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 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**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 20, 2018 | 2017_532590_0026 | 026380-17 | Resident Quality Inspection |

## Licensee/Titulaire de permis

County of Oxford
325 Thames Street South INGERSOLL ON N5C 2T8

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

Woodingford Lodge - Ingersoll
325 Thames Street South INGERSOLL ON N5C 2T8

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

ALICIA MARLATT (590), ANDREA DIMENNA (669)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): November 27, 28, 29, 30 and December 1, 2017.**

**A follow up inspection was completed within this RQI: Log #005212-17 was completed for compliance order #001 from a Resident Quality Inspection #2016_326569_0031 and was related to medication management.**

**During the course of the inspection, the inspector(s) spoke with the Manager of Woodingford Ingersoll, the Manager of Resident Services, a Registered Pharmacist, the Coordinator of Resident Assessment Instrument (RAI), three Registered Nurses (RN), one Registered Practical Nurses (RPN), seven Personal Support Workers (PSW), the Residents' Council representative, three family members and ten residents.**

**During the course of the inspection, the inspector(s) observed all resident home areas, posting of required information, recreational activities, medication administration and storage areas, infection prevention and control practices, resident and staff interactions.**

**During the course of the inspection, the inspector(s) reviewed resident clinical records, meeting minutes relevant to inspection and relevant policies and procedures related to the inspection.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Skin and Wound Care**

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

- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 114. | CO #001 | 2016_326569_0031 | 590 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's Substitute Decision Maker (SDM), 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.

One medication incident from the most recent quarter, and two medication incidents from the previous quarter, were reviewed as part of this Resident Quality Inspection (RQI).

Review of a Medication Incident Report for an incident on a specified date, involving an identified resident, showed that the Practitioner was not notified of this incident. The area to document that the Practitioner was notified was checked off as 'no'. Review of this resident's progress notes for a six day time period after the incident, showed no documentation that the Practitioner was made aware of the medication incident.

Review of a Medication Incident Report for an incident on a specified date, involving an identified resident, showed that the Practitioner was not notified of this incident. The area to document that the Practitioner was notified was checked off as 'no'. Review of this resident's progress notes for a six day time period after the incident, showed no documentation that the Practitioner was made aware of the medication incident.

Review of a Medication Incident Report for an incident on a specified date, involving an identified resident, showed that only the Supervisor was notified of this medication incident. Areas to document that the resident/Power Of Attorney (POA) and Practitioner were notified, were checked off 'no'. Review of this resident’s progress notes for an 11 day time period after the incident, showed no documentation that the Practitioner or resident/POA were notified of the medication incident.

The Home's policy titled Documentation & Reporting Medication Errors & Adverse Reactions, policy number I 6.640 and last revised on June 14, 2016, stated:
"The event is to be documented on the resident record. When a moderate to high risk is identified, disclosure to the resident and family/POA - Personal Care is important."

In an interview with a RN, they shared that the resident/POA, Physician, Supervisor and the pharmacy should all be notified of medication incidents.

In an interview with the Manager, they shared that the home’s policy at the time of the incidents, did not specifically direct staff to notify the resident/POA, however stated that the home's policy and medication incident reporting form had been updated to reflect legislation and the new policy came into effect on November 30, 2017. The updated medication incident reporting form no longer gives the 'option' of notifying the Practitioner or resident POA and areas to document date and time of notification of these persons had been added to the form. They shared that Practitioners and resident/POA’s should be made aware of all medication incidents according to legislation and that their updated policy instructed staff to do so now.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (SDM), 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. [s. 135. (1)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (3) The drugs must be destroyed by a team acting together and composed of,**
**(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),**
**(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and**
**(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that in the case of a controlled substance, the drugs would be destroyed by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. a physician or a pharmacist.

Review of the Home's narcotic disposal process was completed as part of a follow up inspection completed within this RQI.

