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
Mar 4, 2020	2020_583117_0007	002282-20	Complaint

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive OTTAWA ON K1V 8N5

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

St. Patrick's Home
2865 Riverside Drive OTTAWA ON K1V 8N5

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

LYNE DUCHESNE (117), LISA CUMMINGS (756)

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 25, 26, 2020 as well as March 2 and 3, 2020

The following complaint inspection Log #002282-20 is related to medication administration and medication management systems.

During the course of the inspection, the inspector(s) spoke with the Vice-President of Nursing Services (VP Nursing Services), the Assistant Vice-President of Nursing Services, to several Registered Practical Nurses (RPNs), to a Pharmacy Manager, to an external community service provider supervisor as well as to a resident and their family member.

During the course of the inspection, the inspector reviewed a resident's health care record, observed a medication cart, and medication packaging, reviewed the licensee's policies "NSG G 22.00 Medications: Medication Reconciliation" revised March 2017 and "NSG 12.00(c) Nursing Services: Documentation Provided Upon LOAs, Transfers or Discharges" revised April 2013.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #001 has a medical condition which requires that the resident receive a specific medication three times a day, at 0800 – 1200 – 1700 hours. Resident #001 receives the services of an external community service provider. As per the resident's plan of care, registered nursing staff are to put the resident's 1200-hour specified medication in one of the resident's specified belongings, so that the medication can be administered at the external community service provider.

As per RPNs #103, #107 and #108 as well as the external community service provider supervisor, the resident's 1200-hour medication can be placed in either one or the other of specified belongings that the resident brings with them, creating some difficulties for the external community service provider staff to find the resident's medication, and to ensure that the resident receives their prescribed medication. As per RPN #103 and the external community service provider supervisor, the medication is in a small square clear, labelled blister pack and not always easily visible amongst the resident`s belongings.

As per the VP of Nursing Services #100, the resident's care plan does not give clear direction to registered staff to ensure that the resident's medication is consistently placed at the same location so that the external community service provider staff can find and administer the resident's prescribed medication.

As such, the plan of care does not give clear direction to registered nursing staff as to where to place the resident's medication so that the external community service provider staff can find and administer the resident's prescribed medication. [s. 6. (1) (c)]

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.