Office of the Auditor General: Reports on Investigations into Long-Term Care Homes, Tabled at Audit Committee – April 30, 2018

Office of the Auditor General

April 30, 2018

Mayor, Members of Audit Committee and Council,

I am pleased to provide our reports on investigations into long-term care homes carried out by the Office of the Auditor General of the City of Ottawa.

This report includes an executive summary for each of the investigations conducted.

Respectfully,

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Auditor General

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Review of Medication Management at Long-Term Care Homes

Executive summary

Purpose

The Review of Medication Management at City of Ottawa Long-Term Care Homes (LTC Homes) is a special project that was initiated by the Office of the Auditor General (OAG) in May 2017. This review was conducted in response to concerns raised through the City of Ottawa's Fraud and Waste Hotline in 2017.

Background and rationale

The City of Ottawa (City) is committed to providing quality long-term home care to seniors who can no longer live independently in their own homes. The City operates four LTC Homes located throughout the City that provide a range of services and programs designed for the well-being of all residents. Each of the City's LTC Homes is managed by an administrator who is accountable to the City's Director of Long-Term Care Services. The LTC Homes are governed by the Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation 79/10 (Regulation) (hereinafter referred to as the LTCHA and Regulation, respectively). The LTCHA came into force on July 1, 2010. Since that time, there have been a series of amendments to the LTCHA and the Regulation. To meet the requirements of the LTCHA and Regulation, each LTC Home must have written policies and protocols to ensure the accurate acquisition, dispensing, receipt, storage, administration, as well as destruction and disposal of all drugs used in the LTC Home.

The LTC Homes are funded by the City of Ottawa, the Ontario Ministry of Health and Long-Term Care, as well as resident fees set by the Province. Persons with limited income are eligible for a subsidy to reduce their accommodation rate. The four LTC Homes operated by the City of Ottawa are Garry J. Armstrong, Peter D. Clark, Centre d'accueil Champlain and Carleton Lodge.

This review is a special project that was initiated after the City's Fraud and Waste Hotline received a report regarding the medication management practices at one of the City's LTC Homes. In response to the complaint, the OAG is conducting a review of

medication management at two LTC Homes, Garry J. Armstrong Home and Peter D. Clark Long-Term Care Home.

Objectives and criteria

The overall objective of this review is to determine whether LTC Homes, operated by the City, have appropriate practices, procedures and controls in place to ensure the accurate acquisition, receipt, dispensing, storage, administration, as well as destruction and disposal of medication in accordance with the LTCHA and Regulation. In developing the criteria, we referred to the LTCHA, the Regulation and the City's policies and procedures. The review objectives were as follows:

1. Management framework – An effective management framework exists to govern the management of medication within the LTC Homes.
2. Acquisition and receipt – The LTC Homes have effective systems and procedures in place to manage the acquisition and receipt of medications.
3. Storage – Adequate systems are in place to store and safeguard medications to prevent unauthorized access.
4. Dispensing/Pharmacy Service Provider (PSP) – Formal arrangements exist to govern the supply and dispensing of drugs.
5. Administration of drugs – Adequate controls are in place so that drugs are administered in accordance with the Regulation and the City's policies and procedures.
6. Destruction and disposal – Adequate controls are in place so that drugs are destroyed and disposed of in a safe and effective manner.
7. Emergency drug supply – The emergency drug supply is maintained in accordance with the requirements of the Regulation.

Findings

The key findings stemming from the review of the LTC Homes are as follows:

Review objective #1

Management framework – An effective management framework exists to govern the management of medication within the LTC Homes.

1.1 Gaps in the City's policies and procedures relative to the Regulation

We noted that the City's P&P No. 360.22 – Indicators and Audits policy does not include procedures to address the implementation and documentation of corrective actions stemming from audits and/or reviews of destruction and disposal of medications in keeping with the Regulation s.136(5)(b) and s.136(5)(c).

The overarching objective of P&P 360.22 states that quality assurance audits will be conducted on a regularly scheduled basis and that "*results shall be reviewed and action plans identified*". However, P&P 360.22 does not provide a comprehensive set of procedures on *how* action plans will be identified, implemented and recorded as per s.136(5)(b) and s.136(5)(c).

While the scope of the Professional Practice Committee (PPC) includes addressing practice and operational issues such as discussing and providing direction on items related to interdisciplinary care and services, we noted that findings stemming from the Quality Improvement Reviews conducted by the pharmacy service provider indicate that some of the same issues were noted over consecutive reviews. While we were advised that actions are taken to address review findings in practice, there were no supporting documentation that provided evidence that corrective actions were implemented, which contravenes s.136(5)(c) of the Regulation.

Review objective #2

Acquisition and receipt – The LTC Homes have effective systems and procedures in place to manage the acquisition and receipt of medications.

2.1 Lack of sufficient information to determine if orders were placed and received by authorized personnel only

We could not determine whether the DigiOrders or the drug receipt documents were signed by authorized individuals due to the illegibility of the initials and/or signatures on the documents.

2.2 Drugs are not checked at the time of delivery

Our review found that drugs are accepted and signed for, but there was no verification of the drugs received prior to accepting the delivery. While there is a verification process on the following shift, discrepancies, if any, are only identified and communicated after the drugs have been signed for as received.

2.3 Inadequate safeguarding of drugs at the Home during delivery

2.3.1 Drugs stock is not adequately secured at [redacted]

We noted that the week's supplies of drugs for the residents were in boxes left in bags at one Home's [redacted] area while the pharmacy representative took the orders to the nurses' station. The [redacted] is an area that is accessible to residents, volunteers and visitors. Leaving the drugs at the [redacted] area allowed ease of access to the drugs and increases the risk of drug diversion.

