Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 11-12, 2011	2011_158_9566_11Apr112354	Follow up – critical incident M566-000026-11 S-001126-11

Licensee/Titulaire
The City of Sudbury
200 Brady Street
PO Box 5000 Stn A
Sudbury ON
P3A 5P3

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

Name of Inspector(s)/Nom de l'inspecteur(s)
Kelly-Jean Schienbein # 158

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with:
Administrator, Director of Care, Medical Director, registered nursing staff (RN,RPN), Nursing Program Coordinators

During the course of the inspection, the inspector conducted a walk throughout the home, observed the counting of narcotics at shift change on one unit, inspected the medication rooms on all the units, reviewed the home's policies and procedures related to administering narcotics, record-keeping and receipt of narcotics in the home.

The following Inspection Protocols were used during this inspection:
Critical Inspection
Medication

4 Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
4VPC

NON- COMPLIANCE / (Non-respectés)	
Definitions/Définitions **WN** – Written Notifications/Avis écrit **VPC** – Voluntary Plan of Correction/Plan de redressement volontaire **DR** – Director Referral/Régisseur envoyé **CO** – Compliance Order/Ordres de conformité **WAO** – Work and Activity Order/Ordres: travaux et activités	
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O Reg 79/10, s.114(3)(a)
The written policies and protocols must be, developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

Findings:

1. Item #1 of the home's written policy and procedures titled "the Narcotic and Controlled Drugs" states; "count all narcotics at the end of each shift with the oncoming shift. Both nurses then sign the narcotic control sheet".

- On April 11/11, the inspector observed that only one RPN signed the narcotic record after the narcotic count between the day shift RPN and the evening shift RPN was completed.
- The narcotic control sheets in one unit were reviewed by the inspector on April 12/11. There was only one signature noted for the 0700h count on April 6/11.
- The narcotic control sheets in a second unit were reviewed by the inspector on April 12/11. There was only one signature noted for the 0700h count on April 10/11.
- No counting of narcotics between the day shift RPN and the evening shift RPN in one unit was observed by the inspector on April 12/11.

2. The home's policy "Discrepancy in the Controlled Substance Record" states that when there is missing controlled substances, the home area's RN supervisor is notified by the registered staff, the Nursing Program Coordinator is notified by the RN supervisor; and staff members are not to leave until this is done. 28 tablets of a narcotic were noted missing when the narcotic was to be given to a resident. The two RPN's aware of the discrepancy left the home after notifying the RN Supervisor however, the Nursing Program Coordinator was not notified of the discrepancy until ten hours later.
3. Two RPN's and one RN failed to implement the above policy regarding the reporting of a discrepancy in the controlled substance record. The Nursing Program Coordinator confirmed in the April11/11 interview with the inspector that staff did not notify the Nursing Program Coordinator (of that unit) of the missing narcotics or remained in the home as per the home's policy.
4. It was observed by the inspector on April 12/11 that a RPN pre-signed for a resident's narcotic, which was ordered to be given two hours later. The home's medication policy related to administering narcotics was not implemented

Inspector ID #:	158

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 the home's policy related to medication administration of narcotics is followed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O Reg 79/10, s.129(1)(b)
Every licensee of a long-term care home shall ensure that, controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Findings:

1. The Nursing Program Coordinator confirmed during the interview with the inspector on April 11/11 that the 28 missing narcotics were left on the counter in one unit's medication room and not locked in the narcotic cupboard. The home did not store the narcotics in a separate, double-locked stationary cupboard in the locked area.
2. The inspector observed that the narcotics were locked in the narcotic cupboard in one unit's medication room on April 12/11. However, the medication room door was opened for 15 minutes while the RPN attended to other tasks. The RPN did not have the medication room door within the scope of vision at all times. The narcotics were not doubled locked.

Inspector ID #:	158

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 all narcotics are stored in a separate double-locked cupboard in the locked areas of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O Reg 79/10, s.130.1
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

Findings:
Eight pouches, each containing 1 tablet of a lipid reducing medication was found by the inspector on April 12/11 inside the E-MAR training manual located on a desk outside one of the unit's medication room.
The home did not ensure that drugs were stored in an area that is kept locked and secure.

Inspector ID #:	158

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 kept in areas that are locked and secure, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O Reg 79/10, s.133(1-9)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
(1) The date the drug is ordered.
(2) The signature of the person placing the order.
(3) The name, strength and quantity of the drug.
(4) The name of the place from which the drug is ordered.
(5) The name of the resident for whom the drug is prescribed, where applicable.
(6) The prescription number, where applicable.
(7) The date the drug is received in the home.
(8) The signature of the person acknowledging receipt of the drug on behalf of the home.
(9) Where applicable, the information required under subsection 136 (4).

Findings:
1. The inspector reviewed the home's "Live with oneMAR" (E-MAR) on April 11/11. The data reviewed identified that when the bar codes of the medication pouches are scanned, the medication is received into the inventory and a prompt to administer the medication is then initiated.
2. During the RPN's demonstration of the E-mars process with the inspector on April 11/11, it was observed by the inspector that a narcotic which was just counted was identified on the E-MAR as yet to be received. The home did not ensure the receipt of the narcotic.

Inspector ID #:	158

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 all medications including narcotics are signed as received in all of the drug records, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**

Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).