The College of Naturopaths of Ontario

Inspection Committee Report

Ottawa Integrative Health Centre
904 Lady Ellen Place,
Ottawa, ON
K1Z 5L5

Following a review of the Inspector's Report and all other documentation pertaining to the 5-year inspection of the above premises conducted on November 16, 2024 the Inspection Committee has issued an outcome of a pass with conditions.

Conditions

The condition is:

1. As per Inspection Program Requirement 2.3: Items required on crash cart – angiocatheters.

    The Committee requires that the angiocatheters stocked on the crash cart have not expired.

Recommendations

When Inspection Program Requirements are partially met and do not warrant a condition being placed on the premises, the Inspection Committee makes recommendations to the premises.

The Committee makes the following recommendations:

i) As per Inspection Program Requirement 2.1.6: Spill kit is readily available to clean gross spills of blood.

    The Committee recommends that a spill kit be assembled and readily available when needed to decontaminate gross spills of blood.

ii) As per Inspection Program Requirements 2.2.1: Laminar air flow hood has been certified as recommended by the manufacturer.

    The Committee recommends that there is documentation to indicate that the laminar air flow hood has been certified in accordance with the manufacturer's recommendations.

iii) As per Inspection Program Requirement 3.11: A refrigerator temperature log is maintained and up to date.

The Committee recommends that a refrigerator temperature log is created and maintained.

iv) As per Inspection Program Requirements regarding Quality Management processes included in the Policies and Procedures Manual, specifically:

4.7.1: Formation of a Quality Management Committee and the staff members, who are involved with patients receiving IVIT, comprising the committee.
4.7.4: Performance review of naturopath(s) who perform IVIT procedures.
4.7.5: Reviews that staff who are involved in delegated procedures are aware of and have met all requirements outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation*.
4.7.6: Performance review of non-medical staff involved in any of the premise's IVIT related processes and procedures.
4.7.7: Reviewing that staff are aware of and trained in the premise's emergency procedures, including use of the AED.
4.7.8: Reviewing that staff are aware of and consistently using the telephone, in person, and online infectious disease screening protocol when communicating with patients and scheduling appointments.
4.7.9: Reviewing that staff are aware of how and when to use personal protective equipment (PPE).
4.7.10: Reviewing that staff are aware of procedures to follow in the event of exposure to blood and body fluids.
4.7.11: Monitoring and evaluating the quality of patient care provided.
4.7.12: Tracking and reviewing patient outcomes.
4.7.13: Developing and implementing methods to improve patient care.
4.7.14: Identifying and correcting deficiencies in the premises' policies and procedures.
4.7.15: Reviewing all Type 1 and Type 2 reporting and record keeping requirements.
4.7.16: Reviewing all Type 1 and Type 2 occurrences that occurred at the premises and developing policies and procedures to reduce the risk of future occurrences.
4.7.17: Selecting, at least annually, and reviewing 5-10 patient records to assess:

- quality of care to patients,
- completeness and accuracy of entries,
- documentation of informed consent,
- appropriateness of treatment,
- follow-up to abnormal laboratory test results, and
- adherence to the Standard of Practice for Record Keeping.

4.7.18: Monitoring adherence to infection control practices pertinent to IVIT, and
4.7.19: Monitoring proper cleaning procedures for patient surfaces and IVIT equipment.
4.7.20: Monitoring maintenance of IVIT and emergency equipment,
4.7.21: Monitoring the drug and substance inventory and storage (including cold chain management).
4.7.22: Monitoring labelling and disposal of expired drugs, substances, and equipment,
4.7.23: Monitoring use of logs for inventory, cleaning, and maintenance.
4.7.24: Reviewing proper handling and disposal of all biomedical and non-biomedical waste.

The Committee recommends that all Quality Management Program processes, including those listed above, be established and documented in the Policies and Procedures Manual and implemented.

v) As per Inspection Program Requirements regarding the labelling of the IV bag, specifically:
5.2.6: The date that the IV bag was:

- prepared,
- administered to the patient, and
- the expiry date,

5.2.7: The directions for storage of the IV bag.

The Committee recommends that the expiry date, even if it is the same day the iv bag is being administered, and the directions for storage of the IV bag are always included on the IV bag label.

vi) As per Inspection Program Requirements regarding the Quality Management Program:
8.1: The Quality Management Committee meets in accordance with the Policies and Procedures Manual.
8.2: Staff reviews the Policy and Procedures Manual at least annually.
8.3: Naturopathic doctor(s) performance is reviewed as it relates to IVIT processes and procedures.
8.4: Non-medical staff performance is reviewed as it relates to IVIT processes and procedures.
8.5: Reviews that staff who are involved in delegated procedures are aware of and have met all requirements outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation*.
8.6: Reviews that all staff are aware of and trained in the clinic's emergency procedures, including use of the AED.
8.7: Reviews that staff are aware of and consistently use the telephone, in person, and online infectious disease screening protocol when communicating with patients and scheduling appointments.
8.8: Reviews that staff are aware of how to use personal protective equipment (PPE) in order to protect themselves and others.
8.9: Reviews that staff are aware of procedures to follow in the event of exposure to blood and body fluids.
8.10: The quality of patient care provided is monitored and evaluated.
8.11: Patient outcomes are tracked and reviewed.
8.12: Methods to improve patient care are developed and implemented.
8.13: Deficiencies regarding policies and procedures are identified and corrected.
8.14: Reviews that staff are familiar with Type 1 and Type 2 occurrences.
8.15: Reviews that staff have met the reporting requirements for Type 1 and Type 2 occurrences.
8.16: Reviews that staff have met the record keeping procedures for Type 1 and Type 2 occurrences that have happened.
8.17: Type 1 and Type 2 occurrences that have happened are reviewed and the procedures to reduce the risk of future occurrences are reviewed, developed, and implemented.
8.18: At least annually, a random selection of 5-10 patient records is reviewed to assess for:

- adherence to the *Standard of Practice for Record Keeping*,
- documentation of informed consent,
- completeness and accuracy of entries,

- appropriateness of treatment, and
- follow-up to abnormal laboratory test results.

8.19: Reviews that accepted standards of infection control practices pertinent to IVIT are being followed.
8.20: Reviews that cleaning procedures are being followed and the cleaning log is properly maintained.
8.21: Reviews that IVIT and emergency equipment is being maintained and the maintenance log is properly maintained.
8.22: Reviews that drug and substance inventory is monitored, and the inventory log is properly maintained.
8.23: Reviews that drugs and substances are properly stored, and the refrigerator temperature log is properly maintained.
8.24: Reviews that expired drugs, substances, and equipment are labelled and properly disposed of.
8.25: Reviews that biomedical and non-biomedical waste is being handled and disposed of properly.

> The Committee recommends that the Quality Management Program is reviewed to ensure it is complete and being implemented with respect to all requirements including those listed above, and that there is documentation in place to record that the Quality Management Program activities have been completed and when.

vii) As per Inspection Program Requirement regarding Patient Chart Requirements 9.6.4: Patient's history regarding exposure to and infection from methicillin resistance organisms (MROs).

> The Committee recommends that the patient's history regarding methicillin resistant organisms (MROs) is documented in their patient file.