2.3.2 Inadequate controls over custody of drugs at the [redacted] in the residents' area

Our review found that the drugs delivered to one unit at one Home were left unattended at the [redacted] while the pharmacy representative sought the nurse to accept custody of the drugs. Certain [redacted] are accessible to visitors and residents who are in the unit. Leaving the drugs unattended increased the risk of unauthorized access to the drugs, which included narcotics.

2.4 Medication information not adequately safeguarded

[redacted] were left unlocked, and this is where the medical information for each resident is stored within each unit. We also observed that the swipe card access provided to the pharmacy representative delivering medications gave access to a secured unit and the nurse was also not present at the time of delivery of the drugs.

Review objective #3

Storage – Adequate systems are in place to store and safeguard medications to prevent unauthorized access.

3.1 [redacted] were not consistently locked to prevent unauthorized access

We noted several instances when the [redacted] storing the week's supply of drugs could be accessed by unauthorized persons and taken from [redacted] when the nurses administering medications moved away from the [redacted] before the [redacted] auto-lock system was activated. There were also other instances where [redacted] were left unlocked and drawers could be opened to access drugs, which was sometimes due to the nurse being distracted by residents.

3.2 Controls over medications in government stock and residents' excess stock

3.2.1 Lack of controls to prevent unauthorized use of drugs that are stored in the LTC Homes' internal pharmacies

At both LTC Homes, there are no adequate systems in place to document the acquisition, removal and use of the drugs from the government pharmacy, which stores non-prescription drugs in bulk quantities, e.g. acetaminophen. As such, there is no way to know whether the drugs were removed for administration to a resident. There is also no physical stocktaking and/or reconciliation done to identify anomalies between the quantities on hand against the order documents and dispensing documents.

3.2.2 Lack of proper systems to record and track residents' excess medication stock in medication rooms

Our review found that no record is maintained of the excess medications maintained on behalf of the residents. There is also no reconciliation or stocktaking done of the excess medications to ensure that the amounts in storage at any time agree to the amounts that were ordered.

3.2.3 Lack of cameras in rooms storing medications

We noted during our observations at both LTC Homes that the medication rooms and the government pharmacies did not have cameras in them. Given the volume of medication stored in these areas, cameras in the medication rooms and the government pharmacy could provide added security and mitigate the risk of drug diversion.

Review objective #4

Dispensing/Pharmacy Service Provider (PSP) – Formal arrangements exist to govern the supply and dispensing of drugs.

No key findings noted in this area.

Review objective #5

Administration of Drugs – Adequate controls are in place so that drugs are administered in accordance with the Regulation and the City's policies and procedures.

5.1 Evidence of medication administration by an authorized individual could not be determined due to illegible documentation (initials) on the Medication Administration Record (MAR)

We were unable to determine who administered the drugs due to the illegibility of the initials on the MAR, which could be attributed to the size of the space allowed for updating the document for administration. Accordingly, we are unable to conclude on whether the drugs were administered by an authorized individual as required under Regulation s.131(3) and City P&P No. 345.3 – Medication: Administration.

5.2 Identification of residents not consistently checked

During the medication administration process, other than addressing the residents by names, we did not observe a second form of identification being used to identify residents who were non-verbal. We noted several instances when residents who were non-verbal were not wearing bracelet/armbands to identify them in accordance with City P&P No. 345.3 – Medication: Administration.

5.3 Missing documentation on the MAR prevents conclusion on whether medication was administered

There were instances when the MAR had no notation to indicate administration of medication(s) to the resident on the particular dates and there were no corresponding incident reports for the respective dates. We observed that the nurses were frequently interrupted during the medication rounds, which could be attributed to the record not being updated. However, the missing notations could also suggest that the drugs were not administered.

Review objective #6

Destruction and disposal – Adequate controls are in place so that drugs are destroyed and disposed of in a safe and effective manner.

6.1 Non-controlled drugs are not destroyed according to the City's policies and procedures and the Regulation

In several instances observed, the non-controlled drugs were placed in the disposal bins in the original packaging of the drugs. In addition, the bins used to store the drugs marked for destructions were not sealed, in at least two separate observations in separate locations. There was also no water in the bins to render the drugs inactive, even though in at least one instance, the bin was filled to capacity.

6.2 Non-controlled drugs slated for destruction and disposal are not adequately secured

The bins with medications are moved from the secured area within the LTC Homes to a holding area on the property to await pickup by the external party, which could be several days before they are collected. The holding area is not a secured area. In addition, there is no documentation of the number of bins removed from within the LTC Homes, which contravenes City P&P No. 345.02, Medication Disposal Non-Controlled/Controlled.

Review objective #7

Emergency drug supply – The emergency drug supply is maintained in accordance with the requirements of the Regulation.

7.1 Incomplete and inaccurate documentation of emergency drug supply

There were instances where there was no documentation to support the removal of the inventory from the emergency drug supply, including by whom and the purpose for removal. In other instances, there were mathematical errors for calculating the balance on hand.

In addition, there is no periodic stocktaking of the drugs in the supply and no reconciliation is performed.

7.2 Inventory levels are not always in accordance with recommended maximum

There were instances of drugs being held in the emergency drug supply in excess of the recommended maximum for the particular drug. During our observation, we observed drugs in the medication cart and the medication room that were close to expiry.

Conclusion

Overall, we found that the City needs to strengthen the management of medication in LTC Homes to address the issues found with current practices. Although the existing policies and procedures are adequate to guide the functions in relation to medication management, they are not being followed in a number of areas. Within the key cycles of the medication management system, we noted numerous deficiencies in the LTC Homes' practices that increase the risk of drug diversion specifically related to the storage, destruction and disposal of drugs, and the emergency drug supply.

