettlaufer ("**Wettlaufer**.")

76. I recall that a few times, my investigations resulted in the discovery of a discrepancy in the documentation. To investigate, I would go to the MAR. For example, if someone didn't sign the dose on the Narcotic Record but signed on the MAR, I would report it to the DOC for further follow-up as this was not an omission of a dose but a discrepancy in the documentation – multiple places to document can lead to missed steps.

77. I looked at incidents from a clinical perspective: if a resident is not receiving their medication, then that was a problem to solve. System problems or professional practice problems, if any, needed to be identified and resolved. I would advise the DOC of any concerns or questions I had, and it was my understanding that the DOC would follow-up with the team.

78. The Clinical Consultant Pharmacist advises on safe medication practice and how to investigate and document drug diversion. If diversion was identified by Caressant Care and the police were called, then I would be of the view that the diversion was being addressed.

79. If there was an instance of missing medication, the DOC and I would review the Medication Management System to ensure that the recommended processes were in place and the nurses were aware of the procedures to be followed.

80. During the Relevant Period, only pharmacy errors were reported to the Pharmacy and not all medication errors. It was my impression that the staff took medication errors seriously. I encouraged reporting of all errors directly to the Pharmacy, but this did not always occur. The DOC reported the medication errors at PAC, and in this way I would become informed of all of these errors.

81. Each long-term care home has their own policies and MPGL provides each long-term care home with policies and procedures on medication management (the "MPGL **Policy and Procedure Manual.**") I have no specific recollection of seeing Caressant Care's policies. A hard copy of the MPGL Policy and Procedure Manual was kept at the nurses' station and an online version is also available. I encouraged nursing staff to check the MPGL Policy and Procedure Manual. Policies and procedures are regularly reviewed and updated.

82. My role with respect to medication incidents and reporting was to review the medication incidents to determine if preventative steps could be taken. For example, although this didn't occur at Caressant Care, a mix-up between morphine and hydromorphone (because of their similar names), led to me coming up with a way to easily tell them apart.

83. If it was an error of omission - for example, a nurse forgot to give a medication - this was dealt with by the DOC and not me – it might not even be brought to my attention. If an error of omission involved a controlled substance, I would become aware of it when I did the destruction, but otherwise, errors of omission would not routinely be brought to my attention.

MEDICATION DESTRUCTION

84. Controlled substances that are discontinued or no longer required are removed from the active medication orders in the medication cart and details about the medication is documented on a Surplus Monitored Medication List by two nurses. The Narcotic Count (individual and shift count) is updated to indicate the quantity of medication being removed and placed for destruction. The Surplus Monitored Medication List is a record of controlled substances requiring destruction. It is completed as per the regulations to the *Long-Term Care Homes Act, 2007* ("**LTCHA**") with resident's name, medication name, prescription number, quantity, and reason it is surplus or needs to be destroyed. It has to be double-signed by another nurse. The Individual Count is wrapped around the medication (e.g. Card, vial, box) and put in the dedicated double locked wooden disposal box. The Clinical Consultant Pharmacist's role includes reconciling these controlled substances usually twice a month, denaturing the controlled medication so it cannot be reused, and sealing it in the Stericycle container. The container is then picked up directly from the home and destroyed by a contracted company.

85. For the actual physical destruction of controlled substances, a nurse and I denature the medication. We punch out all the narcotic tablets or capsules, break ampoules, cut patches, and then "mush" them up with soap and water in a plastic container to render them unusable. This is then put into the drug disposal bin, which is a Stericycle box, with a red liner in the locked storage room on the lower level of Caressant Care (it was my understanding that only nursing staff had the key). This was done twice/month, usually on each of my visits. During the Relevant Period, I did a triple check: individual narcotic count, the quantity of drug remaining, and the Surplus Monitored Medication List. All should match.

86. For the destruction of non-controlled substances, these were also put in the dedicated drug disposal box, which was a box in the locked medication room separate from active medications and stored in a cupboard under the sink. The nurses at Caressant Care placed non- controlled substances in the dedicated drug disposal box if an order was discontinued, expired, or no longer appropriate for use. I believes empty insulin cartridges were put in the sharps container with the used needles or syringes. I did assist with the destruction of non-controlled substances, on occasion, to help out, because the staff were so busy.

87. The *LTCHA* came into effective in July 2010. When the Act came into effect, the surplus controlled medication required detailed documentation and the non-controlled medication waste did not.

