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 sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 17, 2016	2016_384161_0017	031525-15	Critical Incident System

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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): May 11, 12, 13, 2016.

During the course of the inspection, the inspector(s) reviewed salient policies and procedures, identified residents health care records and home's investigation documentation.

During the course of the inspection, the inspector(s) spoke with the RAI Coordinator, a Manager of Resident Care and the Director of Nursing Practice.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment of a resident that resulted in a risk of harm, immediately report the suspicion and the information upon which it was based, to the Director.

On an identified date in February 2016 the Director was notified via the Critical Incident Report System, that on an identified date in February 2016 during a routine audit of residents' health care records, the home discovered that on 21 occasions, RPN #104 did not administer drugs to seven residents, as specified for use by the residents' attending physician. RPN #104's actions involved seven residents that resided on a specified home area, over a four month period spanning November 2015 to February 2016.

On May 12, 2016, the Director of Nursing Practice and the Resident Care Manager indicated to Inspector #161 that these drugs were improperly administered to the seven identified residents to promote sleep, which was not in accordance with the directions for use specified by their prescriber and thus there was a risk of harm to the residents. The Director of Nursing Practice and the Resident Care Manager further indicated that the home immediately conducted an investigation and notified the residents' Substitute Decision Makers and the Ottawa Police. The conclusion of the home's investigation resulted in disciplinary action of RPN #104 and a report was filed with the College of Nurses of Ontario regarding this matter.

On May 12, 2016 Inspector #161 discussed the information contained in the Critical Incident Report (CIR) with the Resident Care Manager who had initiated the CIR and submitted it to the Director 14 days after the home's discovery of the actions of RPN #104. When questioned by Inspector #161 as to why she did not immediately report the information to the Director, the Resident Care Manager indicated to Inspector #161 that she could not recall the reason. [s. 24. (1) 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 to ensure that (1) a person who had reasonable grounds to suspect that improper or incompetent treatment of a resident that resulted in a risk of harm, immediately report the suspicion and the information upon which it was based, to the Director and (2) that there is a process in place to ensure compliance with these reporting requirements, 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. (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 drugs were administered to seven residents in accordance with the directions for use specified by their prescriber.

On an identified date in February 2016 the Director was notified via the Critical Incident Report System that on an identified date in February 2016, during a routine audit of residents' health care records, the home discovered that on 21 occasions, RPN #104 did not administer drugs to seven residents, as specified for use by the residents' attending physician. RPN #104's actions involved seven residents that resided on a specified home area, over a four month period spanning November 2015 to February 2016.

On May 11, 2016 Inspector #161 asked the home's Director of Nursing Practice for the home's policy and procedures for Medical Directives. The Director of Nursing Practice provided inspector #161 with a document titled "Medical Directives - #GEN-CL-1668" dated 2010.09.14-R. A subsequent review of this document indicated that the purpose of the medical directives was to (1) identify clinical situations where interventions may be implemented for a resident by the nurse when a direct order is not in place and, (2) the

nurse is expected to exercise clinical judgment regarding the appropriateness of the order for the specific resident. Two of the drugs that were identified in the Medical Directives for the purposes above, were as follows:

- Dimenhydrinate (Gravol) 25 mg by mouth every four hours as necessary for nausea or vomiting

- Diphenhydramine (Benadryl) 25 mg by mouth every six hours as necessary for acute allergic reactions.

On May 11, 2016 Inspector #161 reviewed the health care records of the seven residents identified in the Critical Incident Report dated February 2016. Six of the seven residents were administered either Dimenhydrinate or Diphenhydramine to promote sleep, rather than the directions for use as specified by the residents' attending physicians in the Medical Directives. One resident received an analgesic to decrease agitation rather than the directions for use as specified by the resident's attending physician. The details of RPN #104's failure to administer these drugs, to the seven residents, in accordance with the directions for use specified by their attending physicians, are as follows:

Resident #001's attending physician prescribed an analgesic every four hours when needed for pain, on an identified date in October 2015. According to the resident's electronic Medication Administration Record progress note on an identified date in November 2015, RPN #104 administered the analgesic to resident #001 for agitation; not for pain as prescribed.

Resident #002's attending physician prescribed the home's Medical Directives on an identified date in September 2015. According to the resident's electronic Medication Administration Record progress note on an identified date in December 2015, RPN #104 administered Dimenhydrinate 25 mg to resident #002 to promote sleep; not for nausea or vomiting as prescribed in the Medical Directives.

Resident #003's attending physician prescribed the home's Medical Directives on an identified date in December 2015. According to the resident's electronic Medication Administration Record progress notes, on two identified dates in December 2015, RPN #104 administered Dimenhydrinate 25 mg to resident #003 to promote sleep; not for nausea or vomiting as prescribed in the Medical Directives. On an identified date in January 2016 the attending physician for resident #003 re-ordered the home's Medical Directives. According to the resident's electronic Medication Administration Record

progress notes, on three identified dates in January 2016, RPN #104 administered Diphenhydramine 25 mg to resident #003 to promote sleep; not for an acute allergic reaction as prescribed in the Medical Directives.

Resident #004's attending physician prescribed the home's Medical Directives on an identified date in October 2015. According to the resident's electronic Medication Administration Record progress notes, on two identified dates in December 2015, RPN #104 administered Dimenhydrinate 25 mg to resident #004 to promote sleep; not for nausea or vomiting as prescribed in the Medical Directives.

Resident #005's attending physician prescribed the home's Medical Directives on an identified date in November 2015. According to the resident's electronic Medication Administration Record progress notes, on three identified dates in January 2016, RPN #104 administered Diphenhydramine 25 mg to resident #003 to promote sleep; not for an acute allergic reaction as prescribed in the Medical Directives. On an identified date in February 2016 the attending physician for resident #005 re-ordered the home's Medical Directives. According to the resident's electronic Medication Administration Record progress notes, on five identified dates in February 2016, RPN #104 administered Diphenhydramine 25 mg to resident #005 to promote sleep; not for an acute allergic reaction as prescribed in the Medical Directives.

Resident #006's attending physician prescribed the home's Medical Directives on an identified date in November 2015. According to the resident's electronic Medication Administration Record progress note an identified date in February 2016, RPN #104 administered Diphenhydramine 25 mg to resident #006 to promote sleep; not for an acute allergic reaction as prescribed in the Medical Directives.

Resident #007's attending physician prescribed the home's Medical Directives on an identified date in November 2015. According to the resident's electronic Medication Administration Record progress notes, on two an identified dates in January 2016 at and on an identified date in February 2016, RPN #104 administered Diphenhydramine 25 mg to resident #005 to promote sleep; not for an acute allergic reaction as prescribed in the Medical Directives.

On May 12, 2016, the Director of Nursing Practice and the Resident Care Manager indicated to Inspector #161 that these drugs were improperly administered to the seven identified residents to promote sleep, which was not in accordance with the directions for use specified by their prescriber and thus there was a potential for harm to the residents.

The Director of Nursing Practice and the Resident Care Manager further indicated to Inspector #161 that the home immediately conducted an investigation and notified the residents’ Substitute Decision Makers and the Ottawa Police. The conclusion of the home’s investigation resulted in disciplinary action of RPN #104 and a report was filed with the College of Nurses of Ontario regarding this matter.

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 to ensure that drugs are administered to all residents in accordance with the directions for use specified by their prescriber and that there is a process in place to ensure that the home's Medical Directives are followed, to be implemented voluntarily.

Issued on this 17th day of May, 2016

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

Original report signed by the inspector.