We also found discrepancies between the Regulation and the City's policies and procedures, which if addressed could significantly improve the timely identification and correction of issues found in quality improvement reviews conducted by the pharmacy service provider. Overall, there are opportunities to tighten the safeguarding and administration of drugs to reduce the risk of drug diversion and improve the LTC Homes' practices. The recommendations made in this report will help address the deficiencies related to compliance to procedures, mitigate the risk of drug diversion and contribute to the safety of LTC Home residents.

Recommendations and responses

Recommendation #1

That the LTC Homes review the City's policies and procedures against the Regulation to identify gaps in the policies and procedures, and develop and implement new policies so that the LTC Homes are operating in accordance with the Regulation.

Management response:

Management agrees with this recommendation.

Pharmacy services are provided by a third party under contract with the City of Ottawa. The contracted pharmacy provider issues each Home a detailed manual of policies and procedures that meet the requirements of the Regulation and which complement the City Homes' practices and procedures (P&Ps).

P&Ps are in-line with Accreditation Canada standards. During the last survey by Accreditation Canada in 2016, the City met over 98% of all standards relating to medications.

Annually, each Home completes a medication safety self-assessment through the Institute of Safe Medication Practices and makes any required changes to applicable P&Ps as a result of this assessment.

Long-Term Care staff will review the appropriate P&Ps and will work with the pharmacy provider to identify any gaps and ensure that current P&Ps are in accordance with the Regulation, by the end of Q4 2018.

Recommendation #2

That the LTC Homes implement appropriate systems to formally document and track the findings of audits and similar reviews and how the issues have been addressed and resolved. This could serve as a source of information to assist future planning and training activities.

Management response:

Management agrees with this recommendation.

Currently, any medication error or near miss is recorded on a formal tracking tool that details the incident and any contributing factors. These are reviewed regularly in the Homes to examine trends and make improvements to P&Ps.

Staff will develop and implement a formal tracking system that captures audit and review findings, actions taken and results to inform decision-making, orientation and training, by the end of Q2 2019.

Recommendation #3

That the LTC Homes implement a system, whereby both names and signature/initials are recorded on the documents to allow for independent verification of the persons who completed the DigiOrders and who received the drugs in the Home.

Management response:

Management agrees with this recommendation.

The City currently has a system in place to verify signatures/initials recorded on documents when required. In accordance with P&P 345.12, a Master Signature List is maintained in each unit to allow for independent verification of the authorized individual who completed the order.

The City is currently in negotiations for the procurement of a new automated Resident Care Information System. The second phase of this project will include an electronic Medication Administration Record (eMAR) system. This system, which will be implemented by Q2 2019, will provide verification of registered staff who administer medications.

Recommendation #4

That the LTC Homes implement a process to allow for the verification of drugs received at the time of delivery.

Management response:

Management agrees with this recommendation.

Currently, boxes are signed for at the point of delivery to confirm that the box was received. The box remains sealed until authorized staff have the opportunity to undertake a thorough and complete verification of the package contents against the packing slip. Following the verification of the package contents, any discrepancies are communicated to the pharmacy provider for timely rectification.

Staff will complete a review of best practices in the long-term care sector related to verifying receipt of medication at point of delivery and will develop an action plan for improvements identified by Q1 2019.

Recommendation #5

That the City require that all drugs be secured while in transit within the Home.

Management response:

Management agrees with this recommendation.

When medication deliveries are received, the packages will be placed in a secure location by the staff who signed for receipt of the delivery. The staff will notify the nurse on the unit, who will come to reception to retrieve the delivery and take it to a secured storage area.

Further to the response to Recommendation #6, a communication will be sent out to the appropriate staff by the end of Q2 2018 to direct that the xxxxxxx xxxxxxx is to be locked at all times when unattended. Monitoring for compliance will be added to regularly scheduled leadership rounds.

Recommendation #6

That the LTC Homes implement a system whereby the xxxxxxx xxxxxxxx are kept consistently locked when a nurse is not present to reduce unauthorized access.

Management response:

Management agrees with this recommendation.

A communication will be sent out to the appropriate staff by the end of Q2 2018 to direct that the xxxxxxx xxxxxxx is to be locked at all times when unattended. Monitoring for compliance will be added to regularly scheduled leadership rounds.

Recommendation #7

That the LTC Homes explore opportunities to reduce interruptions to nurses during medication rounds, thereby reducing the likelihood that xxxxxxxxxx xxxxx will be left unlocked and vulnerable to unauthorized access.

Management response:

Management agrees with this recommendation.

Long-Term Care staff will explore best practices in the area of safeguarding of medication, and minimizing interruptions to nurses where possible.

A communication will be sent out to the appropriate staff by the end of Q2 2018 to direct that xxxxxxxxxx xxxxx are to be locked when unattended as per P&P 345.3 - Medication: Administration. Monitoring for compliance will be added to regularly scheduled leadership rounds.

Recommendation #8

That the LTC Homes implement proper systems to log the movement of drugs in the government pharmacy including the purpose.

Management response:

Management agrees with this recommendation.

Any medication that is administered, including medication from the government pharmacy, is tracked on the Medication Administration Record (MAR).

Management will review the medication log requirements within P&P 345.15 - Government Pharmacy for non-prescription medications. Currently, the P&P requires that on a weekly basis, registered staff from each Home area lists the required non-prescription items on the order sheet and fills the order from the government pharmacy, internal stores. For audit purposes, staff members will indicate on the order form the number of items left “on hand” at unit level.