88. The controlled medication is always locked and processed for destruction by a pharmacist or physician and a DOC or delegate. The non-controlled medication is transferred out of the cart and into the drug destruction box by the nurses.

QUALITY REVIEWS AND AUDITS

89. I do not recall doing a formal "Medication Management System Program Evaluation," such as the process prescribed by LTCI00016416. However, regular standardized and formal medication management safety compliance audits were conducted on a quarterly basis by the Pharmacy and results were reported to Caressant Care for quality improvement planning. Improvements and changes to processes were made to the system by me in collaboration with the DOC and Caressant Care Staff in a more informal way (discussions), through errors, or through the reporting I did during my visits and auditing. Process improvements were also discussed at the quarterly PAC meetings. Attached hereto and marked as **Exhibit "E"** is a copy of the Medication Management System Program Evaluation.

90. The regular standardized and formal medication management safety audits helped to ensure quality, safety and compliance with the Ministry of Health and Long-Term Care Home inspections. There were different types of audits that were completed during quarterly visits and each was done twice/year. For example, there would be an audit done on storage, which checked for expired medication; fridge temperatures, etc. There would be a documentation audit done, which would look at the MAR, Drug Record Book, etc.

91. The results of the audits and suggested action plans were reported by a Pharmacy CQI (continuous quality improvement) associate and me to the DOC.

92. The audits were helpful in improving quality– for example, the identification and disposal of expired medications improved as a result of the audit findings and discussions with the nurses about the findings. I frequently saw improvements after the audits were done.

93. Insulin audits included checks on proper labelling, dating the insulin when opening a new cartridge, adding expiry dates, safe needle use, availability of hypoglycemic rescue medication and guidelines on use, proper documentation of administration (amount and sites), correct insulin use compared to the MAR, proper storage at room temperature or refrigerated, blood glucose meters and strips properly used and results properly documented, control testing completed for quality control, whether each resident had a dedicated blood glucose meter to prevent contamination, and proper disposal of lancets and needles.

94. Depending on the results of the audits, there were action plans recommended for improvement. The audits resulted in improvements. Although it was ultimately the responsibility of the DOC to ensure action plans were implemented, the CQI associate and I did our best to follow-up on the implementation of action plans and recommendations for improvement that were made following an audit.

EDUCATION

95. My main role with education was to provide "in-service" education on policies and procedures and medications at Caressant Care. Topics chosen were a result of the audits, reports I had done at PAC, or suggestions and requests from Caressant Care. For example, if I had noticed a trend among all the homes where I was the Clinical Consulting Pharmacist, I would run an education session with all of them on the same subject. I also brought new information to Caressant Care through materials created by MPGL, including newsletters, pocket guides for the healthcare team (such as “High Alert Medications”), and pamphlets for the residents’ families (for example, on influenza preparedness).

96. Education sessions for hypoglycemia included formal sessions, *ad hoc* sessions and QI posters about recognizing, monitoring and properly treating

hypoglycemia. The idea was to problem-solve as issues were identified with the staff on the spot or "in the moment" so that the learning opportunity was timely and valuable to the staff.

97. I also conducted education sessions on the insulin pen device, glucometer, and how to inject insulin correctly. The Pharmacy regularly made available pocket guides and quality improvement posters covering these topics (e.g. "Hypoglycemia Signs and Symptoms" or "Rock and Roll – How to Reconstitute and Administer Cloudy Insulin Properly.")

98. I ran the education sessions when I was at Caressant Care, during the day. Typically, I ran the education sessions four times/year. I would run the sessions once/day, in the afternoon which could accommodate day and evening shift nurses. I do not know if night staff were able or did attend. Attendance would depend on what was going on at Caressant Care in terms of resident care demands. Caressant Care management encouraged all staff to attend and the DOC attended as well.

99. Education sessions were held in the dining room. I would leave copies of my PowerPoint presentation for the evening and night staff. In terms of my other communications with evening and night staff, they also had my cell phone that they could call at any time if they needed to.

100. I was not directly involved in the formal Orientation process for new nurses to Caressant Care. The Pharmacy recommended reviewing the MPGL Policy & Procedure Manual and the DVD on orientation to the Medication Management System that MPGL provided to Caressant Care. I am not aware if this routinely occurred. If new staff had specific Pharmacy or medication questions, then they could ask me and I would address them. That routinely occurred.

