Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2020	2020_725522_0006	016201-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 ST. THOMAS ON N5R 5V1

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

Elgin Manor
39262 Fingal Line, R.R. #1 ST. THOMAS ON N5P 3S5

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

JULIE LAMPMAN (522)

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): September 11, 16, 18, and 22, 2020.

Critical Incident System report #M518-000030-20/ Log #016201-20 related to unaccounted for narcotics was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Resident Care Coordinator, a Registered Nurse, Registered Practical Nurses, the SmartMeds Senior Pharmacy Manager and an OPP Constable.

During the inspection, the inspector also reviewed the home's investigation notes, video footage, medication incidents and policies and procedures relevant to this 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Pandemic Procedure for receiving narcotic medication was complied with.

Ontario Regulation 79/10 s. 114 (2) requires the home to have policies for their medication management system to ensure the accurate receipt of all drugs used in the home.

Specifically, staff did not comply with SmartMeds Pharmacy "Pandemic Procedure" Policy (dated April 2020).

A Registered Nurse (RN) received medications, including narcotics, from the SmartMeds Pharmacy delivery driver. The driver and the RN did not meet at the main entrance of the facility to confirm that the number of bags of medications delivered was correct, as the policy directed. Two nurses did not attend to receive the narcotic medications and inadvertently narcotics were discarded in the garbage.

The RN stated that the delivery driver did not stay to verify that the number of bags of medications delivered to the home was correct, that the driver would wait in their vehicle outside and registered staff would wave that they picked up the medications. The RN stated the driver did not inform the RN that there were narcotics in the delivery when they called the RN and the RN attended on their own to pick up the medications. The RN stated during COVID-19 a nurse would go and pick up the medications and take them back to the unit and have another nurse go through the narcotics, double sign the sheet and scan it back to pharmacy. There were times the registered staff would call the second nurse and have the nurse meet them at the front entrance to receive the narcotics.

By not following the policy for properly receiving medications, an accurate count of medications received, including narcotics, was not completed. This lead to narcotic medication inadvertently being disposed of in the garbage. This incident did not affect the resident who was to receive the medication.

Sources:
The LTCH's investigative notes, SmartMeds Pharmacy "Pandemic Procedure" Policy #2-6, dated April 2020, SmartMeds Pharmacy Precautionary Measures on the Coronavirus (COVID-19) dated March 17, 2020, interviews with RN #104, Registered Practical Nurse #103, SmartMeds Senior Pharmacy Manager #107, Manager of Resident Care #101, Administrator #100 and OPP Constable #106. [s. 8. (1) (b)]

Issued on this 6th day of October, 2020

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

Original report signed by the inspector.