Management will ensure that the P&P has been communicated to all appropriate staff and that the tools and templates are completed as per the P&P, by Q1 2019.

Recommendation #9

That the LTC Homes conduct periodic counting of all drugs in the government pharmacy and excess stock of drugs maintained on behalf of residents. Any discrepancies noted should be investigated and addressed in a timely manner.

Management response:

Management agrees with this recommendation.

Management will review the medication audit requirements as per P&P 345.15 - Government Pharmacy.

Management will ensure that the P&P has been communicated to all appropriate staff and that the tools and templates are completed as per the P&P, by Q1 2019.

Recommendation #10

That the City consider installing cameras in the medication rooms and government pharmacies to mitigate the risk of drug diversion.

Management response:

Management agrees with this recommendation.

A risk / cost-benefit analysis will be completed by Q2 2019 to consider the installation of cameras in the medication rooms and government pharmacies to reduce risk of drug diversion.

Recommendation #11

That the City explore opportunities with the pharmacy service provider to more clearly document which staff administered medication, which would allow for subsequent independent verification of compliance with the Regulation.

Management response:

Management agrees with this recommendation.

The City currently has a system in place to verify signatures/initials recorded on documents when required. In accordance with P&P 345.12, a Master Signature List is maintained in each unit to allow for independent verification of the authorized individual who completed the order.

The City is currently in negotiations for the procurement of a new Resident Care Information system. The second phase of this project will include an electronic Medication Administration Record (eMAR) system. This system, which will be implemented by Q2 2019, will track the registered staff who administer medications.

Recommendation #12

That the LTC Homes identify residents who are non-verbal and implement an alternative form of identification, e.g. bracelet/armbands to assist in the identification process, particularly for casual staff who may not be familiar with the residents.

Management response:

Management agrees with this recommendation.

The Homes utilize pictures of the residents as the primary identifier. As per Accreditation Canada standards, a second identifier is provided for residents who are non-verbal. Currently, non-verbal residents wear an identifying bracelet, but residents frequently remove or break bracelets because they dislike wearing them.

The City is currently in negotiations for the procurement of a new Resident Care Information system. The second phase of this project will include an electronic Medication Administration Record (eMAR) system, which will be implemented by Q2 2019. Staff will review opportunities within the system to determine if there is a solution to the identification process for residents. Staff will then consult with our partners at AdvantAge Ontario for sector best practices and will implement an alternative form of identification for residents who are non-verbal by Q3 2019.

Recommendation #13

That the management implement measures to reduce interruptions of the nurses during medication rounds and a system to remind nurses to check the MAR after each administration to verify that the record for the respective resident is updated accordingly.

Management response:

Management agrees with this recommendation.

Long-Term Care staff will explore best practices in the sector and will implement actions to reduce interruptions during medication rounds.

The City is currently in negotiations for the procurement of a new Resident Care Information system. The second phase of this project will include an electronic Medication Administration Record (eMAR) system. This system will include system-generated prompts to ensure that the Medication Administration Records (MAR) are checked after each administration, which will reduce the instances where MAR are not fully completed, below the current 1%. This will be implemented by Q2 2019.

Recommendation #14

That the LTC Homes implement practices to meet the requirements of the Regulation and the City's destruction and disposal policies. This includes verifying that the bin delivered for storing non-controlled drugs marked for destruction and disposal is sealed to render it tamper proof.

Management response:

Management agrees with this recommendation.

Management will review P&P 345.02 - Medication Disposal Non Controlled/Controlled to ensure that it complies with the requirements of the Regulation.

Management will ensure that a communication is sent to registered staff outlining the requirements of the City's P&Ps on the destruction and disposal of medication.

Designated staff will be identified and a procedure will be developed to verify, on a specified frequency, that the bins used for storing non-controlled drugs marked for destruction and disposal are sealed. This will be implemented by Q4 2018.

Recommendation #15

That the City implement practices so that the non-controlled drugs slated for destruction and disposal are maintained in a locked storage area until the third party contractor comes to pick them up. Also, it is recommended that the LTC Homes implement appropriate systems to document the number of bins removed from within the LTC Homes and have the third party contractor sign for the number of bins received. This could provide verifiable records in terms of the number of bins removed.

Management response:

Management agrees with this recommendation.

As per P&P 345.02 Medication Disposal Non Controlled/Controlled, medication disposal bins will be kept in a secured area until they are picked up by the third party contractor. A communication will be sent to appropriate staff reminding them of the P&P to ensure that non-controlled drugs slated for destruction and disposal are maintained in a locked storage area prior to pick-up.

Staff will work in partnership with our third party contractor to develop and implement a sign-off process for bins at time of pick-up. This will be implemented by Q4 2018.

Recommendation #16

That the LTC Homes implement proper record keeping that is easily understood to track the movement of the drugs in the emergency drug supply and provide staff with refreshers on how to complete the forms properly to reflect correct information.

That the LTC Homes conduct periodic counts and perform a reconciliation of all the drugs in the emergency drug supply to detect and resolve anomalies in a timely manner.

Management response:

Management agrees with this recommendation.

As per P&P 345.01 Emergency Supply Medication, all medications removed from the emergency supply are signed for on removal of the ordered medication, indicating balance on hand. Medications are only removed from this supply for a single dose administration and when there is a specific physician's order for the medication being removed. Only registered staff have access to medications from the emergency supply boxes.

Audits of medication in the emergency supply are performed at least quarterly by the pharmacy provider in accordance with P&P 345.01 – Emergency Supply Medication. During the audit, expiry dates are reviewed and medication is replenished. Discrepancies in the tracking and removal of emergency medication are reported to the Program Manager of Resident Care. Audit results will be reviewed through the Professional Practice Committee meetings and improvements will be implemented accordingly across the Homes.