101. I wasn't involved in the formal development of the MPGL Policy and Procedure Manual; however, I had input in the policies that were regularly discussed at MPGL Clinical Consultant Committee meetings that I attended in Toronto. Completion and printing of the Policy and Procedure Manual was done by MPGL's head office. Before computers, the Policies and Procedures Manual was kept in a binder at each nursing unit and in the DOC's office. Now the Policies and Procedures Manual is available through an online portal called the Pharmacy "Resource Centre." Policies and procedures are to be discussed at the quarterly PAC meetings and are recorded on the standard Pharmacy completed template at each meeting.

ELIZABETH WETTLAUFER

102. I met Wettlaufer a couple of times but I don't remember anything specific about her. I don't recall any issues. She usually started work at around 3 pm. I would be doing my chart reviews and she might be in the chart room at the same time as me.

103. I never witnessed, nor was I made aware of, any medication errors by Wettlaufer.

104. I never witnessed any odd behaviour by her. I was never informed of anything about her work performance – positive or negative. I was never informed of anything about her behaviour – positive or negative.

105. The Medication Management System has many safety steps, checks and balances, and safety nets to ensure the policies and procedures are followed as written by the team of healthcare providers (pharmacy, nursing, prescribers, and Personal Support Workers). Regularly-scheduled attention to the audit results and dedicated management time to implement and follow up with improvements should prevent failures in the system.

106. It is my view that no one could ever predict or expect that there would be a serial killer in their midst at Caressant Care. The Medication Management System is predicated on regulated health care professionals conducting themselves in a competent and ethical manner. It is challenging to conceive of what could be built into the system, from a practical perspective, to address such unimaginable conduct. The reality is that Caressant Care is a busy home, but it's not different from any other long-term care home. Homes are all busy and don't have the adequate funds for a challenging population that has dementia and who is very fragile. Proper care of residents is very time consuming and their needs are high.

107. I swear this affidavit for no improper purpose.

SWORN BEFORE ME at the Town of Sebringville, in the County of Perth East, on June 21, 2018

Commissioner for Taking Affidavits
(or as may be)

This is Exhibit "A" referred to in the Affidavit of Joanne Polkiewicz, sworn June 21, 2018

Commissioner for Taking Affidavits (or as may be)

MEDICAL PHARMACIES
LONG TERM CARE SERVICES

21

Pharmacist's Medication Review Form

Resident: Helen Young	Physician: Goldrich
Allergies: Fentanyl	Diagnoses: Anemia - GERD
Meperidine	HTN OP
pentobarbital	AFib Dementia
CrCl/Date:	Arthritis PVD

Date	Pharmacist's Comments/Recommendations	Physician's Comments Signature/Date
3/5/10	Chart reviewed, no recommendations. [signature] 3/8	
6/1/2010	Annual MedsCheck LTC — Review requested by Heidi re: refusing meds esp. Hydromorph contin + resultant pain issues.	
	- Fe 80 q - consider stopping	
	- Oct 2010 Hgb = 131, MCV = 96.9 Ferritin = 120.	
	- Insurance 70/2800 Could change to Vit D 1000 Insurance 70/5600	
	Cond. stop Vit D to minimize number of meds.	
	Hydromorphone 9 mg daily - consider replacing with Duragesic 25 mg patch to ensure resident receives consistent pain relief. [signature] 6/8	Allergy [signature] MD

After physician has signed, file in _____ section of Resident's chart.

This is Exhibit "B" referred to in the Affidavit of Joanne Polkiewicz, sworn June 21, 2018

Commissioner for Taking Affidavits (or as may be)

MEDICAL PHARMACIES
LONG TERM CARE SERVICES

Medical Pharmacies Group Limited
590 Granite Court, Pickering, ON, L1W 3X6
Tel: 905-420-7335 - Fax: 905-420-7342
www.medicalpharmacies.com

Report Date: 2011-04-30

Pharmacy:Woodstock

Consultant:Joanne Polkiewicz

C.C. Woodstock NH

Drug Category Analysis Report

Number of Units: 5 **Number of Residents:** 158 **Number of Residents Receiving >= 9 Regular Dosed:** 102 (64.56%)

Comparative Average Dosage per Resident

	Medication			Treatment		
	Avg.	LHIN Avg.	Prov Avg.	Avg.	LHIN Avg.	Prov Avg.
Reg. Dosed	10.04	9.02	9.83	0.25	0.30	.67
PRN. Dosed	4.04	2.08	2.41	0.13	0.25	
Total	**14.09**	**11.10**	12.24	**0.38**	**0.55**	.67

LHIN Average represents medications supplied by Medical Pharmacies to 33 LTC Homes within the LHIN.
Provincial average for treatments includes both regular and PRN.

