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
Dec 7, 2016	2016_206115_0031	028578-16	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE CITY OF WINDSOR
1881 Cabana Road West WINDSOR ON N9G 1C7

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

HURON LODGE LONG TERM CARE HOME
1881 CABANA ROAD WEST WINDSOR ON N9G 1C7

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

TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 11, 12, 17, 18, 19, & 20, 2016

Inspector Alicia Marlatt (590) was also present for this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, one Director of Care, the Assistant Director of Care, four Registered Nurses, four Registered Practical Nurses, six Personal Support Workers, two activities staff, one housekeeping staff, a Resident Council representative, residents and their families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, observed the provision of resident care, resident staff interactions, and the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
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)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living was included in the residents' plan of care.

During Stage 1 of the RQI, resident #001 was observed using a Personal Assistance Services Device (PASD).

A review of the clinical record revealed that the home had not completed an assessment or included the use for the PASD in the residents' plan of care.

A review of the home's policy Personal Assistance Device Procedure revised October 2013 indicated under definitions:

"Use of PASD's must be documented in the resident's plan of care."

During an interview with Registered Nurse #104 she indicated that the resident was using a PASD, however this had not been assessed nor was it reflected in the residents' plan of care.

The severity of this issue was determined to be a level 2 which is a minimal risk or potential for actual harm, and the scope is a level 1, which is isolated. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 33. (3)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had developed an interdisciplinary medication management system that provided safe medication management and had written policies and protocols developed for the medication management system to ensure the accurate administration of all drugs used in the home.

On October 20, 2016, Inspector #590 completed an medication administration observation, and observed RPN #115 administer an injectable medication to a resident.

During the observation, the RPN #115 had removed an opened glass ampule of medication sitting in a medication cup, from the locked narcotic medication drawer. The ampule was labelled with the drug name and dosage. Upon questioning RPN #115, she shared that the same glass ampule may be used for the same resident who may require multiple injections during a shift. She shared that she would open an ampule at the start of her shift and discard whatever was left at the end of her shift. She confirmed that she was the only person, other than management, who had access to that specific medication cart. She was unsure if this was an acceptable practice in the home or if other staff members practiced like this. RPN #115 reviewed the narcotic sign out sheet with inspector #590, the sheet indicated that other staff were in fact practicing the same way.

During an interview with DOC #101 she confirmed that this was an acceptable practice in their home to reduce waste. She explained that the staff at the start of their shift should be opening a new ampule for safety reasons. She shared that the staff were to store the opened ampule, labelled with the medication name, dosage, resident name and date opened, in the locked narcotic drawer. At the end of their shift they were to discard

whatever medication was left over in the ampule. She shared that the home currently did not have a policy related to this practice, but they did have a new Pharmacist working and would discuss developing a policy for this practice in the future.

During an interview with ADOC #114 she confirmed the same practice and explained the same guidelines the staff were to follow. She also confirmed that there was no policy related to the above practice and would discuss developing a policy with the Pharmacist to provide better direction to staff.

In consultation with the Institute for Safe Medication Practices (ISMP), the ISMP representative described 2 milligram ampules as being meant for "single use only". She expressed safety concerns related to the open ampule as an opportunity for "narcotic diversion".

The home's medication management system did not provide safe medication management as the home was not following best practices by storing open ampules of narcotics for multiple usages and the home did not have a written policy related to the safe storage and administration of injectable narcotics.

The severity of this issue was determined to be a level 2 which is a minimal risk or potential for actual harm, and the scope is a level 1, which is isolated. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. (590) [s. 114. (2)] [s. 114. (1)]

Issued on this 8th day of December, 2016

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

Original report signed by the inspector.