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 TRACY RANEY

I, Tracy Raney, of the Township of Blandford-Blenheim, in the County of Oxford, 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 "Long-Term Care Homes Inquiry"). I have firsthand knowledge of the matters to which I hereinafter depose. Where I do not have firsthand knowledge, I have identified the source of my information and belief and believe it to be true.

2. I am a Registered Nurse ("RN"). I graduated from McMaster University in 1994 and received my registration from the College of Nurses in 1994.

3. I have been with Telfer Place for 28 years as of May 2018. Telfer Place offers three types of accommodation: seniors' apartments, retirement living, and long-term care. I have been a RN in Telfer Place's long-term care home for 22 years. The first six years of my career at Telfer Place, I worked in a nursing position in Telfer Place's retirement residence.

4. Telfer Place's long-term care home is on one floor and it has two hallways, Maple and Evergreen. We have 45 residents in long-term care.

5. When I first started working in long-term care at Telfer Place, I would work a variety of day, evening and night shifts. I now work full-time on the evening shifts and have done so for the last 10 or 11 years. The evening shift is 2 PM to 10 PM.

6. In or around 2015 – 2016, I was the only registered staff on duty during the evening shift. There would be two PSWs in each hallway on evenings, for a total of 4 PSWs on the evening shift. I believe Telfer Place may have also had a fifth PSW to help over the supper hour at that time. Now, on the evening shift, there is an RPN from 3:30 PM until 9:30 PM and there are four PSWs who work from 2:00 PM until 10:00 PM.

MY RESPONSIBILITIES IN 2015 - 2016

7. When I come in at 2 PM, I participate in the shift report. The RPN and RN who worked the day shift meet with me and the four PSWs who are working the evening shift. We review the 24-Hour Shift Reports which are kept in a book at the nursing station and we discuss what happened with the residents during the day. We go over items such as falls, hospital transfers, skin integrity issues, or pain monitoring, for example. Currently, the day shift RPN leaves at 1:30 PM, so she no longer participates in the shift report, but she participated in the shift reports in 2015-2016

8. After that, the PSWs go down their hallways and the RNs do the narcotic count. The outgoing RN is the person who writes in the white binder that we use for narcotic counts. She also verifies the count as we do it. There is a white binder for each hallway because

we have a medication cart for each hallway. Within each of the two medication carts, there is a locked narcotics box. Within the locked narcotics box, there is an additional little box with dividers for all of the residents that have been prescribed narcotics. Each resident has a narcotic card that is placed behind a divider with his or her name on it and the narcotic card also has the resident's prescription labels. For each resident, I take that week's narcotic package out of the box and I count the number of narcotics left in the package. The process takes 10 to 15 minutes and I repeat this process with the night shift's RN at the end of my evening shift.

9. To the best of my recollection, I cannot recall a situation when a narcotic went missing but sometimes we find that someone has forgotten to give a resident a narcotic. If this happens, the narcotic would still be in that resident's narcotic package during the narcotic count and the narcotic count numbers would be off.

10. For instance, if we are to give Tylenol Number 3 to someone 4 times a day then we would have received a package with 28 pills at the beginning of the week. If I was counting and there were 21 pills rather than 20 pills remaining in the package then I would know that the RN missed administering one of the pills .

11. Management would like us to check emails when we come on shift but I typically don't have time to do so before I start checking on our residents. Email topics sometimes include upcoming meetings or follow-up from management such as if, for example, I forgot to do an assessment. Sometimes, I also receive emails about different external programs that are being offered.

12. We track what has happened with residents on the 24 -Hour Shift Reports. There is one for each hallway. Typically, the PSWs will come to the RNs with their comments and then the RN will add it to the report sheet. I say to the PSWs that if they see me write it down then they know I have it and I won't forget it.

13. At the start of my shift, after the shift report and the narcotic count, I follow-up on any issues that were raised by the day RN at the shift report. For instance, if I was told that someone was not feeling well, I would go and check on him or her in order to establish a base line assessment. This way, when I check on them later, I am able track whether the resident is improving or requires further assessment.

14. If the PSWs need help, I will help them. Sometimes we are short on PSWs so, until a replacement comes in, I will help the other PSWs. As the team leader, it is an expectation that you will help.

15. I then log onto the medication cart computer to see what medications are ready to be given.

16. There used to be only one medication cart. I do not remember when we added the second medication cart. There is one medication room. The keys are exchanged between the RNs when we do the narcotic count. Typically I am the one who unlocks the cart to get the narcotics out to count and, once we finish the count, I lock the cart back up. In 2015, I think we had the medication computers (eMAR).

17. I have been at Telfer Place a long time so I am pretty efficient at doing the medication pass. In 2015-2016, I had to do both hallways so I would start at 16:00 and would usually

be done at 17:30. Now that there is an RPN working with me on the evening shift, we each take a medication cart and we each complete the medication pass on one of the two hallways.

18. In 2015 - 2016, the bedtime medication pass (at around 19:00) took approximately an hour or so.

19. To administer medications, I click on eMAR to see the required medications. In order to see resident alerts, we use Point Click Care.. On that system there are quick little notes to tell us things like if someone has had a fall or is in the hospital or if there have been new move-ins.

20. The information on Point Click Care can also include what the PSWs may have inputted. If someone has not had a bowel movement, for example, that will come up on Point Click Care's dashboard. From there, I look to see what that resident's orders are so I can know what I can give the resident to assist. Other things that come up on the dashboard include information regarding meal or fluid intake. A resident's meal intake will pop up if that resident has eaten poorly on six or more occasions within three days. The PSWs do the lion's share of personal care, and fluid and food intake recording.

21. We get other alerts on the Point Click Care dashboard if someone is experiencing pain. I am not sure if there must be one or multiple episodes of pain before the alert pops up on the dashboard. When I am alerted about a resident's pain, I will follow up with the PSWs to ask them when it happened and what they saw. I carry on with my assessment of that resident from there.

22. Typically management likes registered staff to try and be in the dining room during meals. The PSWs are required to be in the dining room. We have a large assist dining room and then another smaller dining room where less assistance is needed. The PSWs are in the large dining room. Most residents are in the large dining room. The dietary aide and PSWs help hand out meals and refreshments and the PSWs assist the residents to eat. If we are short a PSW, or I have time, I will go into the dining room and help.

23. I do all the pain assessments and oral health assessments for the RAI/MDS. This is a significant amount of work. I typically try to do this work over the supper hour, unless I have to be in the dining room. Every week, there are four or five residents that require their quarterly or annual pain assessments. The pain assessments must also be completed any time there is a change in a resident's pain symptoms. The oral health assessment only needs to be completed once per year per resident, unless there is a significant change.

24. I am typically very busy during my shift. At any time, I could get a call to go to a fall or address responsive behaviours. I typically don't take a break.

25. The BSO (Behavioural Supports Ontario) may see the residents for behaviours. If we have a concern we put in for a referral to the BSO. We have one person who works with behaviours in conjunction with the BSO that comes in. I think they have a meeting once a month.

26. I have noticed an increase in the number of residents with dementia over the years. This results in more responsive behaviours, especially on the evening shifts. This has

also resulted in more resident on resident abuse than I have ever seen in my 28 years of nursing. In addition, more residents require total assistance with all aspects of their care. This has resulted in significantly increased workload.

27. I typically start charting at supper but it's not uncommon for me to have to stay after the end of my shift to complete my charting. Depending on what has happened during the shift, I may have to stay an hour or two after my shift to complete my charting.