Unit Breakdown for Combined Orders

Unit	# of Residents	Avg. Orders
1	27	15.37
2	30	14.53
3E	42	14.21
3N	40	14.68
3S	19	13.21

Combined Orders by Selected Therapeutic Categories

	# of Residents	%
Analgesics - Non Narcotic	150	94.94
Antidepressants	100	63.29
Anti-Infectives - Oral	9	5.70
Antipsychotics	70	44.30
Benzodiazepines	40	25.32
Externals / Topicals	82	51.90
Heparin & LMWH	0	0.00
Insulins	13	8.23
Narcotics - Regularly Dosed	38	24.05
Trazodone***	34	21.52
Warfarins	15	9.49

The report reflects medications supplied by Medical Pharmacy.
***Trazodone is pharamacologically categorized as an antidepressants; however, in the geriatric population this drug is frequently used as an antianxiety and/or bedtime sedative agent thus it is listed separately

Report Date: 2011-04-30

Consultant:Joanne Polklewicz

C.C. Woodstock NH

Drug Category Analysis Report

Unit Breakdown of Residents by Selected Therapeutic Categories

Units	Residents	Analgesics - Non Narcotic	Antidepressants	Anti-Infectives - Oral	Antipsychotics	Benzodiazepines	Externals / Topicals	Heparin & LMWH	Insulins	Narcotics - Regularly Dosed	Trazodone***	Warfarins
1	#	25	19	1	16	9	15	0	1	5	6	2
	%	92.6	70.4	3.7	59.3	33.3	55.6	0.0	3.7	18.5	22.2	7.4
2	#	27	16	2	4	8	22	0	1	8	8	5
	%	90.0	53.3	6.7	13.3	26.7	73.3	0.0	3.3	26.7	26.7	16.7
3E	#	41	26	3	20	12	15	0	7	10	5	2
	%	97.6	61.9	7.1	47.6	28.6	35.7	0.0	16.7	23.8	11.9	4.8
3N	#	38	26	1	22	8	23	0	3	10	10	4
	%	95.0	65.0	2.5	55.0	20.0	57.5	0.0	7.5	25.0	25.0	10.0
3S	#	19	13	2	8	3	7	0	1	5	5	2
	%	100.0	68.4	10.5	42.1	15.8	36.8	0.0	5.3	26.3	26.3	10.5

The report reflects medications supplied by Medical Pharmacy.

***Trazodone is pharamacologically categorized as an antidepressants; however, in the geriatric population this drug is frequently used as an antianxiety and/or bedtime sedative agent thus it is listed separately

This is Exhibit "C" referred to in the Affidavit of Joanne Polkiewicz, sworn June 21, 2018

Commissioner for Taking Affidavits (or as may be)

MEDICAL PHARMACIES
LONG TERM CARE SERVICES

Medical Pharmacies Group Limited
590 Granite Court, Pickering, ON, L1W 3X6
Tel: 905-420-7335 - Fax: 905-420-7342
www.medicalpharmacies.com

Pharmacy:Woodstock

Report Date: 2011-04-30

Consultant:Joanne Polkiewicz

C.C. Woodstock NH

Therapeutic Category Analysis

Summary for Home

Total Number of Residents in Home: 158

Therapeutic Category	# Resident	%
Acetaminophen	149	94.3
Anticonvulsants	26	16.5
Antidepressants	100	63.3
Antiplatelet Therapy (ASA,Plav	56	35.4
Antipsychotics	70	44.3
Anxiety Therapy	43	27.2
ASA	47	29.7
Bisphosphonates	50	31.6
Calcium Supplements	76	48.1
Cardiovascular	120	75.9
Cholesterol Lowering Medicatio	43	27.2
Cholinesterase Inhibitors	59	37.3
Dermatoligical	61	38.6
Digoxin	6	3.8
Diuretics	55	34.8
GI medications	124	78.5
Hypnotics	8	5.1
Hypothyroid Therapy	33	20.9
Inhaled Medications	35	22.2
Insulins	13	8.2
Iron Supplements	20	12.7
Laxatives	145	91.8
Long-Term Anti-Infectives	5	3.2
Low Molecular Weight Heparins	0	0.0
Multivitamins	49	31.0
Narcotics - Regularly Dosed	38	24.1
NSAID's (includes COX-2 inhibi	21	13.3
Opthalmic Therapy	29	18.4
Oral Hypoglycemics	25	15.8

