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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: September 01, 2023	
Inspection Number: 2023-1063-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare New Orchard Lodge, Ottawa	
Lead Inspector Marko Punzalan (742406)	**Inspector Digital Signature** Marko Punzalan Digitally signed by Marko Punzalan Date: 2023.09.01 15:19:18 -04'00'
Additional Inspector(s) Laurie Marshall (742466)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16,17,18,21,22,23,24,25,28, 2023.

- Intake: #00094518 - PCI for Extendicare New Orchard Lodge.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.

The licensee has failed to ensure that storage of a controlled substance medication was kept in a double locked storage area separate from any controlled substances that were available for administration to a resident, until the destruction and disposal occurred.

Rationale and Summary:

As required in O.Reg s. 11 (1) the licensee of a long-term care home shall institute any plan or policy that has to be complied with and all applicable requirements under the Act. Upon review of the home's policy regarding the destruction and storage of narcotics, it was identified that staff were not following the home's policy for storage and destruction of narcotics.

The inspector observed the RPN storing an open ampoule of a controlled substance in the medication slot assigned to the resident, which also contained current medications for administration. It was observed that this section of the medication cart has one lock.

Review of the home's policy for the management of Insulin, Narcotics, and controlled drugs, Policy # RC-16-01-13, under Procedures for Disposal of Narcotic/Controlled Drugs and Discontinued drugs indicated:
3. The storage area for narcotic and controlled drugs awaiting destruction must meet the following criteria:
a. The storage area must be a specific, fixed, permanent area that is used exclusively for the storage of narcotic and controlled drugs;
b. The narcotic and controlled drugs must be double locked at all times.

During an interview with RPN, they reported that an open medication ampoule of a controlled substance for the resident was kept in the drawer of the medication cart in the event the resident requested another dose. The medication from the ampoule is then discarded at the end of the shift if

not used.

During the interview with RN, it was identified that the disposal of high risk medications is required to be witnessed by two staff. If there was no staff available to waste the medication then the medication is to be stored in the narcotic box in the medication cart until it can be witnessed by two registered staff. They added that the opened ampoule was not stored in the narcotic box as the narcotic box in the medication cart was full.

RPN reported that if there are no other registered nursing staff available to waste medication then store it in the narcotic box in the medication cart.

During the interview with DOC, they reported that narcotics were to be destroyed immediately by two registered nursing staff and that if the high risk medications could not be destroyed immediately then they would be stored in the narcotic box in the medication cart and destroyed as soon as possible by two registered nursing staff. The DOC reported that medications drawn up from ampoules cannot be reused and must be discarded immediately as ampoules are for single dose use. The DOC confirmed that the home's policy indicated that if the registered nurse could not get another registered nurse to co-sign the medication for waste then the high risk medications that were to be wasted should be kept in the narcotic box in the medication cart and destroyed at the end of the shift.

By not storing the open ampoule of morphine in a double locked medication storage area away from residents' current medications may increase the risk of potential medication errors.

Sources: Observations; Management of Insulin, Narcotics, and Controlled Drugs Policy # RC-16-01-13; Interviews with RPN, RN and DOC [742466].

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