28. I also have to complete treatments and chart the treatment on the eTARs (Electronic Treatment Administration Records). There is a lot of barrier cream to administer. That can be done by the PSWs. I follow up with the PSWs to make sure that the treatments are being done.

29. If there are dressings to do then I do them.

30. After supper between 18:30 and 21:00 the pharmacy delivers medications. Right now we receive one week's worth of medications at a time. On Mondays, the residents' routine medications for the Maple hallway come in a big box and paper bags. On Tuesday, Evergreen hallway's medications are delivered for the week and they are also in a big box and in paper bags. Narcotics come in a plastic sealed bag that is off-white with big red tape sealed across it to hold it closed.

31. On any night, new medications may come in. The driver will stand until he sees someone come down the hallway. The driver has a form that says how many bags or boxes of medications he has and the driver and I both sign the form. Occasionally if a medication needs refrigeration it will come in a cooler bag.

32. The RN on the night shift is the one who typically logs the medications in the drug record book. If I'm looking for new medications such as a new antibiotic, however, I will go in and take them out of the bag and sign that I received it in the drug record book.

33. There have been a couple of times when narcotics have come in a bag that was not sealed. When that happens, we have to verify what is in the bag with the driver before he leaves.

34. No one watches us when we unseal the narcotics bag. For narcotics, there is a sheet that comes from the pharmacy that we sign and date. For instance, we sign and date that we have received Tylenol Number 3, 21 pills in the blister pack.

35. When narcotics are delivered, after I sign them in, I place them directly into the medication cart.

INSULIN

36. In 2015, everyone on insulin had their own box of cartridges. Now, they have their own box of pens. Outside the box, it has the name of the insulin and the resident's name. There is a peel-off label on the box. In terms of ordering insulin, we pull off the peel-off label and put it in the drug record book and fax it to the pharmacy.

37. We store the boxes of insulin in the fridge. Currently we have three fridges in the medication room. We have a fridge for the resident's supplements, water jugs, etc. We have another fridge for insulin and vaccines, and we have another fridge for specimens.

38. Day and evening shifts monitor the temperature of the fridges.

39. Depending upon where it is stored in the fridge, we may also write the resident's name on the box in order to see it better. When we do this, the label is still on the box.

40. Within the box, the cartridges come in what looks like a blister pack. You need to push a cartridge and take it out individually.

41. Each resident has his or her own pen, which is labelled with the resident's name. The label on the pen lists the order, including dosage. If a resident's orders changes, we put a green sticker on the pen as a flag.

42. Each cartridge has the name of the insulin on it. There is no way to individually put someone's name on the cartridge.

43. On the back of the cartridge we note date opened, because a cartridge can only be open for so long.

44. In 2015 each cartridge contained enough insulin for more than one dose. There would be at least 100 units. Most residents who took insulin were on a fixed dosage, but I think we may have had some residents on a sliding scale. We had one lady whose sugars were quite variable. So, depending upon her sugars, she may or may not get insulin. It depended on the doctor's orders.

45. The end of the pen twists. It starts out at zero. You turn the knob until you hit the number of units required (you dial it up) but that is only after you have primed the pen. There is maximum amount of insulin that the pen will dispense. A bit of insulin is wasted at the beginning when you have to put the needle in and prime it.

46. No one double checks the dose that you have drawn up. Nothing prevents you from drawing more, even if someone had checked the dose you had dialed up. No one watches while we administer insulin. The pen reverts back to zero once the insulin is administered.

47. I did not know that Telfer Place has a high alert medication policy. I have now seen the policy "High Alert/High Risk Medications – Independent Double Check". Attached hereto and marked as Exhibit "A" to my Affidavit are copies of the current and prior policies, which have been recently brought to my attention [Doc ID LTCI00025603] and [Doc ID LTCI00072540]. I know Telfer Place has had us review some policies, I just don't remember which ones they were.

48. I know how expensive the insulin is so I try to use everything that is in the cartridge then I get another cartridge. If there is not enough insulin in the pen to complete the dose, then the resident would be given two injections.

49. I dispose of the empty pens (previously cartridges) in the sharps container. I am not aware of any written policy used at Telfer that pertains to the disposal of insulin.

50. We have a policy regarding hypoglycemic and hyperglycemic reactions. Attached at Exhibit "B" is a copy of the current version of this document. [DOC ID LTCI00072551] In 2015-2016, I believe we had a slightly different document posted in the medication room.

51. We have a drug destruction bucket, which is kept in the medication room. I believe that the lid cannot be removed once it is snapped on. There is a small hole, with a screw-

on lid, that we put the medications through. We put a lot of medications in it. For instance, if someone refused to take medication or if the doctor came in and changed the strength of someone's pills, we would dispose of the pill that the resident refused to take or the old package of medication in the destruction bucket. I don't know if we put unopened or partially used insulin cartridges in the destruction bucket.

52. We do not count the insulin that is used, and we do not note if we have thrown a cartridge out. If we order something too soon, the pharmacy will say that it is too soon. I don't know if the pharmacy monitors insulin.

53. We cannot take apart the new pens. They are now disposable pens. Each box contains four or five disposable pens. Each pen has the resident's name on it as well as what the medication is and the direction for use. A resident may have more than one pen if he or she is on different types of insulin.

54. The mechanisms for giving the dose have not changed with the new disposable pens.

55. The medication cart has drawers which are locked. The medication cart is kept in the medication room, which is also locked. The top drawer is where we keep glucometers for blood sugar checks.

56. The next couple of drawers have the resident's medications. Each resident has his or her own box. The non-controlled medications are in individual plastic strips and they fit into those boxes. The insulin pens are in the resident's box or in an empty box beside it. Each box has the resident's room number on top of it as well.

THE USE OF AGENCY NURSES

57. We have had difficulty ensuring adequate staffing at Telfer Place. In particular, we have a hard time covering sick time and vacation time.

58. At any given time we typically have six RNs on staff. Two for day shifts, two for evening shifts and two for night shifts. We also have casual and part-time registered staff. This was the case in 2015-2016 and is still accurate today.

59. There are challenges in recruiting and retaining registered staff in long term care. The workload is very hard. It is mentally taxing. When working by yourself, it is physically taxing. Further, it is my understanding that hospitals pay more than long-term care.

60. I have had experience providing orientation to new agency staff. The agency staff member is provided a package of documents they have to read and sign.. We have a checklist that we use when providing orientation to agency staff. Orientation consists of both having the agency staff review Telfer Place policies and showing then around the facility. There is a lot of material to review. The challenge for new agency staff is that they do not know our residents or our routines.

61. I have looked at the Agency Staff Orientation Checklist – Reg. Staff signed by Elizabeth Wettlaufer. Sue Farley is the Registered Nurse who works my opposite shift on evenings. It appears that she oriented Elizabeth Wettlaufer. Attached hereto and marked as Exhibit "C" to this my Affidavit is a copy of the checklist [Doc ID LTCI00024849].

62. The orientation forms are now longer than they were when Elizabeth Wettlaufer was provided orientation. Attached hereto and marked as Exhibit "D" to my Affidavit is a

copy of Agency Checklist as of December 2016, which is the version we currently use for agency staff [Doc ID LTCI00072553].

63. Sometimes, I found with Agency nurses that they did not always report everything that happened on their shift. Further, the medication room was not always left the way I would leave it.

ELIZABETH WETTLAUFER

64. In 2015 and 2016, when Elizabeth Wettlaufer worked at Telfer Place, Dian Shannon as the Administrator and Sherri Toleff was the Director of Care until January of 2016. Michelle Cornelissen assumed the role of Director of Care in or around April of 2016. Lindsay Astley was the Assistant Director of Care. Management at that time had a tendency to micro manage the staff. They also strongly encouraged staff to report errors or inappropriate conduct by other staff members. For instance, they made it clear that if someone did something wrong and you knew about it and did not say anything you would be subject to the same discipline.