Summary for LHIN

Total Number of Residents in LHIN: 3115

Therapeutic Category	# Resident	%
Acetaminophen	2347	75.3
Anticonvulsants	390	12.5
Antidepressants	2070	66.5
Antiplatelet Therapy (ASA,Plav	1373	44.1
Antipsychotics	1178	37.8
Anxiety Therapy	883	28.3
ASA	1158	37.2
Bisphosphonates	509	16.3
Calcium Supplements	982	31.5
Cardiovascular	2245	72.1
Cholesterol Lowering Medicatio	1010	32.4
Cholinesterase Inhibitors	773	24.8
Dermatoligical	1147	36.8
Digoxin	176	5.7
Diuretics	1315	42.2
GI medications	1881	60.4
Hypnotics	162	5.2
Hypothyroid Therapy	783	25.1
Inhaled Medications	826	26.5
Insulins	284	9.1
Iron Supplements	429	13.8
Laxatives	2018	64.8
Long-Term Anti-Infectives	154	4.9
Low Molecular Weight Heparins	12	0.4
Multivitamins	828	26.6
Narcotics - Regularly Dosed	664	21.3
NSAID's (includes COX-2 inhibi	214	6.9
Opthalmic Therapy	796	25.6
Oral Hypoglycemics	509	16.3

The report reflects medications supplied by Medical Pharmacy.

MEDICAL PHARMACIES
LONG TERM CARE SERVICES

C.C. WOODSTOCK
PAT MEETING
PHARMACY REPORT
17 May 2011

1. The new retirement home Policy and Procedure Manual is available on the resource center and the printed version is scheduled to be available at the end of May.

2. Management reports from the Resource center are included for review.

3. ESB- Famciclovir available, is there a need for valacyclovir as well?

4. There are an increasing number of warnings about using PPIs. They are associated with a higher risk of pneumonia, C. Difficile diarrhea and fractures. They may decrease the ability of bisphosphonates to decrease absorption and may cause hypomagnesemia. Pantoloc

Wean off gradually.

This is Exhibit "D" referred to in the Affidavit of Joanne Polkiewicz, sworn June 21, 2018

Commissioner for Taking Affidavits (or as may be)

CML HealthCare

CML HealthCare Inc.
6560 Kennedy Road, Mississauga, Ontario L5T 2X4
Tel: (905) 565-0433 (416) 465-9907 (Toll Free) 1-800-263-0801

PATIENT
YOUNG, HELEN WHITELAW

DATE OF SERVICE: 12-OCT-10
TIME PRINTED: 13:19
DATE PRINTED: 28-OCT-10

SEX: F
DATE OF BIRTH (YYYYmmdd): 19230629
HEALTH NUMBER: 3785454772

CLIENT (519)539-6461
DR. R. REDDICK
510 INGERSOLL AVE
WOODSTOCK, ONT
N4S4X9

190645
(519)537-6501
60
FINAL REPORT

DATE COLLECTED: 12-OCT-10
ACCESSION NO.: BQ68274

TEST NAME	RESULT	ATTENTION	REFERENCE RANGE	UNITS	FN LOC
RIA					
TSH	1.14		0.30-5.60	MU/L	70
	NOTE ** NEW REFERENCE RANGE ** TSH is the single initial test of thyroid function. It should be performed only on symptomatic patients or pregnant, post partum and post menopausal women.				
T4 FREE	13.9		7.9-14.4	PMOL/L	
	****** * Note: New Reference Range * ******				
VITAMIN B12	199		>133	PMOL/L	
	NOTE ** NEW REFERENCE RANGE ** Serum Vitamin B12 should be considered for assessment of peripheral neuropathy, megaloblastic anemia or malabsorptive conditions. Routine screening should only be ordered on seniors, and then only once every few years.				
FERRITIN	120		11-145	UG/L	
	****** * Note: New Reference Range * ******				