Management will ensure that a communication is sent to staff outlining the proper process for record keeping and form completion. This will be implemented by Q3 2018.

Recommendation #17

That the LTC Homes observe the established maximum quantities for re-ordering drugs for the emergency drug supply to reduce the risk of medication reaching expiry date before the stock is depleted.

Management response:

Management agrees with this recommendation

As per P&P 345.01 Emergency Supply Medication, the Professional Practice Committee discusses the contents, relevance and utilization of the emergency supply medications annually. The Medical Directors of each of the City's Homes are required to approve, sign and date the list of approved medications.

Management will continue to work with the Professional Practice Committee to review the emergency drug supply on an annual basis to review established maximum quantities and drugs included, according to legislation, trends and medical expertise related to re-ordering and any risk of expiration, by Q4 2018.

Investigation into the Reporting of an Incident at a City of Ottawa Long-Term Care Home

Executive summary

Purpose

In the fall of 2017, the Office of the Auditor General ("OAG") received anonymous letters (the "Letters") with respect to allegations of questionable management practices in relation to an alleged incident of sexual abuse, that occurred at a City of Ottawa (the "City") Long-Term Care Home earlier in 2017. In response to the Letters, the OAG initiated a special investigation project (the "Investigation") to review management practices at this Home.

The objective of the Investigation was to refute/validate the allegations/concerns raised in the Letters in relation to management's actions and to provide a fact-based report.

Background and rationale

The City operates four Long-Term Care (LTC) Homes, located throughout the city that provide a range of services and programs designed for the well-being of all residents. Each of the City's LTC Homes is managed by an Administrator who is accountable to the City's Director of Long-Term Care Services.

The LTC Homes are governed by the Long-Term Care Homes Act, 2007 (the "LTCHA") and Ontario Regulation 79/10 (the "Regulation"). The LTCHA came into force on July 1, 2010. In addition to complying with the LTCHA, the City also has implemented certain policies and procedures ("P&P") to which City employees are required to adhere.

In 2017, an alleged incident of sexual abuse (the "Incident") occurred between two residents after a male resident took a female resident (confined to a wheelchair) to his room. The Incident was discovered by a Personal Support Worker ("PSW"). Other staff members who responded to the Incident included another PSW, a Registered Practical Nurse ("RPN") and a Registered Nurse ("RN"). Based on the RN's understanding of the circumstances and guidance from the On Call Manager, certain decisions were taken in response to the Incident. On the shift of the Incident, the Police and the Ministry of Health and Long-Term Care ("MOHLTC") were not notified.

The next day, the day shift RN ("RN#2") arrives at the Home and becomes aware of the details surrounding the Incident through her review of Progress Notes in GoldCare[1] and has concerns that the MOHLTC and the Police were not contacted. RN#2 contacts the On Call Manager (the same On Call Manager as the evening the Incident occurred) and provided additional details of the Incident. Based on this additional information provided by RN#2, they both agree that the Police and MOHLTC should be notified.

The Letters state that the On Call Manager did not recognize the Incident as sexual abuse and he should have known that the Police should have been notified immediately following the occurrence of the Incident.

Scope and approach

The scope of the Investigation was to obtain the facts surrounding management's response/actions to the Incident under the requirements of the LTCHA, the Regulation and the City's P&P for reporting an incident. The scope of the Investigation relates specifically to management's alleged actions/inactions in response to the Incident and does not include investigating the nature/description of the Incident, including its occurrence.

The approach to the Investigation was designed to gather evidence to refute or validate the allegations/concerns raised in relation to management's response to the Incident and whether they complied with the LTCHA, the Regulation and City P&P. The Investigation was comprised of conducting interviews, reviewing the LTCHA, the Regulation and certain of the City's P&P, and examining relevant documentation.

[1] GoldCare is the City's health and information management software program to manage resident health care information/records

Findings

The findings as a result of the Investigation are as follows:

1. **Inconsistencies in external reporting requirements between: (1) the City's P&P No. 750.56 – Critical Incident System – Mandatory and Critical Incident Reporting[2] ("P&P 750.56" or the "Reporting Policy"); (2) the City's P&P No. 750.65 – Abuse[3] ("P&P 750.65" or the "Abuse Policy"); and, (3) the requirements under the LTCHA and the Regulation.**

We compared the content of the City's relevant P&P with the LTCHA and the Regulation and identified inconsistencies in terms of when to report an alleged resident-to-resident sexual abuse incident.

S.24 (1) of the LTCHA states that when a person has reasonable grounds to suspect abuse of a resident by anyone, the suspicion must be reported immediately.

The quick reference guide (the "Guide") contained within the City's P&P 750.56 requires immediate notification to the MOHLTC and the Police **only if** the alleged abuse resulted in **injury**. P&P No. 750.56 is also inconsistent with P&P No. 750.65 – Abuse[4] which states that the MOHLTC must be notified immediately if there are: 1) reasonable grounds to suspect that sexual abuse has occurred or may occur, and; 2) there was touching, behavior or remarks of a sexual nature, or sexual exploitation directed to a resident; and 3) it was not consensual.

2. **The Home's management did not immediately report the Incident to Police and MOHLTC as per the City's P&P 750.65, the LTCHA and the Regulation.**

Based on our understanding of the facts surrounding the Incident, the matter should have been reported immediately to both the Police and the MOHLTC in accordance with the City's P&P 750.65, the LTCHA and the Regulation. Based on information from the examination of records and interviews conducted, the MOHLTC and the Police were notified on the day following the Incident. This action was in response to RN#2 enquiring and following up on the matter with the On Call Manager.