65. Abuse is taken very seriously. You would certainly report another staff member if you suspected abuse. Sometimes, it is difficult to identify whether or not something constitutes abuse. For example, someone may have been raising their voice to speak with someone who was hard of hearing and yet that could potentially be interpreted by someone else as yelling at that person.

66. I did raise concerns about Elizabeth Wettlaufer. I went to my Director of Care, Sherri Toleff, on more than one occasion to discuss Elizabeth Wettlaufer. I would talk to Sherri in person. She would not make any notes. She would just listen.

67. I recall that when I told Sherri Toleff about my concerns regarding Elizabeth Wettlaufer, she responded that she could not do anything about it as Elizabeth Wettlaufer was not one of her employees. I do not know if Sherri contacted the agency at which Elizabeth Wettlaufer worked to discuss these concerns. I do not know if she took any action, as she did not report back to me. I cannot recall how many times I spoke with Sherri Toleff about Elizabeth Wettlaufer, nor do I remember what concerns, in particular, I raised with Sherri Toleff. I also do not recall when I had these discussions.

68. I also sent emails to Sherri about Elizabeth Wettlaufer. I believe these emails were sent after I had spoken to Sherri in person. On one occasion, I recall that Elizabeth Wettlaufer left the medication door open and followed me down the hall. I spoke to her about the door and reminded her that it had to be kept closed. She did not say anything. I emailed Sherri Toleff about the incident on January 6, 2016. Attached hereto and marked as Exhibit "E" to this my Affidavit is a copy of the email [Doc ID LTCI00072536].

69. On January 10, 2016 I emailed Sherri Toleff and Lindsay Astley about other concerns I had about Elizabeth Wettlaufer. One issue was about a resident's toenail that had a bleed after his nail care. No information had been passed onto me about the incident at the shift report and Elizabeth Wettlaufer, who had been the nurse on staff on January 7, 2016, when the incident occurred, had not noted it in the 24-Hour Shift Report. While there was a notation in the resident's progress notes, which I believe had been entered

by the nail care company, there was nothing in the daily sheets or the ETAR to say there was any issue. If it were me, I would have put it in the ETAR for monitoring and raised it at the shift report. I would have also notified the family that there was a concern that we were monitoring. When the matter did come to my attention, I checked the patient and observed that the toenail had been healing properly.

70. In terms of the second issue referred to in my email of January 10, 2016, I could see in the progress note that Elizabeth Wettlaufer had called the family to report that the resident had experienced sleep apnea. The best practice is to also call the doctor. The resident could have been in pain or there may have been another cause for the apnea. Attached hereto and marked as Exhibit "F" to this my Affidavit is a copy of my email of January 10, 2016 [Doc ID LTCI00024212].

71. On February 7, 2016 I wrote to Lindsay Astley that the previous night Elizabeth Wettlaufer seemed to be on a mission to see if we were using another Agency. I did get an email from Lindsay Astley which said that she had passed on my concerns to Dan Relic, who was the Director of Care at that time. I would have appreciated getting some feedback that my concerns were being addressed or investigated. Attached hereto and marked as Exhibit "G" to this my Affidavit is a copy of my February 7, 2016 email [Doc ID LTCI00072536].

72. I never heard Elizabeth Wettlaufer make any inappropriate comments, but stories were relayed to me by the PSWs. I told the PSWs they should speak to Sherri Toleff directly.

73. I recall being told that Elizabeth Wettlaufer had told one of our elderly female residents how much she loved her and that because of the times now they could get married but

for their age difference. I think that comment was about Beth's sexual orientation. I believe I told Sherri Toleff about this comment. I do not remember hearing this comment first hand.

74. I did hear other stories as well. She had apparently made a comment to a PSW about putting Tic Tacs in her vagina or knowing someone who had. I did not report this comment to anyone.

75. Elizabeth Wettlaufer had also spoken to one of the male PSWs inappropriately. She had said she would pay him money so he could be her sperm donor. He was embarrassed and uncomfortable when he told me this story. I can't remember if I was there when she said it or if I just heard the story afterwards.

76. I understand that one of the PSWs did speak to management about Elizabeth Wettlaufer. I don't know what it was about or when this occurred, but believe it was shortly before Elizabeth Wettlaufer's last shift.. Elizabeth Wettlaufer spoke to me and she was very angry. She didn't know who had complained about her but when she was speaking about it to me she looked very angry. Something had changed in her eyes when she was talking about it.

77. Management leaves the building between 4:00 PM and 5:00 PM. Management is typically not present on the weekends. Management would be on call.

78. I would call the on-call manager if we had a sick call on evenings and I couldn't cover it and didn't know what to do next. I would also call if there were building concerns, or if

there was a patient altercation. On two or three instances, I have had to call the on-call manager to report resident abuse.

79. I might also call management if a family member was really upset about something.

80. Once management leaves the building, the Registered Nurse is responsible for the residents and the building.

81. I do recall one of the PSWs asking me if they could call the Manager on call if they had concerns about agency staff. I do not know, however, if this was about Elizabeth Wettlaufer. I do not recall which PSW it was. I did tell Sherri Toleff about this discussion with the PSW, but I cannot recall when this occurred.

82. I had no reason to believe that Elizabeth Wettlaufer had any alcohol or drug addiction problems. I only learned that Elizabeth Wettlaufer was a recovering alcoholic when the offences came to light. I had no reason to believe that she suffered from any mental health issues. During the interactions I had with her, she seemed really jovial. There was never a time that I thought she was under the influence of drugs or alcohol. At no time did I think she would be capable of intentionally harming a patient. I was completely shocked when her crimes came to light.

83. I swear this affidavit for no improper purpose.

SWORN BEFORE ME at the City of St. Thomas, in the County of Elgin on June 25th, 2018

Commissioner for Taking Affidavits
(or as may be)

This is Exhibit "A" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

SECTION:	**Medication / Treatment Standards**	**INDEX:**	LTC-F-30
SUBJECT:	High Alert/High Risk Medications – Independent Double Check	**PAGE:**	1 of 3
APPROVED BY:	VP, Clinical Services and Quality	**Effective Date:** Feb. 2012 **Revised Date:** May 2013	

STANDARD

To ensure Resident safety, a process will be in place for identifying and administering high-alert medications.

Where possible, the Nurse will seek an independent double check before administering high alert/high risk medications.

PURPOSE

Residents' safety will be maintained through heightened awareness of high alert medications.

Definitions

High-Alert Medications are drugs that bear a heightened risk of causing significant Resident harm when they are used in error.

Independent Double Checks:

i. Is doing an independent double check by two (2) nurses on the same medication prior to administration; or

ii. If the medication has been prepared in unit dose and dispensed by a pharmacist, this is considered the first check, then the Nurse checking the same medication prior to administration is considered a second independent check; or

iii. If none of the previous situations are possible, the Nurse will prepare the medication, go away to do a different task and return 5-10 minutes later to do a second independent check on the same medication prior to administration.

iv. If none of the circumstances above are possible due to the use of a stat/emergency medication requirement by a Resident, the Nurse will use critical judgment in checking that medication.

