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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 27, 2016	2016_360111_0020	027693-16, 027696-16	Follow up

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 21, 22, 23 & 26, 2016

There were two follow up inspections (log # 027983-16 & 027696-16) and one critical incident inspection (log # 028334-16) related to unaccounted for controlled substances that were completed concurrently.

During the course of the inspection, the inspector(s) spoke with Director of Operations, Director of Care (DOC), Resident Home Area Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), and Manager of Quality Education.

During the course of the inspection, the inspector(s) reviewed: health records, home's investigations, home's policies (Monitoring of Transdermal Analgesic Patches) and staff training records.

The following Inspection Protocols were used during this inspection:
Medication

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)**

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	Legendé 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. 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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Re: critical incident Log # 028334-16 for resident #008:

Interview with RN #105 (by Inspector #607),during the inspection, the RN indicated a transdermal narcotic was found on resident #001's mobility aide on a specified date, that belonged to resident #008. The RN indicated that resident #008's transdermal narcotic had been placed on hold and should not have been administered. RN #105 reported the medication incident to RN #106 (RCC).

Review of the e-MAR for a specified date, and review of the physician's order for resident #008 (by Inspector #111) indicated the transdermal narcotic patch was put on "hold" two weeks before the transdermal narcotic was applied.

Interview with RN #106 (by Inspector #111), during the inspection, confirmed resident #008 was administered a transdermal narcotic on a specified date, while the drug was on hold.

Therefore the licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed, as resident #008 was administered a transdermal narcotic on a specified date without a physician order.

WN #2: 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 every medication incident involving a resident is:
(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 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.

A Compliance Order (CO#001) was issued on September 9, 2016 for O.Reg.79/10, s. 135(1) with a compliance date of September 16, 2016. The incident identified under log # 028334-16 for resident #001 and the incident with resident #008 both occurred prior to the compliance date, therefore a Written Notification (WN) was issued as a result.

Re: critical incident Log # 028334-16 for resident #001:

A critical incident report (CIR) was received by the Director for a medication incident that

occurred on a specified date. The CIR indicated a missing or unaccounted for transdermal narcotic for resident #001 that was discovered by RPN #108 and #109 at shift change.

A review of the home's, medication - Monitoring of Transdermal Analgesic Patches, Policy # 8-107 dated October 02, 2015 (page 1 of 1) directs Responsibility of Registered Staff:
1. When a Narcotic Analgesic Patch is ordered an accompanying order is to be entered in the e-MAR to check and document for the presence each shift.
2. Enter the time closet to the start time of each shift i.e. 0730, 1630 and 2130 hrs
3. If a patch is unable to be located a medication Incident Report form must be completed
4. The attending physician or On-call physician will order for the replacement of the missing patch.

Interview with the DOC (by Inspector #111), during the inspection, confirmed the Medical Director was not informed of the medication incident.

Review of resident #001's health care records, review of the home's investigation notes, interview with RPN #108, #109, #113, #114, RN #105 & RN #106, and review of the home's policy indicated six RPN's and one RN were involved in the medication incident of a missing transdermal narcotic. When the transdermal narcotic was ordered, an accompanying order to check for placement each shift was omitted for a five day period. When the omission was discovered, it was not put on the e-MAR until the following day. The attending physician (or on-call physician) was not contacted to order for the replacement of the missing transdermal narcotic for resident #001 until the following day, despite a replacement transdermal narcotic applied. The medication incident was not documented until eight days after the incident occurred and the investigation identified only four RPN's involved in the medication incident. No other actions had been completed to date.

2. Re: critical incident Log # 028334-16 for resident #008:

During an interview with RN #105, during the inspection, (by Inspector #607), the RN indicated that resident #008 transdermal narcotic (with a specified date) was found on resident #001's mobility aide. The RN indicated RN #106 (RCC) was notified regarding the medication incident.

Review of the health record of resident #008, the home's investigation, and interview with RN #106 (by Inspector #111) during the inspection, confirmed the transdermal narcotic was applied on a specified date, two weeks after the drug was placed on hold, and was the transdermal narcotic that belonged to resident #008 was found on another resident's mobility aide, and no documented medication incident report was completed for the missing transdermal narcotic for resident #008 and no other actions were taken.(607)

Issued on this 28th day of October, 2016

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

Original report signed by the inspector.