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[2] rev. September 2016

[3] rev. February 2017

[4] rev. February 2017

3. **There is a discrepancy between the particulars that the RN states was verbally reported to the On Call Manager in relation to the Incident and what the On Call Manager recorded in the on call log.**

When incidents occur after hours, the Charge Nurse is required to contact the On Call Manager. We noted that the GoldCare Incident Report ("GIR") contains explicit details of the Incident that was completed by the Charge Nurse that was not documented in the On Call Manager's on call log. The On Call Manager stated during his interviews that these explicit details were not verbally reported to him by the Charge Nurse. In the event that they had been provided, he would have changed his determination that the Incident did meet the definition of sexual abuse, thus requiring immediate reporting to the Police and the MOHLTC. The MOHLTC and the Police were notified the following day when these additional details were reported to him by RN#2 on the following day shift. During the interview with the Charge Nurse (RN), it was her position that the explicit details were provided to the On Call Manager.

4. **Reported inadequate staff-to-resident ratio, which has implications on staff and their ability to provide the expected level of resident care.**

During the course of conducting interviews with personnel, a recurring concern that arose is that the front-line staff feel that the staff-to-resident ratio is not conducive to the work demands. Resulting in staff burnout, absenteeism and staff not consistently following protocols.

5. **Measures to mitigate the occurrence of the Incident were not implemented on a timely basis.**

The male resident was located in a unit at the Home where the majority of residents are female; and, many of whom do not have the mental capacity to have a consensual relationship. Based on the review of Progress Notes recorded on the day shift prior to the occurrence of the Incident, staff documented an incident report categorized as *"Inappropriate Sexual Behaviour"* which involved the male resident. Immediate treatment documented in the Progress Notes stated that medication was administered, the resident was spoken to and was being closely monitored. An additional entry was initiated on the same day involving the male resident, which documents that he made sexual comments and exhibited sexual behaviour. Stronger measures to protect the female residents within the unit were only implemented after the occurrence of the Incident by providing one-on-one monitoring of the male resident. The male resident was eventually transferred to an all-male unit within the Home. The occurrence of the

Incident may have been mitigated had management taken additional proactive measures due to the environment and the male resident's identified sexual behaviours.

6. **The perception of staff is that the Home's management does not consistently respond to concerns on a timely basis.**

During the course of the Investigation, a recurring fact noted by the interviewees is that there is a perception that the Home's management does not always respond to concerns on a timely basis. In some instances, staff had the impression that there is a lack of follow through by management in developing and implementing action plans to address issues identified at the Home.

7. **Lack of awareness within the Home of the City's Fraud and Waste Hotline (the "Hotline") for raising concerns.**

During the course of the Investigation, it was noted that the majority of the interviewees were not aware of the Hotline. For those employees who were aware of the Hotline, they were not aware that it could be used to report concerns with respect to non-compliance of City practices or other non-financial questionable related matters. It appears that the perception of the Hotline is for reporting matters or concerns of a financial nature only.

8. **The City's email backup procedures limit the City's ability to recover sufficient electronic evidence in support of internal investigations.**

The City's email backups are overwritten every three months. Given that several months may lapse from the date of the initial occurrence/incident, to the time in which it is detected/reported and an investigation commenced, overwriting email backups every three months limits the City's ability to recover possible evidence related to the matter(s) under investigation. Without sufficient evidence, the City may not be able to take the appropriate actions including pursuing or seeking recoveries to protect the City's interests.

Conclusion

Based on our examination of records and interviews with relevant personnel, the Home did not report an alleged abuse incident immediately in accordance with the City's P&P 750.56, the LTCHA and the Regulation. The basis for management's decision to not immediately report the Incident to the Police and the MOHLTC was due to purported incomplete information provided by the Charge Nurse (RN) to the On Call Manager. The

On Call Manager did not follow up with the Charge Nurse to discuss the purported lack of reporting detail that was provided on the evening of the Incident to mitigate a reoccurrence. It was the Charge Nurse's position that complete facts were reported to the On Call Manager, as reflected in the Progress Notes recorded in GoldCare.

While we did note some discrepancies within the City's own policies (P&P 750.65 and P&P 750.56) in relation to reporting alleged abuse, the City's commitment to zero tolerance of abuse requires all staff to take appropriate action to report alleged abuse incidents immediately. When the Incident under the scope of this investigation was followed up by another nurse (RN#2) on a subsequent shift, the Incident was reported in accordance with the City's P&P 750.56, the LTCHA and the Regulation.

The reported inadequate staff-to-resident ratio has an impact on the Home's ability to provide comprehensive resident care on a consistent basis. Front-line staff feel that the staff-to-resident ratio is not conducive to their work demands, resulting in staff burnout, absenteeism and the inability to consistently follow protocols during the course of their duties. It is recommended that the City review the staffing model in the City's long-term care homes to identify and remedy any found gaps.

Based on the information obtained during interviews and our review of Progress Notes, there was an identified known risk of potential sexual abuse based on behaviours exhibited by the male resident earlier the same day of the Incident. Based on documentation in the Progress Notes, medication was administered to the male resident and he was closely monitored; however, stronger measures were only taken after the Incident by the implementation of one-on-one monitoring. The male resident was eventually transferred to an all-male unit within the Home. Had additional safety measures been taken by staff on shift, the Incident may have been prevented.

Staff have a perception that management does not take action on a timely basis when matters are raised within the Home. Specifically, the matters identified during the course of the interviews conducted related to the staffing allocation within the Home. Furthermore, there is a lack of awareness of the Hotline as an anonymous reporting mechanism to voice concerns. It is recommended that the City actively promote the awareness and purpose of the Hotline to all City employees.