NATIONAL OPERATING PROCEDURE

1. The Home will display the Institute for Safe Medication Practices: ISMP's List of High-Alert Medications.

Note: Manual independent double-checks is not always the optimal error-reduction strategy and may not be practical for all of the medications on the list. Source: Institute for Safe Medication Practices: ISMP's List of High-Alert Medications 2012

2. Residents on high-alert medications will be identified in the Home.
3. Following is a list of High Alert Medications commonly used in the long term care or geriatric setting:
    - Hypoglycemics, including oral hypoglycemics and insulin products;
    - Antithrombotic agents (anticoagulants);
    - Narcotics / Opiates;
    - Cytotoxic agents;
    - Methotrexate (oral, non-oncologic use);
    - Digoxin;
    - Potassium Chloride.
4. The Home will limit the availability of heparin products and will remove high-dose formats of unfractionated heparin products (50,000 unit total drug quantity).
5. The Home will not store concentrated electrolytes including but not limited to potassium chloride, potassium phosphate and sodium chloride>0.9%.

STANDARD OPERATING PROCEDURE (province specific)

QUALITY MANAGEMENT

All clinical programs have a Quality Management component that includes outcome indicator tracking as well as CQI audit tools to monitor outcomes and identify opportunities for Quality Improvement. Medication Audit Monthly Narcotic Count Audit

EDUCATION/RESOURCES

A comprehensive education program is available. Education

SECTION:	**Medication / Treatment Standards**	**INDEX:**	LTC-F-30
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OUTCOME

Precautions will be taken so that risk of incidents associated with high-alert medication administration will be minimized.

BIBLIOGRAPHY

Institute for Safe Medication Practices: ISMP's List of High-Alert Medications 2012

PROCEDURE			revera
MANUAL:	Care	INDEX:	CARE13-030.04
SECTION:	Medication	EFFECTIVE DATE:	August 31, 2016
DESCRIPTION:	LTC - High Alert Medications	REVIEWED DATE:	July 31, 2016
APPROVED BY:	Wendy Gilmour SVP, LTC	MODIFIED DATE:	

POLICY

LTC - Medication Risk Management

PROCEDURE

Residents' safety will be maintained through heightened awareness of high-alert medications.

- ☐ The Home will display the ISMP's List of High-Alert Medications.

> Alberta Specific:
> i. AHS Policy #PS-46 – Management of High-Alert Medications
> ii. AHS Procedure #PS-46-01 – Management of High-Alert Medications
> iii. AHS - Provincial High-alert Medication List

- ☐ Residents on high-alert medications will be identified in the Home.
- ☐ Following is a list of high-alert medications commonly used in the long term care or geriatric setting:
  - Hypoglycemics, including oral hypoglycemics and insulin products
  - Antithrombotic agents (anticoagulants)
  - Narcotics / Opiates
  - Cytotoxic agents
  - Methotrexate (oral, non-oncologic use)
  - Digoxin
  - Potassium Chloride
- ☐ The Home will limit the availability of heparin products and will remove high-dose formats of unfractionated heparin products (50,000-unit total drug quantity).
- ☐ The Home will not store concentrated electrolytes including but not limited to, potassium chloride, potassium phosphate and sodium chloride >0.9%.
- ☐ Independent double checks will be conducted by the Nurse for the following criteria:
  - Unusual or high dose narcotic order
  - All new high alert medication orders
  - High alert mediations that need reconstitution /mixing/calculations
  - New or high dose PRN narcotics
  - Whenever an insulin vial has been changed in an insulin pen
  - Whenever an insulin (in a vial) order has been changed
  - Whenever the Nurse is unfamiliar with the medication, and it is the first dose preparation
- ☐ The first Nurse will calculate the required dose, and then ask a second Nurse to perform the independent double check; does not share the calculated answer with the second Nurse.
- ☐ A second Nurse will perform the independent double check by starting from a different vantage point, without any advance knowledge of what findings to expect.

- ☐ If the medication has been prepared in unit dose and dispensed by a Pharmacist, this is considered the first check, then the Nurse checking the same medication before administration is considered a second independent check.
- ☐ If an independent double check is not possible, the Nurse will prepare the medication and then repeat the steps to ensure right medication and dose will be administered to the Resident.

Independent Double-Checks Scenarios:

- An independent double-check is done by two Nurses on the same medication before administering.
- If the medication has been prepared in unit dose and dispensed by a pharmacist, this is considered the first check, then the Nurse checking the same medication before administration is considered a second independent check.
- If none of the previous situations are possible, the Nurse will prepare the medication, go away to do a different task and return 5-10 minutes later to do a second independent check on the same medication before administering.
- If none of the circumstances above are possible due to the use of a stat/emergency medication requirement by a Resident, the Nurse will use critical judgment in checking that medication.

NOTE: A manual independent double-check is not always the optimal error-reduction strategy and may not be practical for all medications on the list. Source: Institute for Safe Medication Practices (ISMP)'s List of High-Alert Medications.

TOOLS

1. LTC - ISMP's List of High-Alert Medications
2. LTC - AHS Policy #PS-46 – Management of High-Alert Medications
3. LTC - AHS Procedure #PS-46-01 – Management of High-Alert Medications
4. LTC - AHS – Provincial High-alert Medications List

REFERENCES

i. Institute for Safe Medication Practices Canada © January 2005. Adapted with permission from: Institute for Safe Medication Practices (US). The virtues of independent double-checks – they really are worth your time! ISMP Safety Alert. 2003 March 6;8(5):

ii. Institute for Safe Medication Practices: ISMP's List of High-Alert Medications 2008

This is Exhibit "B" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

CHANGINGlife WITHDIABETES

Hypoglycemia (Low Blood Glucose)

Causes: Too little food or skipping a meal; too much insulin or diabetes pills; more active than usual.

Onset: Often sudden.

Some Symptoms:


SHAKY


FAST HEARTBEAT


SWEATING

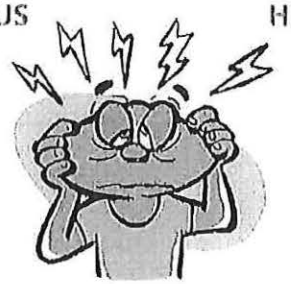

DIZZY

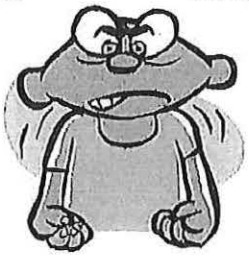

ANXIOUS


HUNGRY


BLURRY VISION


WEAKNESS OR FATIGUE

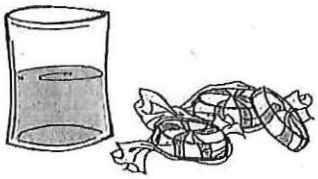

HEADACHE


IRRITABLE

IF LOW BLOOD GLUCOSE IS LEFT UNTREATED, YOU MAY PASS OUT AND NEED MEDICAL HELP.

What Can You Do?

CHECK your blood glucose, right away. If you can't check, treat anyway.



TREAT by eating 3 to 4 glucose tablets or 3 to 5 hard candies you can chew quickly (such as peppermints), or by drinking 4-ounces of fruit juice, or 1/2 can of regular soda pop.

CHECK your blood glucose again after 15 minutes. If it is still low, treat again. If symptoms don't stop, call your healthcare provider.

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

Concept developed by Rhonda Rogers, RN, BSN, CDE

 126379R ChangingDiabetes-us.com 6/2006

novo nordisk®

CHANGINGlife WITHDIABETES

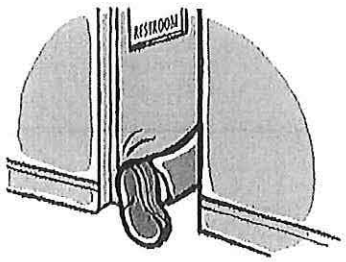
Hyperglycemia (High Blood Glucose)

Causes: Too much food, too little insulin or diabetes pills, illness, or stress.

