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

London Service Area Office
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
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Original Public Report

Report Issue Date: October 28, 2022

Inspection Number: 2022-1520-0002

Inspection Type:
Follow up
Critical Incident System

Licensee: St. Joseph's Health Care, London

Long Term Care Home and City: Mount Hope Centre for Long Term Care, London

Lead Inspector	**Inspector Digital Signature**
Peter Hannaberg (721821)	Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2022.11.10 15:53:19 -05'00'

Additional Inspector(s)
Debbie Warpula (577)
Vernon Abellera (741751)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 18, 2022
October 19, 2022
October 20, 2022
October 21, 2022

The following intake(s) were inspected:

- Intake: #00002027 - Second follow-up to High Priority Compliance Order #003 from inspection #2022_988522_0001 regarding O. Reg. 79/10 s. 229. (4). Original Compliance Due Date March 16, 2022.
- Intake: #00002442 - [Critical Incident: C596-000031-22] Resident with low blood sugar.

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg 79/10	s. 229 (4)	2022_988522_0001	#003	Peter Hannaberg (721821)

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #1 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with FLTCA, 2021, s. 184 (3).

Introduction
The licensee has failed to comply with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, effective April 15, 2020, when they did not report all of the incidents of severe hypoglycemia (low blood sugar levels) and the treatment (glucagon) provided to all parties per the directive. The licensee also failed to review and analyze all instances of severe low blood sugar and its treatment nor conducted quarterly and annual reviews of these incidents as required by the directive.

Rationale and Summary
The Directive, updated April 11, 2022, stated that the home was to ensure that every use of glucagon involving a resident and every incident of severe low blood sugar, was to be reported to the Director of Nursing and Personal Care (DOC), the Medical Director, the prescriber of the glucagon, the resident's attending physician or the registered nurse in the extended class

attending the resident, and the pharmacy service provider. In addition, all uses of glucagon and every incident of severe low blood sugar were to be reviewed and analyzed and corrective action was to be taken as necessary. The home was to ensure a quarterly and annual review of these incidents and to identify any changes necessary to improve the use of glucagon and the care and treatment of severe low blood sugar.

A Critical Incident (CIS) System report was submitted to the Director in May 2022, concerning a resident who experienced a severe low blood sugar episode where they received treatment and required further medical attention.

During an interview the DOC reported that staff were required to initiate a report in the home's electronic system when glucagon was administered, and the report was an automatic notification to the DOC and Administrator. They advised that the home had not reviewed and analyzed all uses of glucagon and every incident of severe low blood sugar; nor conducted quarterly and annual reviews. In addition, the incidents had not been reported to the Medical Director.

Sources: interviews with Registered Practical Nurses #109 and #112, Registered Nurse #113, DOC, and the resident, review of the resident's progress notes, care plan, hypoglycemic incident huddles, Medication Incident Reports, CIS Report # C596-000031-22, review of the home's policy "Diabetes: Care of Resident's with Diabetes" revised August 2020, 'Blood Glucose Testing" revised August 2020, the home's 'Quality Council' meeting notes dated July 20, 2022, the home's 'Hypoglycemic Management Decision Tree' revised August 2020, and the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, updated April 11, 2022.

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