The City's email backups are overwritten every three months, which limits the City's ability to recover possible evidence related to the matter(s) under investigation. It is recommended that the City review existing email backup procedures to ensure the

safeguarding and preservation of email for a sufficient time to support future investigations.

Recommendations and responses

Recommendation #1

That the City review and revise P&P 750.56 and P&P 750.65 so that both policies are aligned with each other and in accordance with both the LTCHA and the Regulation.

Management response:

Management agrees with this recommendation.

Currently, P&P 750.65 is reviewed and updated annually following a management debrief of all incidents that occurred in the long-term care homes during the calendar year.

P&P 750.56 and 750.65 will be reviewed and revised to ensure they are aligned, and in accordance with the Long Term Care Homes Act and Regulation. This will be completed by the end of Q3 2018.

Recommendation #2

That the City consider streamlining P&P 750.56 and P&P 750.65 so that they are succinct and facilitate referencing by staff who are responding to incidents.

Management response:

Management agrees with this recommendation.

All staff review P&P 750.65 as part of the annual mandatory training.

P&Ps are available onsite for staff to reference. Hardcopy P&Ps are available in binders located centrally in the Home. Staff can also access P&Ps through any desktop computer, either on the Long-Term Care page of the City's intranet on Ozone or by clicking the P&P icon installed on each desktop.

Management will conduct a consistency review of both P&P 750.56 and 750.65 to streamline procedures when reporting incidents. Management will provide revised versions to staff by Q3 2018.

Long-Term Care Residents and/or their families receive P&P 750.56 and 750.65 in their information packages upon admission to the Home so that they are aware of

staff's duty to report. Updated versions of these P&Ps will also be provided to Residents/Power of Attorney when they are updated.

Recommendation #3

That the City provide mandatory regular training (i.e. annually) and coaching to staff on the City's P&P, the LTCHA and the Regulation in relation to the identification, response and reporting (both internal and external) to management of incidents of abuse. Such training should also outline the consequences in the event a City employee fails to report.

As part of the training curriculum, it is recommended that the City implement a system for evaluating staff's understanding of the relevant City P&P, the LTCHA and Legislation.

As part of the training curriculum, it is recommended that the City provide incident call intake guidance to all On Call Managers so that full particulars of incidents are obtained to allow for decision-making that meets the requirements of the City's P&P, the LTCHA and the Regulation.

Management response:

Management agrees with this recommendation.

Staff are provided with mandatory annual training on abuse and neglect. This training includes a review of the City's P&Ps as well as the requirements of the LTCHA and Regulation.

All staff review P&P 750.65 as part of the annual mandatory training. Following their review of the P&P, staff sign a declaration that they have read and understood the material and they are prompted as to whether or not they have any questions concerning the content. In addition to P&P 750.65, supervisors and managers are also required to review P&P 750.56, and sign a similar declaration acknowledging that they have read and understood the contents of the P&P.

Since Q3 2017, all staff have received enhanced in-person training on the prevention, recognition and reporting of abuse and neglect, which addresses the consequences of the failure to report abuse and neglect. The training includes case scenarios demonstrating different types of abuse and discussion points for staff to talk about abuse and potential abuse. Following the training, staff complete

a test to evaluate their understanding of the material. Staff who do not achieve a mark of 100% on the test receive a one-on-one follow-up session.

Graphic posters, including a slogan ("See something? Hear something? SAY something") and quick reference cards have been developed to serve as a visual reminder for staff of their obligation and duty to report alleged or suspected abuse and neglect. Each Home has also scheduled an annual abuse awareness week providing further opportunities to educate and inform residents, families, volunteers and staff on the prevention of abuse and neglect.

A training module for on-call managers will also be developed and delivered at an upcoming Extended Services Management Team meeting by Q4 2018. To accompany the training, a new reference document will be developed with a standardized list of intake questions to ensure that consistent and complete information relating to an incident is obtained. This reference document will also be reviewed with all registered nursing staff.

Recommendation #4

That as part of the recommended mandatory training to be provided to employees, that it include subject content with respect to increasing the awareness of the obligation and duty to report. This includes providing and documenting full particulars of an incident so that management has the necessary information to make decisions in accordance with relevant policies, procedures and legislation.

Management response:

Management agrees with this recommendation.

As indicated in the response to Recommendation #3, the current annual enhanced training on the prevention of abuse and neglect includes information on the obligation and duty to report.

The annual training will be enhanced to include additional information on describing and documenting incidents and clarifying which information should be provided to supervisors and on-call managers when reporting incidents. This will be launched in Q3 2018 as part of the annual mandatory training program.

Recommendation #5

That City management of Long-Term Care Services in collaboration with the management teams of the City's long-term care branches review their staffing model and implement an action plan to address any gaps identified through the review process.

Management response:

Management agrees with this recommendation.

Long-Term Care services completed an engagement process for its stakeholders in Q4 2017. Based on feedback received from stakeholders during this process, a review of staffing levels was already identified as a necessary step towards improving Long-Term Care services.

As part of the compliance plans submitted to the Ministry of Health and Long-Term Care, a direct care service delivery model review has been completed by an independent third party reviewer, which will include a benchmarking exercise of direct care staffing hours in long-term care homes in the province. Management expects to receive the results of this review in Q2 2018.

Long-Term Care management will review recommendations received related to its service delivery model and will develop an action plan to implement changes to address any gaps based on approved direction and timing determined by Council given the financial implications.

Recommendation #6

That the Home review their procedures for responding to identified inappropriate sexual behaviours exhibited by residents to ensure that appropriate safety measures are taken on a proactive timely basis. This will assist in mitigating the occurrences of abuse and protect all residents.

