Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 4, 2015	2015_349590_0004	007357-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

BANWELL GARDENS
3000 BANWELL ROAD P. O. BOX 3246 TECUMSEH ON N8N 2M4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 29, 2015.

CI#2263-000038-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care and a Resident. The inspector(s) reviewed a residents clinical record, two staff members educational records, an internal incident report, a Critical Incident report and relevant policies related to the inspection.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care.

Resident #1 required hospitalization and was re-admitted to the home.
Upon the resident's return to the home, two registered staff members completed the medication reconciliation process and transcribed the physicians orders using the hospital's Medication Administration Records. The registered staff members failed to review the hospital's Discharge Prescription List which revealed changes to the resident's medication regime when discharged from the hospital and clarified the medication orders. The medication error was identified by the homes Pharmacist during a medication reconciliation process audit.
The homes policy titled "Medication Reconciliation - Ordering and Receiving Medication" Policy No: 2.7.1 last revised in October 2010, section three of the "Procedure" indicates that the best possible medication history is to be created from all possible sources, including, but not necessarily limited to: a. MAR(LTCH/RH,Hospital), b.CCAC/Resident Assessment Instrument, c. Discharge List/Prescriptions from Hospital, d. Community Pharmacy Medication List, e. Medication Vials/Package, f. Family/Resident List and g. Other.
The Administrator and Director of Care confirmed the registered staff did not review all possible sources of information as the Hospital Discharge Prescription List was not reviewed and the staff used only the hospital Medication Administration Records to transcribe the physicians orders. They both confirmed that all staff are expected to follow the Medication Reconciliation policy to prevent these errors from happening. [s. 117. (a)]

Issued on this 4th day of February, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.