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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 4, 2023
Inspection Number: 2023-1615-0003
Inspection Type: Complaint Critical Incident System
Licensee: The Regional Municipality of Halton
Long Term Care Home and City: Post Inn Village, Oakville

Lead Inspector	**Inspector Digital Signature**
Nishy Francis (740873)	Nishy Francis Digitally signed by Nishy Francis Date: 2023.04.06 08:45:27 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 16, 20, 22-24, 27-30, and April 3, 2023.

The following intake(s) were completed in this complaint inspection:
- Intake: #00011521 related to whistleblowing protection and retaliation;
- Intake: #00021942 related to falls prevention and management; food nutrition and hydration; and medication management.

The following intake(s) were completed in this Critical Incident (CI) inspection:
- Intake #00017289 related to falls prevention and management.

The following intakes were completed in this inspection: intake #00002407, intake #00004199, intake #00008098, intake #00011346, intake #00013326, intake #00014333, intake #00019373, and intake #00005978, related to falls.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Whistle-blowing Protection and Retaliation

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: #01 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)

The licensee failed to ensure that the written policies and protocols for a resident's drugs were implemented for accurate dispensing and administration.

Rationale and Summary
An incorrect medication order was transcribed by pharmacy on the electronic medication administration record (eMAR).

The home's policy, Processing Physician Orders, indicated that nursing staff were to firstly, compare the physician's written order with the eMAR to ensure that the order was transcribed correctly. Upon verification, the first nurse was to sign the physician's order sheet in the resident's chart, followed by a secondary nurse's signature to complete a final check.

The physician's order sheet confirmed the first and second checks had not been signed.

The eMAR confirmed the resident was administered the medication with incorrect frequency. Interview with the home's medical director indicated the medication error did not result in harm to the resident.

When written polices and protocols to ensure accurate dispensing and administration of a resident's drugs are not implemented correctly, there is the potential for the resident to not receive the therapeutic outcome as prescribed.

Sources: Interviews with staff and Pharmacy; residents progress notes, medication administration record, physician order sheets, Processing Physician Orders policy, revised August 2018. [740873]