Management response:

Management agrees with this recommendation.

As part of the 2018 annual mandatory training plan, a module on de-escalation, "10 Ways to De-escalate" has been assigned to all direct care staff as a reminder of effective de-escalation techniques.

The program content has already been updated for 2018 and now includes a formal review of the Care Plans and Kardexes to ensure they contain all necessary information.

Each Home also leverages the Behavioural Support PSW champion in the Home, who has received additional training in responsive behaviours and is available as a resource for all staff to consult with during incidents. Long-Term Care services has received additional funding for 2018 from the Local Health Integrated Network to provide additional hours of Behavioural Support in each Home.

Long-Term Care Services has also consulted with the outreach team from the Royal Ottawa Hospital to identify best practices in de-escalation techniques for inappropriate sexual behaviours exhibited by residents.

A group of staff representing all four City Homes will review procedures and best practices and recommend improvements, which will be implemented by Q1 2019.

Recommendation #7

That the Home's management develop a system for prioritizing and tracking all staff reported issues, their resolution and management's communication plan for sharing progress with staff on a timely basis.

Management response:

Management agrees with this recommendation.

The management team at the Home will communicate the existing mechanisms, corporately and within the Long-Term Care Homes, for reporting and escalating staff issues and will ensure that communication related to specific issues are timely. This will be completed by the end of Q3 2018.

Recommendation #8

That the City launch awareness training on the City's *Employee Code of Conduct*, which may include an annual declaration process.

Management response:

Management agrees with this recommendation.

A preliminary *Employee Code of Conduct* eLearning module is currently under development by the City Clerk and Solicitor's Office. The aim is that this module will be supplemented by others in the future as part of the ongoing work to raise

awareness of the *Employee Code of Conduct* and to foster consideration of ethical issues amongst City staff. The module will review the ethical foundation of the *Employee Code of Conduct*, the basis of ethical decision-making, the City's expectations of employees, and how to report improper (unethical) conduct or breaches of the *Code*. The City Clerk and Solicitor's Office is currently reviewing ways in which to encourage consideration of ethical issues, which may include quizzes and practice exercises so employees can test their ability at identifying and deciding how to handle ethical dilemmas. The initial module and others will be made available on iLearn via Ozone and uLearn (for non-networked employees).

The City currently offers several courses with ethics-related material in their content, including the New Employee Orientation program for newly hired employees. In addition, the City Clerk and Solicitor's Office regularly delivers information sessions on ethical issues to large and small employee groups, and also often posts articles in employee communications such as *In the Loop* as an element of its *Code*-related communication plan.

Additional (mandatory) training for newly promoted/hired supervisors and managers is also required which contains linkages to the *Code*. The curricula include 'Supervising/Managing in a Unionized Environment' and 'Leading a Diverse Workforce', which is the supervisor/manager version of 'Respectful Workplace Training'.

Additionally, the City Clerk and Solicitor's Office is looking at expanding the ethics and *Employee Code of Conduct* curricula and training offerings, which are planned to be available starting in Q4 2018/Q1 2019. Management will also look at opportunities to promote the Fraud and Waste Hotline in future *Code*-related training and communications.

Management will consider an annual declaration process as part of its ongoing efforts to raise awareness of the *Employee Code of Conduct* and ethical issues to all employees.

Recommendation #9

That the City actively promote the awareness and purpose of the Hotline to all City employees on a regular basis.

Management response:

Management agrees with this recommendation.

Management will engage the internal communications unit within the Public Information and Media Relations branch to actively promote the Fraud and Waste Hotline through a variety of communication channels with a focus on strengthening awareness of the Hotline amongst all City staff.

The City currently offers several courses with ethics-related material in their content and information is broadly available for employees with respect to accountability and transparency (the Employee Code of Conduct, the Fraud and Waste Hotline and the Lobbyist Registry) on the front page of the City's intranet "Ozone". Orientation for new employees and training provided to new managers references the Hotline and provides an overview of staff's responsibilities with respect to the Fraud and Waste Policy.

As indicated in the response to Recommendation #8, the City Clerk and Solicitor's Office is looking at expanding the ethics and *Employee Code of Conduct* curricula and training offerings, which are planned to be available starting in Q4 2018/Q1 2019. A preliminary *Employee Code of Conduct* eLearning module is currently under development by the City Clerk and Solicitor's Office. The aim is that this module will be supplemented by others in the future as part of the ongoing work to raise awareness of the *Employee Code of Conduct* and to foster consideration of ethical issues amongst City staff. The module will review the ethical foundation of the *Employee Code of Conduct*, the basis of ethical decision-making, the City's expectations of employees, how to report improper (unethical) conduct or breaches of the *Code* and will reference the Fraud and Waste Policy and Hotline. Management will also incorporate information with respect to the Fraud and Waste Hotline in future *Code*-related training.

Recommendation #10

That the City review existing email backup procedures to ensure the safeguarding and preservation of email for a sufficient time to support future investigations.

Management response:

Management agrees with this recommendation and has already undertaken this work.

In response to one of the recommendations in a previous audit, the City reviewed the existing three-month retention period for emails in June of 2011. It was confirmed that there was no Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), labour relations or other legal or corporate requirements for extending the email archiving period from 90-days to a longer period. Given the consensus that there is no corporate requirement, as well as the cost to implement a two-year archive (estimated at between $150K and $500K), no changes to the current email management practices and associated policies are planned. The results of the Email Retention Review were summarized in an information report that was tabled at the IT Sub Committee on August 22, 2011, the Finance and Economic Development Committee on September 6, 2011 and Council on September 14, 2011.