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
May 13, 2022	2022_548756_0002	001548-22, 001958-22	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

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): March 9, 10, 14-17, 21-23, 2022.

The following intakes were completed during this Complaint inspection:
- Log #001548-22 regarding end-of-life care and a medication administration error.
- Log #001958-22 regarding a medication administration error.

During the course of the inspection, the inspector(s) spoke with the Vice President of Nursing (VP of Nursing), the Assistant Vice President of Nursing (AVP of Nursing), the Clinical Educator, the Records Management Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the Coroner.

During the course of the inspection, the inspector observed the entrance of the home and resident home areas and Infection Prevention and Control Practices. A review of relevant records was completed including resident health records, medication incident reports, a complaint response letter, Narcotic Master Shift Count Sheets, Palliative Symptoms Medication Order Form, Controlled/Targeted Substance Record Sheet, Vaccine consent and administration records, Vaccine audit reports, Physician orders, and policies; Pain and Symptom Management (Policy #IX NSG E-10.00, revised April 2021), Emergency Medication Box Protocol and Storage (Policy #IX NSG G 21.00, revised July 2018), Medication Reconciliation (Policy #IX NSG G 32.00, revised March 2017), and Medication Incident and Adverse Drug Reactions (Policy #IX NSG F-10.00, revised July 2018).

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was provided with end-of-life care in a manner that met their needs.

The resident returned from hospital for comfort care measures and had received a medication in hospital prior to the transfer. An RN documented that the resident returned with discharge paperwork from hospital but they did not contact the physician for new medication orders on that shift. Another RN worked the following shift and received an order for the medication. The medication was administered by an RPN twelve hours after the dose of medication in hospital and was documented as being ineffective in managing the resident's pain.

The RPN stated they contacted the RN at the start and throughout their shift requesting the new medication order as the resident required this medication and the family had requested to keep the resident comfortable. The RPN confirmed they administered the medication when it was provided by the RN but the resident's pain remained ineffectively managed at the end of the shift.

Sources: Resident healthcare record including the Medication Administration Record and Progress Notes, the emergency drug supply record, Physician's orders, and interviews with RNs, an RPN and other staff. [s. 42.]

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 every resident receives end-of-life care when required in a manner that meets their needs, 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. (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 a resident was administered the COVID-19 vaccine as prescribed.

The resident was administered the fourth dose of the COVID-19 vaccine and was administered a fifth dose of the same vaccine in error seven days later.

The VP of Nursing confirmed that the resident received two doses of the COVID-19 vaccine booster as a result of a computer error.

Sources: Resident healthcare record, complaint response letter, vaccine consent and administration records, vaccination audit reports, and interviews with an RN, the VP of Nursing and other staff. [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 administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident received two doses of the COVID-19 vaccine booster the incident was reported to the substitute decision-maker (SDM).

The resident received a booster dose of the COVID-19 vaccine and received another dose of the COVID-19 vaccine in error seven days later. The SDM was notified by an RN ten days after the error occurred.

The VP of Nursing stated they confirmed the error three days prior to when the SDM was notified and stated the SDM should have been notified of the error immediately.

Sources: Resident healthcare record, complaint response, interviews with the VP of Nursing and other staff. [s. 135. (1)]

2. The licensee has failed to ensure that the medication incident of administering two COVID-19 vaccine booster doses to a resident was documented, reviewed and analyzed.

The resident received a booster dose of the COVID-19 vaccine and received another dose of the COVID-19 vaccine in error seven days later. The Clinical Educator indicated they review and analyse the medication incidents when they receive the report. They indicated they had not received a written record for this incident.

The VP of Nursing confirmed they did not keep a written record of this incident.

Sources: Resident healthcare record and interviews with the Clinical Educator, the VP of Nursing and others. [s. 135. (2)]

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 all medication incidents are documented, reviewed and analyzed, and immediately reported to the substitute decision-maker, to be implemented voluntarily.

Issued on this 26th day of May, 2022

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

Original report signed by the inspector.