DUPLICATE: original printed on 20101013 at 16:07:34

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N4S4X9

190645
(519)537-6501
60
FINAL REPORT

DATE COLLECTED: 12-OCT-10
ACCESSION NO.: BQ68274

TEST NAME	RESULT	ATTENTION	REFERENCE RANGE	UNITS	FN	LOC
HEMATOLOGY						
HEMOGLOBIN	131		115-165	G/L		70
HEMATOCRIT	0.388		0.37-0.47	L/L		
WBC COUNT	5.3		4.0-11.0	X10 9/L		
RBC COUNT	4.00		3.80-5.80	X10 12/L		
MCV	96.9		80-97	FL		
MCH		32.9	27.0-32.0	PG		
MCHC	339		320-360	G/L		
RDW		15.6	11.0-14.5	%		
PLATELET COUNT	223		150-400	X10 9/L		
ABSOLUTE: NEUTROS (A)	3.6		2.0-7.5	X10 9/L		
LYMPH (A)	1.1		1.1-3.3	X10 9/L		
MONO (A)	0.4		0.0-0.8	X10 9/L		
EOS (A)	0.2		0.0-0.5	X10 9/L		
BASO (A)	0.0		0.0-0.2	X10 9/L		
ESR	12		0-20	MM/H		
	NOTE ESR should be used to assess the degree of activity in inflammatory conditions like rheumatoid arthritis, never as a screening test.					
hs-CRP	0.4			MG/L		
	CUT POINTS FOR CARDIAC RISK ASSESSMENT ARE: LOW RISK LEVEL <1.0 MG/L; AVERAGE RISK LEVEL 1.0 - 3.0 MG/L; HIGH RISK LEVEL >3.0 MG/L. VALUES >8.0 MG/L INDICATE INFLAMMATORY CONDITIONS AND MAY NOT PREDICT CARDIAC RISK					
CHEMISTRY						
CREATININE	54		60-115	UMOL/L		
eGFR	92		****	****		
	For patients of African descent, the reported eGFR must be multiplied by a correction factor of 1.21.					
	****		****	****		
URATE	267		120-400	UMOL/L		
SODIUM	138		135-146	MMOL/L		
POTASSIUM	4.3		3.5-5.2	MMOL/L		
CHLORIDE	99		95-108	MMOL/L		
HEMOGLOBIN A1C	0.059		0.040-0.060			
	NOTE HbA1C is best performed every 3 months in unstable diabetics and every 6 months in stable ones. More frequent testing is meaningless.					

This is Exhibit "E" referred to in the Affidavit of Joanne Polkiewicz, sworn June 21, 2018

Commissioner for Taking Affidavits (or as may be)

Medication Management System
Program Evaluation

Review of Service from:		To:	
Review completed by: (PAC members including RD)		Date:	

Brief Description of Program(Goals):	

Person Accountable for Program:	

NOTE: Complete the **Inspection Protocol : Medication** as part of this program evaluation and attach results.

	Criteria	Yes	No
1.	There is a multidisciplinary team which meets at least quarterly? (Professional Advisory Committee - PAC)		
2.	Minutes for these team meetings are documented including the results of reviews and improvements made?		
3.	The quarterly reviews consist of at least, drug utilization trends, utilization patterns in the home? (use of any drug or combination of drugs including psychotropic drugs)		
4.	There is evidence of quarterly reviews of all medication incidents and adverse drug reactions? These reviews identify changes to improve the system in accordance with evidence-based and prevailing practices?		
5.	Written policies and procedures are current and available?		
6.	All registered staff have been in-serviced on how to access policies on-line? (Corporate and Pharmacy Resource Center)		
7.	Does the facility participate in the Institute for Safe Medication Practices, Medication Safety Self-Assessment? **If so,** is there evidence that the results have been reviewed and acted upon?		

	Criteria	Yes	No
8.	Are all medication rooms kept: - clean & tidy? - locked or under supervision of registered staff at all times? - walls painted & in good repair? - signage appropriate?		
9.	Are all medication carts: - clean & tidy? - locked or under supervision of registered staff at all times? - in good repair?		
10.	All new employees undergo consistent baseline competence evaluation, including specific assessment criteria, before participating independently in the medication use process?		
11.	The method of ordering and re-ordering medication is efficient/effective?		
12.	Drugs are delivered in a safe & secure manner?		
13.	Infection control practices are followed when preparing and administering medications?		

Indicators to Review (over past year)

1	Results of monthly medication audits
2	Results of pharmacy audits and visit reports
3	Narcotic count records
4	In-service offered r/t medication system, safety practices/strategies to prevent errors
5	Monthly QI data
6	Results of inspections by MOH, MOL, PH

Summary of changes/improvements made over the past year with date of change
(storage, distribution, orientation/in-service program, data collection/reporting, documentation)

_____

_____

_____

_____

_____

_____

Program remains effective? Yes: No:

Areas for Improvement

_____

_____

_____

_____

Date results taken to CQI Committee: _____