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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2018	2018_785732_0001	022751-18, 028453-18	Critical Incident System

Licensee/Titulaire de permis

Dundas Manor Limited
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

EMILY BROOKS (732)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 4, 5, 10, 11, and 12, 2018.

The following Critical Incident logs were inspected:

Log #022751-18 (CIS 2674-000018-18) related to fall with fracture
Log #028453-18 (CIS 2674-000023-18) related to medication incident

Non-compliance has been observed in regards to O. Reg. 79/10, s.6(9)1 of the Long Term Care Homes Act that will be addressed in inspection #2018_618211_00003 by inspector #211. Non-compliance was also observed in regards to O. Reg. 79/10, s. 8(1)b of the Long Term Care Homes Act that will be addressed in inspection #2018_761733_00001 by inspector #733.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), the Associate Director of Care (ADOC), the Director of Care (DOC), a Pharmacist, and the Administrator.

During the course of this inspection, the inspector reviewed resident health records, progress notes, policies and procedures, and medication administration records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date, two drugs were ordered together for resident #006. Resident #006 had an allergy to drug #1. Drug #1 was discontinued by the physician and a new drug was ordered instead. The order for drug #2 was not filled, and subsequently not administered to the resident for three days. This resulted in resident #006 transfer to hospital with injury.

On a specified date, Inspector #732 asked Associate Director of Care (ADOC) #109 to explain what went wrong that lead to resident #006 not being administered drug #2. ADOC #109 explained that this was very much a pharmacy driven error. ADOC #109 went on to explain that the physician had ordered new medications – drug #1 and drug #2. Pharmacy was questioning the order for drug #1 as resident #006 chart stated they had an allergy to the drug. Pharmacy put that order to the side, faxed the physician, and awaited a reply from the physician before proceeding.

The physician called the home to discontinue drug #1 and start a new drug - drug #3. This order was written on a different order sheet. Drug #3 was processed by pharmacy, but the order for drug #3 was not. It was a different pharmacist who processed the order and they did not see the order for drug #2. ADOC #109 told Inspector #732 that a pharmacist made a note in Resident #006 chart that stated there should be an additional drug ordered with drug #3, but went ahead and processed the order for drug #3.

When Inspector #732 asked ADOC #109 if they had a drug record for this incident, ADOC #109 explained that there would not be one as the incident involved a medication omission. Inspector #732 confirmed with ADOC #109 that medication omission meant resident #006 did not receive drug #2.

Inspector #732 telephone interviewed pharmacist #133 on a specified date. Pharmacist #133 explained that when the order for drug #1 and drug #2 came through for resident #006 on a specified date, they were alerted to resident #006 allergy to drug #1. Pharmacist #133 confirmed that the order for drug #2 was not filled at this time until clarification of the order for drug #1 was received from the physician. This order was placed in the follow-up bin.

Pharmacist #133 told Inspector #732 that on a specified date, the physician discontinued drug #1 and ordered drug #3. This was written on a new order sheet. The order was placed on top of the previous drug #1 and drug #2 order. A different pharmacist came on shift and filled only the order for drug #3. Inspector #732 reviewed resident #006 chart and was able to verify order sheets.

Pharmacist #133 confirmed that the order for drug #2 was never added to resident #006 electronic medication administration record (eMAR).

On a specified date, Inspector #732 reviewed resident #006 chart. Inspector #732 located the "Prescriber's Orders" sheet where the order for drug #1 and drug #2 were written on a specified date. There was a stamp with the word 'faxed' and an initial below. Below that, there was a second initial. ADOC #109 confirmed that the first initial was theirs and the second initial was that of registered practical nurse (RPN) #122. ADOC #109 confirmed with Inspector #732 that a second initial meant the order was processed by pharmacy, it was entered in the electronic medication administration record (eMAR), and that what was on eMAR matched what the physician ordered. Inspector #732 reviewed resident #006 eMAR and confirmed that drug #2 was not on resident #006 eMAR for a specified month, and therefore not administered.

In an interview with RPN #122 on a specified date, RPN #122 confirmed that they did not fully check eMAR to make sure the order was processed correctly before signing their name. RPN #122 also confirmed that the order was never put on eMAR.

The licensee failed to ensure that resident #006 was administered drug #2 in accordance with the directions for use as specified by the provider. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 17th day of December, 2018

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

Original report signed by the inspector.