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
May 13, 2021	2021_815623_0010	004054-21	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East Whitby ON L1N 6A3

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

Fairview Lodge
632 Dundas Street West P.O. Box 300 Whitby ON L1N 5S3

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

SARAH GILLIS (623)

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): April 8, 9, 13 - 16, 2021

The following intake was inspected:
A Critical Incident Report for a medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Manager of Nurse Practice (MNP), Resident Care Coordinators, Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff and residents.

The Inspector also reviewed internal investigation records, resident health care records, infection control practices in the home, meeting minutes, policies, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff involved in resident #001's care collaborated with each other regarding the resident's assessment so that their assessments were integrated, consistent and complemented each other when the resident received medication that was not prescribed to them, in error, and enhanced monitoring was required.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report regarding a medication incident involving resident #001 which resulted in an adverse reaction.

RPN #102 discovered that they had administered resident #002's medications to resident #001 in error. The RPN notified RN #112 who notified the Nurse Practitioner (NP). Orders were received from the NP to assess resident #001 every four hours for 24 hours.

Staff interviews identified that RPN #102 did not document in detail the medications that resident #001 had received in error. They also did not provide detailed information to oncoming RPN #111, a verbal report was provided which only indicated that resident #001 had received the wrong medication and was to be assessed every four hours. RPN #111 indicated that they had to search to find details of the incident including the medications resident #001 had received, the time the next assessment was required to be completed, details of the last assessment and information related to what symptoms the resident was being monitored for. RPN #102 did not document this in the progress notes and did not include this information in the 24-hour nursing report indicating this was confidential information that the PSW's were not supposed to have access to. The assessment completed by the NP once becoming aware of the incident, was not

documented at the time, but was documented as a late entry, after the residents health status had declined and the resident was transferred to the hospital the following day.

The Manager of Nurse Practice (MNP) and the Director of Care (DOC) confirmed in separate interviews that RPN #102 should have documented in resident #001's progress notes and communicated both verbally and in writing from shift to shift so that all staff received the same consistent information. Documentation should be completed as close to the time of the event as possible. The MNP also indicated that the PSW's should be provided with enough information so that when a resident requires additional monitoring, they are aware of what to watch for and know to report any changes in resident condition.

Resident #001 was at risk of adverse medical effects after receiving the wrong medication, when staff did not collaborate with each other to provide clear communication from shift to shift regarding the type of medication resident #001 received in error, the time the resident was to be assessed, and what symptoms the staff were to monitor for. PSW staff were also not included in the circle of care and were not provided with information so that they could assist to monitor the resident for any adverse changes in condition. When resident #001's condition changed, registered staff documented they would continue to monitor, and the changes were not communicated until the resident was unresponsive resulting in the residents transfer to hospital.

Sources: CIS Report, resident #001's health records, and interviews with RPN #102. RPN #110, Manager of Nurse Practice RN#103, and the DOC. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A Critical Incident Report (CIR) was submitted to the Director for a Medication incident/adverse reaction which resulted on resident #001 requiring transport to the hospital.

The CIR indicated that RPN #102 administered resident #002's medications to resident #001 in error at a specified time. This error was not discovered until the RPN went to administer medications to resident #002 and realized the medications were missing, but resident #001's medications were still in the cart.

Review of the licensee's internal investigation indicated that resident #001 received resident #002's medications in error.

During an interview RPN #102 indicated that they administered resident #002's medications in error to resident #001 on a specified date. As soon as the error was discovered it was reported to the RN and the Nurse Practitioner who assessed the resident. The RPN indicated that they did not complete the proper checks before administering resident #002's medications to resident #001 in error.

During an interview with Manager of Nurse Practice indicated that the expectation of the home is that in accordance to the Medication Administration Program, all Registered Staff who administer medications are held accountable for adhering to the College of Nurses of Ontario Practice Standard for Medication to ensure safe, effective and ethical medication practice. This includes confirming the identity of the resident prior to administering the medications.

When RPN #102 failed to confirm the identity of resident #001 before administering medications, causing resident #001 to receive medications that were not prescribed to

them, this resulted in actual harm which required resident #001 to require further intervention.

The licensee failed to ensure that no drug was used by or administered to resident #001 unless the drug has been prescribed for the resident.

Sources: CIS Report, Medication Incident Report, Medication Administration Records, related policies, interview with RPN #102 and Manager of Nurse Practice. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee failed to ensure that a medication incident involving resident #001 and the adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A Critical Incident Report (CIR) was submitted to the Director for a Medication incident/adverse reaction that resulted on resident #001 requiring transport to the hospital.

Review of the medication incident report identified that resident #001 received a specific identified medication. The detailed description of the incident indicated that resident #001 received all of resident #002's medications.

During a staff interview, RPN #102 indicated it was their responsibility to complete the online medication incident report and they did not include all the medications that resident #001 received in error. The Manager of Nurse Practice (MNP) indicated that all details of the medication incident are required to be documented on the incident report including a complete list of medications that were received in error.

The resident was at risk of adverse medication reactions when RPN #102 failed to provide the full details of a medication incident where resident #001 received the incorrect medications.

Sources: CIS Report, medication incident report, related policies, medication administration records for resident #001 and #002, interview with RPN#102 and MNP. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

Issued on this 26th day of May, 2021

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

Original report signed by the inspector.