Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: June 13, 2024	
Inspection Number: 2024-1014-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation	
Long Term Care Home and City: Perth Community Care Centre, Perth	
Lead Inspector Gabriella Kuilder (000726)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 16, 17, 21, 22, 2024.

The following intakes were completed in this Critical Incident (CI) inspection: Intake: #00114454/CI#0962-000010-24 related to infectious disease outbreak.

The following intakes were completed in this complaint inspection: Intake: #00114973, Intake #00115000/ CI#0962-000012-24, and Intake: #00115001/CI#0962-000011-24 related to care.

The following Inspection Protocols were used during this inspection:

Medication Management
Infection Prevention and Control
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to comply with O. Reg 246 / 22 s. 124 (3) (a) specific to ensuring written policies and protocols for the home's medication management systems are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rational and Summary

On a specific day a resident experienced a decline in their condition, and a change in an approach to care was implemented. In consultation with a substitute decision maker (SDM), an attending physician ordered, two specific medications for the treatment of a specific medical condition.

The two specific orders were faxed to a pharmacy by a Registered Nurse (RN) on the specific day to be processed.

A review of an electronic medication record (EMAR) for a specific month indicated the first order for the specific medication was transcribed onto the EMAR by the pharmacy, however the second order was not transcribed.

On a specific day the second order for the specific medication was entered into the EMAR by a Registered Practical Nurse (RPN), as the resident's condition changed, and the administration of the second medication was required. However, the frequency of the medication administration was entered incorrectly into the EMAR.

On a specific day, the medication ordered entered into the EMAR by the RPN was discontinued by the pharmacy, and the correct order for the medication was entered.

A review of a policy related to Medication Incident Reporting indicated all medication incidents or near misses (Home or Pharmacy derived) must be reported, and should be documented electronically on MED-e-Report or a Care Home defined Medication Incident Report Form.

During an interview with a Director of Care (DOC) they indicated the pharmacy did not transcribe the second medication order into the resident's EMAR correctly when ordered on a specific day. The DOC indicated the pharmacy error was identified on a specific day and entered the EMAR by the RPN. However, the RPN entered the frequency of the administration of the specific medication incorrectly.

The DOC indicated a medication incident report should have been completed by the registered staff, when the error in transcription of the medication order for the resident was identified. The DOC indicated all staff were trained on the home's medication incident reporting process.

By not ensuring that a medication incident report is completed for all types of medication errors could lead to a delay in the correction of the error, and increase the risk of the resident not receiving the ordered medication to manage their pain and discomfort.

Sources: Interview with a DOC, records for the resident ,Policy related to Medication Incident Reporting.
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