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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Dec 7, 2016	2016_384161_0055	033274-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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

KATHLEEN SMID (161)

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): on site November 29, 30, 2016.

This critical incident inspection is related to a critical incident the home submitted related to a medication error.

During the course of the inspection, the inspector(s) reviewed an identified resident's health care record and salient policies and procedures.

During the course of the inspection, the inspector(s) spoke with registered nursing staff, RAI Coordinator, Program Manager of Resident Care and the Administrator.

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a drug was administered to resident #001 in accordance with the directions for use specified by the prescriber.

On an identified date in November 2016 the Director was notified via the Critical Incident Report System that on the evening of an identified date in November 2016, resident #001 was inadvertently administered a medication by RPN #103. On the following day of the identified date in November 2016 at morning shift change, the medication error was discovered by RPN #105. Resident #001 was immediately assessed by RN #106, oxygen administered and the resident's attending physician notified. Resident #001 was transferred to the hospital via ambulance and returned several hours later in stable condition. This drug had not been prescribed by the resident's attending physician to be administered at that time of day.

On November 29, 2016 Inspector #161 reviewed the health care record of resident #001. In the physician's orders for an identified date earlier in November 2016, the attending physician of resident #001 had prescribed this medication to be administered daily at 0800 hours.

On November 29, 2016 Inspector #161 discussed the information contained in the Critical Incident Report with the home's Acting Administrator and the Program Manager of Resident Care. They indicated that on the evening of an identified date in November 2016, RPN #103 administered resident #001 the regularly scheduled medications, and in addition, RPN #103 had also inadvertently administered another medication which had been prescribed to be administered every morning, not in the evening. The Acting Administrator and the Program Manager of Resident Care further indicated that RPN #105, who had worked the night shift starting on the identified date in November 2016 at 2300 hours, had discovered the medication error at a time unknown to them, during her night shift that finished at 0700 hours on the following day. They also indicated that in the morning after the identified date in November 2016, at shift change, the night shift RPN #105 told the day shift RN #106 about the medication error that had occurred the evening before. RN #106 immediately assessed resident #001, called the attending physician and sent resident #001 to hospital. The resident was transferred back to the home during the afternoon of the same day, on an identified date in November 2016.

On November 29, 2016 Inspector #161 asked for and received from the home's Program Manager of Resident Care, the "Narcotic and Controlled Drug Administration Record" for an identified date and the following day, for resident #001 related to this medication. This record indicated at the top of the page the name of the medication, and to give 1 capsule of this medication by mouth every morning. A review of this record indicated that in the morning of the identified date in November 2016, resident #001 received the regularly

scheduled dose of this medication. This record also indicated that on the evening shift of the same date in November, resident #001 received the same medication administered by RPN #103. There was a question mark in red ink adjacent to this entry. The Acting Administrator and the Program Manager of Resident Care indicated that it was RPN #105 who had written the question mark at a time unknown to them.

On November 30, 2016 Inspector #161 had a discussion with RPN #105 who had discovered the medication error. She indicated that she had worked the night shift, which started on the identified date in November 2016 at 2300 hours through to the following morning at 0700 hours. RPN #105 indicated to Inspector #161 that on the morning after the identified date in November 2016 at approximately 0700 hours, RPN #105 was conducting the night shift to day shift narcotic count with RN #106. During this narcotic count, RPN #105 observed on resident #001's Narcotic and Controlled Drug Administration Record, that on the evening of the identified date in November 2016, the medication was documented as having been administered the previous evening by RPN #103. Given this information, RN #106 proceeded to the room of resident #001 where she found the resident drowsy with irregular respirations marked with periods of apnea. RN #106 administered oxygen, notified the resident's attending physician and called an ambulance for immediate transfer of resident #001 to the hospital. The resident was transferred to the hospital and was transferred back to the home several hours later.

On November 30, 2016 Inspector #161 discussed the medication error with the attending physician of resident #001. The attending physician confirmed that he had prescribed this medication to be administered daily at 0800 hours. The attending physician indicated to Inspector #161 that resident #001 should not have received this medication in the evening of the identified date in November 2016. [s. 131. (2)]

Issued on this 7th day of December, 2016

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

Original report signed by the inspector.