Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Original Public Report

Report Issue Date: August 10, 2023	
Inspection Number: 2023-1272-0005	
Inspection Type: Critical Incident System	
Licensee: Collingwood Nursing Home Limited	
Long Term Care Home and City: Collingwood Nursing Home, Collingwood	
Lead Inspector Kim Byberg (729)	**Inspector Digital Signature** Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2023.08.10 11:42:23 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1-3 and 8, 2023.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00091432, related to a medication incident

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee failed to ensure the procedure to transcribe physician's orders was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure there was a procedure to ensure physician's medication orders were correctly transcribed to medication records prior to administering the medication to residents' was complied with.

Specifically, staff did not comply with the home's policy titled "Transcribing Orders" policy #04-03-04 revised January 1, 2022, which was included in the home's Pharmacy and Therapeutics Program.

Rationale and Summary
A resident required a new medication to be administered when their condition was deteriorating.

The registered staff called the physician and obtained an order to administer a medication and a specific treatment that required a physician's order.

The home's policy titled "Transcribing Orders" policy #04-03-04 revised January 1, 2022, stated that after the medication order was obtained the registered staff was to write the medication on the medication record in order of the drug name, strength and/or dose, frequency, route, and include the ordering physician's name at the bottom of the form and the date ordered.

The resident did not have the physician's order for the medication or the treatment transcribed on to the medication record or on the physician's order form.

The home's DOC stated that both the medication and the treatment should have been transcribed into the resident "Physician Order" record and the homes electronic medication record (eMAR).

The resident was at risk of harm when the registered staff did not transcribe the physician's order into the physician order record or eMAR. The specific directions for administering the medications was not documented and may have caused harm if additional medication or treatment was required and not given as the physician had prescribed.

Sources:
Review of progress notes, physician orders sheet, eMAR, the home's policy titled "Transcribing Orders" policy #04-03-04 revised January 1, 2022. Interview with registered staff and the DOC.
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WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee failed to ensure that when a resident had an adverse reaction to medication there were assessments to maintain the residents' health.

Rationale and Summary
A resident was administered two medications that were newly prescribed within seventy-two hours. After receiving the medications for three consecutive days the resident was assessed and was unresponsive. The physician ordered addition medication and requested the resident be monitored until they were stable. The resident was assessed initially after the administration of the medication. They did not have a clinical assessment documented until seven hours after the initial assessment was completed and their vital signs were not at their baseline.

The registered staff stated that they did not document any clinical assessments during their shift and acknowledged that they should have.

The residents' vital signs remained below their baseline after they had an adverse reaction to medication that was administered. The resident may have been at further risk when the registered staff did not continue to monitor and document their clinical assessments that should have included the residents' vital signs. The residents' vital signs did not return to baseline until fourteen hours after the medication was administered.

Sources:
Review progress notes, vital signs records, the home's policy titled: Policy titled "Medication Incidents and adverse reaction" policy # 04-02-04, revised January 1, 2022, and the medication incident report. Interview with registered staff and the DOC.
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