Onset: Often starts slowly.

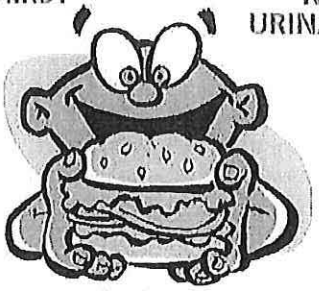
Some Symptoms:

EXTREME THIRST



NEED TO URINATE OFTEN

DRY SKIN



HUNGRY

BLURRY VISION

DROWSY

SLOW HEALING WOUNDS

HIGH BLOOD GLUCOSE MAY LEAD TO A MEDICAL EMERGENCY IF NOT TREATED.

What Can You Do?

CHECK BLOOD GLUCOSE

If your blood glucose levels are higher than your goal for three days and you don't know why,

CALL YOUR HEALTHCARE PROVIDER

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

Concept developed by Rhonda Rogers, RN, BSN, CDE

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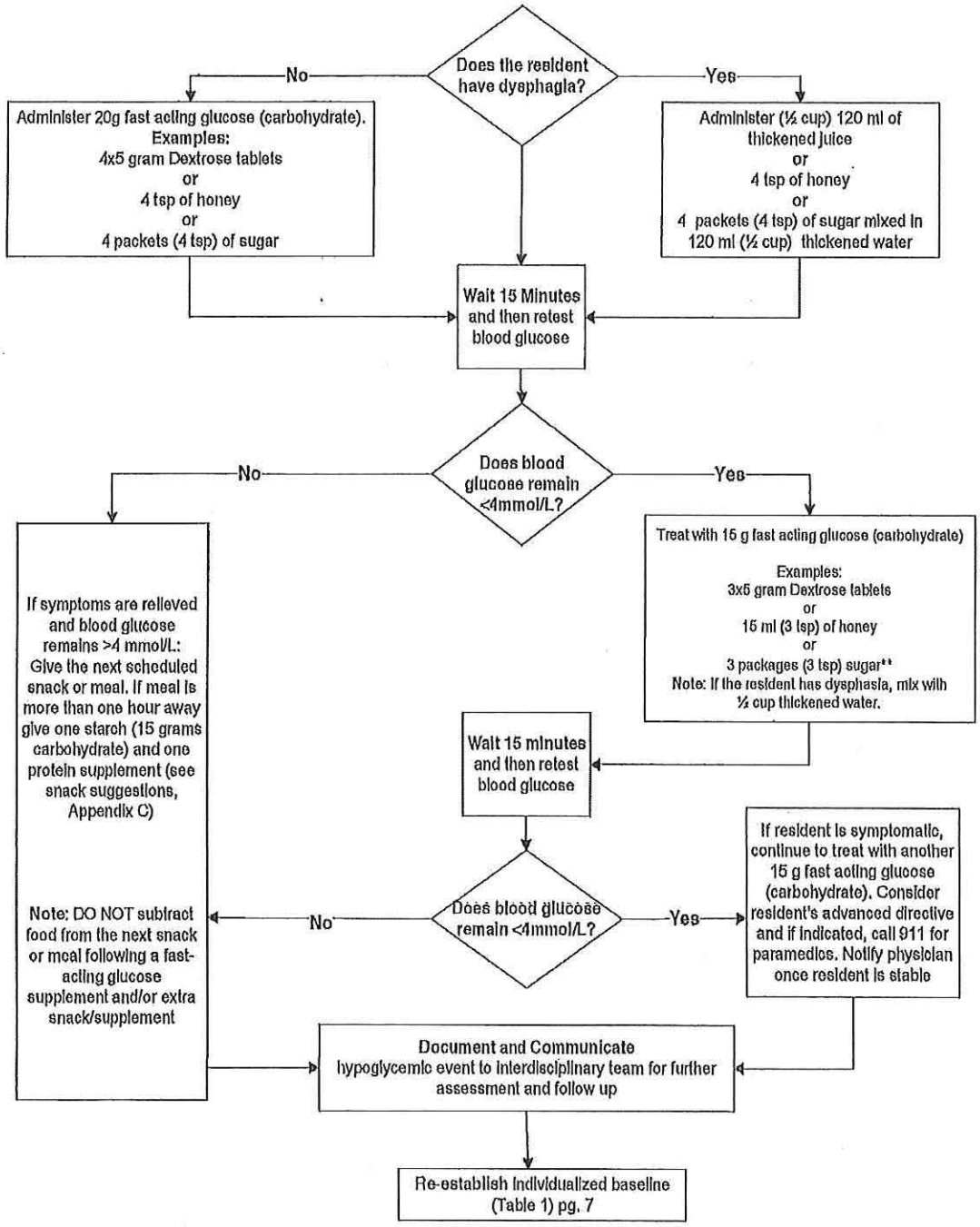
TREATMENT of HYPOGLYCEMIA (blood glucose < 4mmol/L)
CONSCIOUS RESIDENT

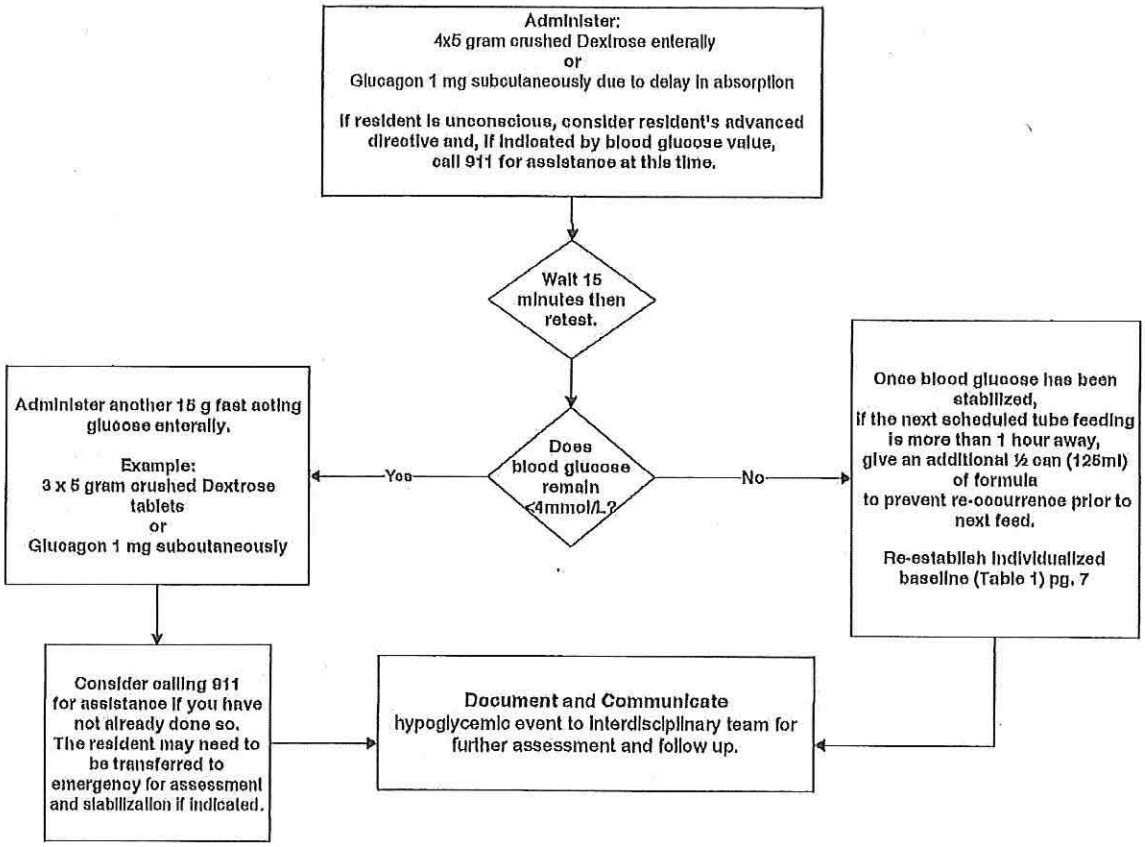
NOTE: Treatment for hypoglycemia should not be delayed. Resident treatment precedes informing the physician and documentation



