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 prévue 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 soins 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

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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
Apr 3, 2019	2019_770178_0002	029191-18, 029903-18	Complaint

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Peter D. Clark Centre
9 Meridian Place OTTAWA ON K2G 6P8

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 27, 28, March 1, 4, 5, 6, April 1, 2019.

Complaint Logs #029191-18 and #029903-18, regarding a medication error, were inspected.

During the course of the inspection, the inspector(s) spoke with the family of a resident, the Program Manager of Personal Care (PMOPC), the Program Manager of Resident Care (PMORC), Registered Nurses (RNs), Registered Practical Nurses (RPNs).

During the course of the inspection, the inspector also observed the home's vaccine fridge, and reviewed residents' medical health records, the home internal investigation records, medication incident report and records, and medication administration policies.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. 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 :

1. The licensee has 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.

This non compliance is related to complaint logs #029903-18 and #029191-18.

On February 27, 2019, family member #110 indicated to Inspector #178 that on an identified date in October 2018, their loved one and 19 other residents received expired vaccine which was meant for the 2017 influenza season. Family member #110 indicated that while representatives from the LTCH initially told them that the vaccine was not expired, the former Administrator eventually indicated that Ottawa Public Health had confirmed that the 2017 vaccine would have been expired by October of 2018.

Inspector #178 reviewed the Medication Incident Report regarding the above mentioned incident. The Medication Incident Report indicated that expired 2017 flu vaccines were administered to residents on an identified unit. The attached list indicated that 20 residents received the expired vaccine.

On March 1, 2019, Inspector #178 interviewed the Program Manager of Personal Care (PMOPC), who is also the Infection Control Practitioner (ICP). The PMOPC/ICP indicated that on an identified date in October 2018, an RPN administered expired vaccine that was meant for the 2017 influenza season to twenty residents. The PMOPC/ICP indicated that the expired vaccine was present in the home's vaccine fridge because it is normally returned to Ottawa Public Health for destruction when the new season's influenza vaccines are picked up, but since the 2018 influenza vaccines had not yet been obtained by the home, the 2017 vaccine remained in the vaccine fridge. The PMOPC/ICP indicated that they worked with Ottawa Public Health (OPH) to respond to the error, and that OPH staff provided information that there was no harm in receiving a second dose of the 2017 influenza vaccine, and that the twenty residents affected could safely receive the 2018 influenza vaccine. OPH further indicated that the residents would need to receive the 2018 influenza vaccine in order to be protected for the 2018/2019 influenza season. The PMOPC/ICP indicated that the 20 residents were monitored for any reaction to receiving the 2017 vaccine in October 2018, and no residents showed evidence of adverse reaction or harm.

On March 4, 2019, Inspector #178 interviewed RPN #103, who indicated that on an identified date in October 2018, they and RPN #100 administered influenza vaccine to a total of 20 residents. RPN #103 indicated that the physician's order for the immunizations appeared on each resident's consent form, and that the physician's order did not specifically name the vaccine that was to be used for the 2018 influenza season.

RPN #103 indicated that when they found a number of boxes of influenza vaccine in the vaccine fridge on an identified date in October 2018, they assumed that these were for the 2018 influenza season. RPN #103 indicated that they felt sure they had checked the expiry date on the vaccines before administering them, but two days later the Program Manager of Resident Care (PMORC) told them that the vaccine they administered had been expired. RPN #103 indicated that the 20 residents were monitored after the error and no residents suffered an adverse reaction or harm as a result of the error. RPN #103 indicated that the physician and each resident or their substitute decision maker (SDM) was informed of the error as soon as it was identified.

On February 28, 2019, Inspector #178 observed the home's vaccine fridge. Several boxes of Influenza vaccine were present in the fridge, all with the expiry dates of either April 2019 or June 2019.

On March 5, 2019, Inspector #178 interviewed the PMORC, who indicated that they investigated the medication error when 2017 influenza vaccine was administered to residents in October 2018. The PMORC indicated that RPN #103 should have ensured they had the right medication and should have checked the expiry date before administering the vaccine. The PMORC did not personally observe the expiry date on the vaccine that RPN #103 administered on an identified date in October 2018, but Ottawa Public Health told management that the 2017 influenza vaccine should not have been used after August 2018. The PMORC indicated that by analyzing the medication error, gaps in process were identified and the home is making changes to their policy to correct those gaps. The PMORC indicated that in the future, the home will use the Ottawa Public Health consent for residents receiving the influenza vaccine. This consent reflects the specific influenza vaccine to be given that year. The physician's order will also indicate exactly what vaccine is to be given for that year. Finally, going forward the ICP will ensure that the vaccines from the previous influenza season are removed by May of the following year, in order to prevent recurrence of this error. The PMORC provided a copy of the home's written follow up plan in regards to this medication error. The follow up plan identified the gaps in process which led to the error, and included the proposed changes to the Influenza Vaccine process in order to prevent recurrence of the error. [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 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, to be implemented voluntarily.

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.