Review of the Home's Storage of Narcotic/Controlled Drugs policy number I 6.665, last revised on April 27, 2017, was completed and it stated in the "Refused/Wasted Narcotics/Controlled Drugs" section that:

"Wasted narcotics occurs in the presence of two nurses and is documented on the narcotic record on the line representing that dose. The same process applies to the disposal of refused and/or unused partial tablets and unused portions of single dose ampuoles. Unused or discontinued control medications are placed in the locked cupboard within the mail slot on each Resident Home Area for safekeeping in a securely locked area with restricted access until destroyed in accordance with legislation, refer to policy 6.645 for Pharmacy Services - Drug Destruction. Medication that is denatured can be wasted into the biohazard container if it has been denatured to the extent that it could not be retrieved from the container."

Review of the Home's Drug Destruction policy number I 6.645, last revised on April 27, 2017 stated in part that:

"Two Registered Nurses will double check and co-sign the Narcotic and Controlled Drug Record AND the Surplus Medications Record for all controlled substances that meet the requirements for drug destruction. The medication will be kept in its original packaging. Two Registered Nurses will record the discontinued medication in the Surplus Binder (with either the reorder tag, or by completing the required information) and co-sign. Both Registered Nurses will sign then Narcotic and Controlled Drug Record indicating the quantity remaining and co-sign. This count sheet will then be wrapped around the medication, fastened with an elastic band, and both Registered Nurses will witness the placement of the medication into the locked cupboard in the med room." This policy also stated that: "The Pharmacist will come in on a regular basis, every six weeks or sooner if deemed necessary to destroy an accumulated amount of controlled substances."

In an interview with a RN, they said that when they disposed of half used ampules of controlled substances, they added applesauce to the ampule and discarded the ampule in the sharps container on the medication cart. This was done in the presence of another registered staff member and then they completed the appropriate documentation on the narcotic administration record that half an ampule was wasted.

In an interview with another RN, they shared that when they disposed of half used ampules, they placed the ampule into a special plastic bag, the opening was covered with tape, and then completed the appropriate documentation witnessed by another registered staff member. The RN would then place the ampule into the controlled substances destruction box in the medication room. They shared that another common practice in the home was that the staff would add applesauce to the ampule and discard in the sharps containers.

In an interview with the General Manager, they said that the sharps containers were removed from the home by the Steri-Cycle company.

In an interview with a Pharmacist, they shared that they reached out to the College of Nurses of Ontario (CNO) to inquire about best practice guidelines for disposal of partially used narcotics after receiving their compliance order related to narcotic disposal. The Pharmacist stated that the CNO indicated that best practice would be to have two registered staff members dispose of partially used narcotics into the sharps containers at the time of administration, and that the appropriate documentation would also have to be completed with the disposal of the drug. The Pharmacist stated that adding applesauce to unused portions of ampules was not best practice, however not harmful as the drug

was being disposed of. The Pharmacist said that disposing of partially used narcotics into the sharps containers was acceptable and considered the possibility of retrieval of the drugs from the sharps containers improbable. The Pharmacist said that partially used narcotic tablets were considered denatured when crushed with applesauce added and that ampules that were poured out or had applesauce added were also denatured. The Pharmacist agreed that meant that staff were denaturing narcotics, however this practice could not be changed as registered staff had no idea which resident was going to refuse a narcotic prior to preparing the medication, which may include 'denaturing' of crushing the tablet and adding applesauce to it. The Pharmacist further shared that adding open glass ampules of liquid into the destruction bin would not be safe when retrieving medication from the bin during destruction time and further, may ruin any documentation in the destruction bin if the bag the ampule was stored in leaked. The Pharmacist further shared that adding bags of narcotics in applesauce to the destruction bin would not be expected as when retrieving the drug from the box there would only be the completed documentation to identify what drug was mixed up in the bag of applesauce. The Pharmacist shared that only drugs that have been discontinued, or rather, drugs that were still in their original packaging and had not been prepared for administration, should be placed in the destruction bin as per the Home's destruction and storage policies.

In an interview with General Manager, they said that registered staff members would be required to waste controlled medications as some medications came delivered in large doses and the remaining dose would have to be wasted. They shared that there was not a pharmacist in the building at all times and it would be unrealistic to expect a pharmacist to be present to destroy every controlled medication that was wasted.

The licensee has failed to ensure that when a drug that was to be destroyed was a controlled substance, it was done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist. [s. 136. (3) (a)]

**Issued on this 21st day of February, 2018**

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

**Original report signed by the inspector.**