**Note: Use Dextrose tablets or honey to treat hypoglycemia in residents taking Acarbose (Prandase) as this medication interferes with the absorption of sucrose

TREATMENT of HYPOGLYCEMIA (blood glucose < 4mmol/L)
CONCIOUS or UNCONCIOUS RESIDENT
WITH Enteral Feeds

NOTE: Treatment for hypoglycemia should not be delayed. Resident treatment precedes informing the physician and documentation .

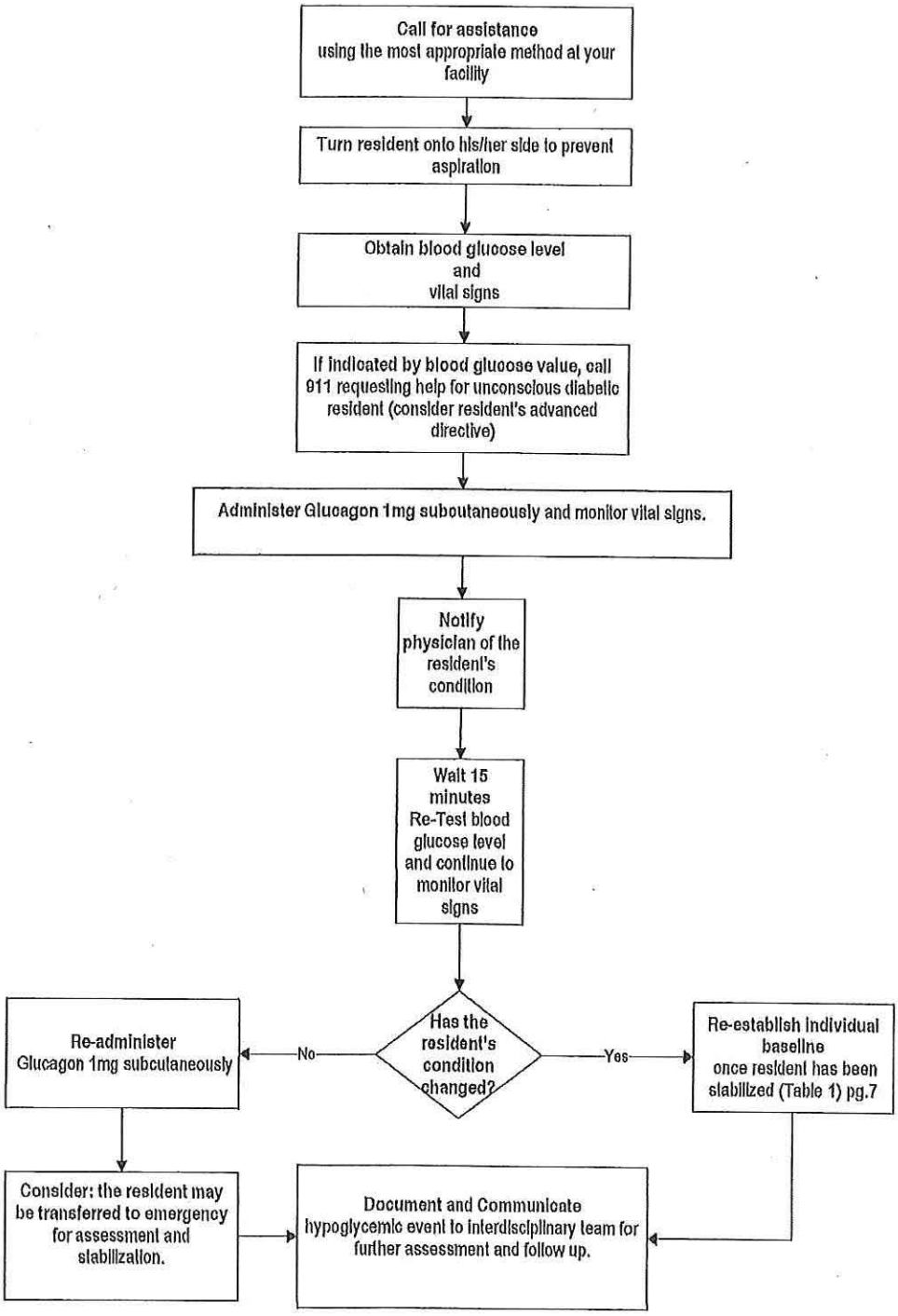


Note:
Diabetics on enteral feeds require special IDT attention.

Adapted from: Alberta Health Services: Clinical Practice Guidelines for Residents with Diabetes in Long Term Care

TREATMENT of HYPOGLYCEMIA (blood glucose < 4mmol/L)
UNCONSCIOUS RESIDENT

NOTE: Treatment for hypoglycemia should not be delayed. Resident treatment precedes informing the physician and documentation



Adapted from: Alberta Health Services: Clinical Practice Guidelines for Residents with Diabetes in Long Term Care

POSSIBLE SIGNS & SYMPTOMS OF HYPOGLYCEMIA

Physical	Neurological
Trembling Palpitations Sweating Anxiety, Irritability Hunger Nausea Tingling Pallor	Difficulty concentrating Confusion Delirium Weakness (falls, decreased transfer ability, position in chair) Drowsiness Difficulty speaking Headaches Vision changes Dizziness – falls Tiredness – falls

A hyperglycemic emergency may be considered if the following signs and symptoms are present. This may require clinical management in an emergency setting:

Hyperosmolar State*	**Diabetic Ketoacidosis****
Agitation, confusion	Agitation, confusion
Fatigue	Fatigue
Glucose and ketones positive in urine	Glucose and ketones positive in urine
Polydypsia (Increased thirst)	Polydypsia (Increased thirst)
Polyuria (Increased urine)	Polyuria (Increased urine)
Tachycardia	Tachycardia
Weight loss	Weight loss
Grossly elevated blood glucose >34 mmol/L	**Elevated blood glucose >12 mmol/L**
	Sweet odor to the breath
**more common in Type 2 Diabetes*	***more common in Type 1 Diabetes*

Adapted from: Alberta Health Services: Clinical Practice Guidelines for Residents with Diabetes in Long Term Care

This is Exhibit "C" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

AGENCY STAFF ORIENTATION CHECKLIST – REG. STAFF

DOC to review checklist with agency staff each time new agency staff comes into the home.

		Agency initial	DOC initial
INTRODUCTIONS	Tour of the building		
REPORTING:	Introduce agency to: ▪ all staff who report to agency nurse	BW	DF
	Identification of residents	BW	DF
	24 Hour Report – Shift Report	BW	DF
	How to complete Report to ED (if applicable)		
	Giving and receiving report from HCAs	BW	DF
	Doctor On-Call	BW	DF
	Date Lab comes in - Check for blood work orders & FBS	BW	DF
	Unit Calendar/ reference materials	BW	DF
	▪		
	Care Assessments/Change in Condition process…	BW	DF
	Emergency Response	BW	DF
TEAM RESPONSIBLITIES:	Job routines as per manual ▪ Nightly checks ▪ All residents must be accounted for	BW	DF
	PCA/PSW/HCA Assignments / time schedules	BW	DF
	Food Services ▪ Highlight special services (as applicable)	BW	DF
	Staff Replacement – ▪ location of time sheets ▪ call-in list/ procedure ▪ absence reports	BW	DF
		BW	DF
LOCATION OF:	Long Term Care Services Manual	BW	DF
	Fire & Emergency Plan Manual	BW	DF
	Pharmacy Manual	BW	DF
	Nursing Supplies	BW	DF
	Telephone Numbers/ phone system ▪ Numbers for on call manager ▪ Environmental Manager	BW	DF
	Other:		
MEDICATION:	Med Room & Treatment Supplies	BW	DF
	Sign master signature list	BW	DF
	First Aid	BW	DF
	Equipment for Vital Signs	BW	DF
	Review medication system: ▪ time of med passes	BW	DF

		Agency initial	DOC initial
	▪ list of diabetics ▪ emergency drug supply	BW BW	DF DF
	MARS and Quarterly Med Review		
	Narcotic Count	BW	DF
	Individual Narcotic Record	BW	DF
	PRN Medication and documentation	BW	DF
	Ordering and receiving medication from Pharmacy		
	Drug re-order book	BW	DF
KEYS	Review keys on ring: ▪ include food service dept. keys	BW	DF
RESIDENT CHART & DOCUMENTATION:	Resident Charts / Care Plans	BW	DF
	Advanced care directives ▪ Emergency contact ▪ Phone numbers	BW	DF
	PSW/HCA/ Documentation Records	BW	DF
	Admission /Discharge Procedure	BW	DF
	Procedure when a resident dies	BW	DF
	Incident Report (resident or staff)	BW	DF
	Transfer Sheet		
	Appointments		
	SALT/Mechanical Lifts Program overview (if applicable)		
SAFETY:	Fire Procedures: ▪ Fire Panel ▪ Alarm Systems	BW	DF
	Emergency Preparedness		
	Resident Non-Abuse Policy		
	Security Checks		
	Door Alarm Systems and all exits to the building	BW	DF
	Telephone & Intercom systems		
	Maintenance Requisition Book	BW	DF
	Care of aggressive residents		
	Emergency codes – review ▪ Missing person – code yellow ▪ Priority Code	BW	DF
	Wanderer's Checklist		
	Least Restraint Policy		
	Smoking policy		
	Hazardous waste disposal		

		Agency initial	DOC initial
OTHER:	Overview of Privacy policy		

Print Agency Staff's Name: Bethe Wettlaufer

Name of the Agency: Life Guard Homecare

Home's Charge Nurse Signature/ Person Orientating: A Farley RN
Date: Feb 15/15

Agency Staff's Signature: Bethe Wettlaufer
Date: Feb 15/15

This is Exhibit "D" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

Part 2 - Role/Discipline Specific Onboarding Checklist

revera

Agency Registered Staff

HR-F-05-15 August 2010
Revised Dec 2016

Employee Name:	Date of Hire:

TOPIC	LEARNING RESOURCES	EMPLOYEE INITIAL	MENTOR/COACH SIGNATURE	DATE
HEALTH & SAFETY				
☐ Provincial Regulations ☐ Hazards in the LTC setting ☐ WSIB ☐ First Aid Station ☐ Eye Wash Station	**Health and Safety Manual**			
EMERGENCY PREPAREDNESS				
☐ Fire Plan ☐ Emergency contact numbers ☐ Roles & Responsibilities ☐ All code testing	**Review roles location of plan and numbers Fire system**			
REGULATORY AGENCIES				
☐ Regional Health Authorities (BC/AB/MB) ☐ Ministry of Health ☐ Health & Safety Enforcement Agencies ☐ Ministry of Labour ☐ Provincial Fire Regulations ☐ Provincial Public Health Agencies ☐ Accreditation - CARF ☐ Regulatory Provincial Bodies ☐ Professional Organizations	Overview			
Quality of Life				
☐ Person Centered Care Approach ☐ Resident's Bill of Rights ☐ Informed Consent to Treatment ☐ Supporting Spiritual and Religious ☐ Social Leave of Absence ☐ Management of Personal Belongings ☐ Promoting Quality of Life	**Care Section 15 Philosophy**			
INFORMATION MANAGEMENT AND TECHNOLOGY				
Password Management				
Revera VPN-My Quality Reporting				
Point Click Care ☐ (POC/eMAR/eTAR) ☐ Point Click Care ☐ Risk Management Module (RMM) ☐ Resident Chart	**Clinical Informatics Overview**			

Part 2 - Role/Discipline Specific Onboarding Checklist

revera

Agency Registered Staff

HR-F-05-15 August 2010
Revised Dec 2016

TOPIC	LEARNING RESOURCES	EMPLOYEE INITIAL	MENTOR/COACH SIGNATURE	DATE
Tour of Facility				
Introduction to key staff i.e. ED, DOC, ADOC, Charge Nurse, Clinical Manager, Environmental Manager, etc.				
RISK MANAGEMENT				
Quality and Risk Section C ☐ Adverse Event Policy	**Legal 3 Revera Adverse Event Policy** **Legal 3 Appendix A Adverse Event Algorithm**			
Complaints Management ☐ Client Service Response	**Administration Manual-Admin3 Location of forms**			
STAFF TRAINING AND EDUCATION				
☐ Orientation Toolkit ☐ Annual mandatory In-services ☐ SURGE Learning ☐ Clinical Program education and implementation ☐ PEPID	**Overview**			
Registered staff Responsibilities				
Move In, Discharge and Transfer				
☐ Management of Move-In, Discharge and Transfer (ENT)	**Administration Manual-Admin 8** Home process location of forms			
Safety and Security				
☐ Maintaining a Safe and Secure Environment (ENT) ☐ Hot weather ☐ Smoking ☐ Visitor Access ☐ Video surveillance ☐ Power mobility	**Admin Section 10**			
NON-ABUSE				
☐ Mandatory Reporting of Abuse or Neglect ☐ Investigation of Abuse or Neglect ☐ Disciplinary Action of Abuse or	**Administration Manual-Admin 1**			

TOPIC	LEARNING RESOURCES	EMPLOYEE INITIAL	MENTOR/COACH SIGNATURE	DATE
Neglect ☐ Interventions for Victims of Abuse or Neglect ☐ Resident Non-Abuse Analysis and Education ☐ Resident Non-Abuse Program				
Ethics				
☐ Ethics Consultation Process ☐ Ethics Consultation Process (AB) ☐ Ethical Decision Making Framework ☐ Ethics Program	**Administration Manual-admin6**			
Medical and Professional Services				
☐ Medical and Professional Services ☐ Contacting physicians/NP ☐ On call lists	**Admin Section 2**			
Auxiliary Services: ☐ Diagnostic ☐ Laboratory ☐ Dental ☐ Podiatry / Foot care ☐ Optometry ☐ Audiology ☐ Speech therapy ☐ Respiratory / Oxygen therapy ☐ Physiotherapy ☐ Occupational therapy ☐ Enterostomal nurse ☐ Psychogeriatric Support ☐ Hair Dresser/Barber ☐ Pastoral Care ☐ Transportation/Transfer ☐ Ambulance/Emergency	**Home specific and location of referral forms and process**			
NURSING COMMUNICATION				
24 Hour Unit/RHA Report	**Electronic PCC**			
Shift to Shift Report				
PCC Dashboard				
Bulletin Boards				
Committee Meetings as Required:				

Part 2 - Role/Discipline Specific Onboarding Checklist

revera

Agency Registered Staff

TOPIC	LEARNING RESOURCES	EMPLOYEE INITIAL	MENTOR/COACH SIGNATURE	DATE
☐ Interdisciplinary Resident Focused Meeting ☐ Admission/Annual Resident Care Conference ☐ UCP/Nursing staff meetings ☐ Huddles	**Overview**			
Staffing:				
☐ Scheduling ☐ Replacement ☐ Location of time sheets ☐ Call in list/procedure ☐ Use of agency staff/when to call agency staff ☐ Absence reports ☐ Staff contingency plan	**Home process and location of forms**			
DOCUMENTATION (TOOLS)				
SOAP Documentation				
IDC Schedule				
Assessment and Care Planning ☐ Approval for Admission ☐ Move-in Assessment Process ☐ Admission Checklist ☐ Return Assessment from Hospital, Healthcare Centre ☐ Move in Assessment-Short-Stay-Respite ☐ RAI-MDS 2.0 Assessment Process ☐ Resident Quarterly and Annual Assessments ☐ Care Conferences ☐ Physician-NP Assessment ☐ External Consultation ☐ Resident Assessment and Plan of Care	**Care Section 1**			
Health Records & Documentation ☐ Health Records Interdisciplinary Documentation (ENT)	**Admin Section 4**			
CLINICAL PROGRAMS				
Resident Hygiene	**Care 14 Personal Care**			
Skin & Wound Care Program	**Care Section 12**			

Part 2 - Role/Discipline Specific Onboarding Checklist

revera

Agency Registered Staff

TOPIC	LEARNING RESOURCES	EMPLOYEE INITIAL	MENTOR/COACH SIGNATURE	DATE
	Clinical Resource Guide for Skin and Wound Care			
Restorative Care	Care Section 11			
Falls Prevention and Injury Reduction Care5 ☐ Fall Prevention and Injury Reduction Program (ENT)	Care Section 5			
Resident Safe Handling ☐ Safe Resident Handling Program (ENT)	Care Section 6			
Continence Care Program	Care Section			
Pain Management Care8 ☐ Pain Assessment and Symptom Management Program (ENT)	Care Section 8			
Infection Control Program ☐ Prevention/Routine Precautions ☐ TB Screening Process ☐ Immunizations Residents & Staff ☐ Specimen Collection ☐ Equipment Cleaning/Disinfection/ Environmental Cleaning ☐ Surveillance/Line Listing ☐ Hand hygiene PPEs (Gloves, gowns, masks, facial) ☐ Isolation Procedures ☐ Infection Control Nurse and Committee ☐ Outbreak Management and Team ☐ Pandemic Planning and Supplies ☐ Regulatory Body Reporting ☐ Online Outbreak Reporting	Infection Prevention and Control Manual			
Nutrition and Hydration ☐ Nutrition and Hydration Program (ENT)	Care Section 7			
Dementia Care ☐ Dementia Care Program (ENT)	Care Section 3			
End of Life Program	Care Section 4			

Part 2 - Role/Discipline Specific Onboarding Checklist

revera

Agency Registered Staff

TOPIC	LEARNING RESOURCES	EMPLOYEE INITIAL	MENTOR/COACH SIGNATURE	DATE
☐ End of Life Care (ENT)				
Medication ☐ Medication Administration	**Care Section 13**			
Resident Safety Program ☐ Least Restraint Program ☐ Emergency Restraint Use ☐ Personal Assistive Service Device ☐ Bed Rails and Entrapment ☐ Safety Rounds ☐ Resident Safety	**Care Section 10**			
OTHER				
☐ Recreation ☐ Housekeeping/Laundry ☐ Maintenance	**Overview of other departments**			

I have been orientated to all that is signed off by signature / initial, as indicated on checklist and have had an opportunity for my questions to be answered.

Sign-offs:

Employee Signature: _____ Date Completed: _____

Director of Care Signature: _____ Date: _____

Executive Director: _____ Date: _____

This is Exhibit "E" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

RE: Agency staff

Sherri Toleff

Sent: Wednesday, January 06, 2016 1:55 PM

To: Tracy Raney

I will follow up, thank you!

Thanks,

Sherri Toleff RN
Director of Care, LTC

Telfer Place
245 Grand River St N, Paris ON N3L 3V8
Direct 519-442-4411 Fax 519-442-6724
sherri.toleff@reveraliving.com
www.reveraliving.com

Respect | Integrity | Compassion | Excellence

From: Tracy Raney
Sent: Wednesday, January 06, 2016 1:31 AM
To: Sherri Toleff
Subject: Agency staff

HI Sherri--Despite the signs on the door, Beth continues to leave the med room door and chart room door wide open and walks away, far away down the hall. Noted on the last night shift that she followed me. Thought you should know. Thanks--Tracy

RE: Agency staff

Lindsay Astley

Sent: Monday, February 08, 2016 6:17 AM

To: Tracy Raney

Hi Tracy,

Thank you, I have passed your concerns on to Dan.

Thanks,

Lindsay Astley

Associate Director of Care/Restorative Care Coordinator- LTC

Telfer Place Seniors' Community

245 Grand River Street North

Paris, ON N3L 3V8

519-442-4411 Fax 519-442-6724

lindsay.astley@reveraliving.com

www.reveraliving.com

Respect | Integrity | Compassion | Excellence

From: Tracy Raney
Sent: February 7, 2016 11:56 PM
To: Lindsay Astley
Subject: Agency staff

Hi Lindsay--I have some concerns in regards to the new Agency RN that worked this weekend. She did not give out all the narcotics, she put feed into the water bag of [D.] levity, she did not complete dressings ie. [M.V.] which did not have a dressing on at all for Saturday until I came on and put it on, other meds were missed. I am past frustrated with these Agency girls, they seem to only want to do the bare minimum and nothing else. Last night Bethe from Lifegard was on a mission trying to find out the name of the other Agency that we are using because Heidi thinks they are underbidding her. I don't want to be dragged into that. Many thanks--Tracy

This is Exhibit "F" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

Agency

Tracy Raney

Sent: Sunday, January 10, 2016 11:06 PM

To: Sherri Toleff

Cc: Lindsay Astley; Tracy Raney

Hi ladies--I have some concerns in regards to Beth from the Agency. I am not sure of the role they are supposed to take in LTC. Beth does not always relay important information to Dr.s and to other Registered staff. I had a nurse from Jenuine Care call tonight to ask how [redacted]'s toe was after nail care because there had been a bleed post care on January 7th. No information had been passed onto me the next shift, she did not chart on it nor write it in the report book. Therefore for 3 days it has not been assessed until the foot care nurse called to inquire how it was doing. The other issue I have is that on January 7th she addressed that [redacted] had apnea and that she called the family but did not call the Dr. When I called the Dr. he came in, changed her status to palliative and initiated all the necessary drug changes in regards to palliation status. Yet she apparently did not feel a need to inform the Dr. herself. Unsure what to think about these issues. Thanks--Tracy

This is Exhibit "G" referred to in the Affidavit of Tracy Raney, sworn June 25, 2018

Commissioner for Taking Affidavits (or as may be)

RE: Agency staff

Sherri Toleff

Sent: Wednesday, January 06, 2016 1:55 PM

To: Tracy Raney

I will follow up, thank you!

Thanks,

Sherri Toleff RN
Director of Care, LTC

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Respect | Integrity | Compassion | Excellence

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From: Tracy Raney
Sent: February 7, 2016 11:56 PM
To: Lindsay Astley
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