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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2017	2017_566669_0023	019085-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE TECUMSEH
2475 ST. ALPHONSE STREET TECUMSEH ON N8N 2X2

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

ANDREA DIMENNA (669), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 5, 6, 7, 8, 11 and 12, 2017.

The following critical incidents were completed with this inspection:

2904-000008-17/Log #017951-17, related to a fall;
2904-000012-17/Log #020969-17, related to an injury.

During the course of the inspection, the inspector(s) spoke with residents, a representative of Family Council, a representative of Residents' Council, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurse (RPN)/Back-up RAI Coordinator, Resident Program Manager, Documentation Coordinator, three Registered Nurses (RNs), nine RPNs, one Housekeeper, one Hairdresser, four Health Care Aides (HCAs), and seven Personal Support Workers (PSWs).

During the course of the inspection, Inspectors conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspectors observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system, (a) was in compliance with and was implemented in accordance with all applicable requirements under the Act; and (b) was complied with.

Section 68 (2) (e) (ii) of the Ontario Regulation 79/10 states that the nutrition care and hydration programs included a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter.

During stage one of the Resident Quality Inspection (RQI) census record reviews and staff interviews, it was noticed that many residents' most current heights were older than one year.

The home's policy, "Weight Change Program," dated November 2013, was reviewed and instructed that care staff take residents' heights on admission and at least annually thereafter.

There were 16 residents from stage one who were admitted more than one year ago, and eight of these residents' most current heights in Point Click Care (PCC) were all dated more than one year from the current date.

Two HCAs stated that the RPNs were responsible for measuring the heights of residents. One of the HCAs explained that they had never measured a resident's height.

Two RPNs and the Resident Assessment Instrument (RAI) Coordinator said that heights were measured on admission and annually. One RPN said that RPNs measured residents’ heights on admission, but that PSWs measured heights annually thereafter. The RPN was unable to recall measuring a resident’s height at a time other than admission.

The DOC was interviewed and said that residents’ heights were supposed to be measured annually, and that all heights were now documented in PCC. The DOC identified that there were residents with missing heights, and that the home had put out reminders for registered staff to complete any outstanding heights.

The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system, related to heights was complied with. [s. 8. (1)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Section 48 (1) of the Ontario Regulation 79/10 states that every licensee of a long-term care home shall ensure interdisciplinary programs are developed and implemented in the home, including a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

During the RQI, a resident triggered for incontinence from Minimum Data Set (MDS) information.

The home’s policy, "Continence Management Program," last updated February 2017, stated that continence assessments were completed upon admission for all residents, with any deterioration in continence level, and with any change in condition that may affect bladder and bowel continence.

The resident’s MDS Assessment from a specified date was coded for a specific level of continence, and a subsequent MDS Assessment from a specified date was coded for a different level of continence, designating that the resident's continence had deteriorated.

A review of the resident’s electronic record showed a Continence Assessment from a specified date that was blank and had not been completed.

An RPN was interviewed and said that continence assessments were done on admission, quarterly, and with any changes in continence, which would be initiated based on input from staff or residents.

The Documentation Coordinator was interviewed and said that continence assessments were initiated by the RAI Coordinator when there was worsened bowel or bladder continence noted for a resident during coding for MDS assessments.

The RPN/RAI Back-up was interviewed and explained that continence assessments were completed on admission, whenever there was a change in continence, and after a significant change. The RPN/RAI Back-up acknowledged that the resident’s MDS assessment from a specified date included information that the resident's continence had deteriorated in comparison to a previous MDS assessment. The RPN/RAI Back-up explained that a continence assessment should have been conducted and acknowledged that there was an open continence assessment that had not been completed.

The RAI Coordinator was interviewed and explained that continence assessments were completed on admission and when there was a change in a resident’s continence. The RAI Coordinator continued that when coding a resident’s continence during an MDS assessment, if a change was noted, or when a resident’s significant change was triggered by a change in continence, a continence assessment would be completed. The RAI Coordinator reviewed the resident’s MDS assessment for a specified date and acknowledged that the resident had a change continence level. The RAI Coordinator noted that there was an open continence assessment in PCC for the resident but that the assessment was not completed, and should have been.

The DOC was interviewed and stated continence assessments should be completed when a resident had a significant change in continence. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Section 114 (2) of the Ontario Regulation 79/10 states 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.

Review of the Medication policy, “Patch Disposal for Monitored Medication," dated

February 2017, stated the following:
-"Use one patch disposal record sheet per shift. If there are fewer than six patches removed per shift, any unused boxes on the patch disposal record sheet can be crossed off."
-"keep the patch disposal record sheet and used patches in a zip lock bag in the double locked narcotic cabinet in the medication cart until the nurse has completed the medication pass."
-"Document the number of patches removed from the resident in the amount wasted column of the count sheet. This number should equal the number of new patches applied to the resident. The nurse will document the remaining quantity of patches in the quantity/remaining column."
-"at the end of the shift, once all patches have been removed and documented, there will be a reconciliation of the nurse of patches by a second nurse. The second nurse will verify that number of patches placed on the patch disposal record sheet equals the number of patches wasted on the count sheet. Once this reconciliation has taken place the second nurse will cosign the patch disposal record sheet on the nurse signature two line and will cosign the count sheet in the quantity/remaining in card column."
-"both nurses must place the patch disposal record sheet into double locked secured monitored surplus box."

Observation of the medication narcotic count on September 7, 2017, noted there was a sheet that had fentanyl patches taped to it. An RPN stated that narcotic patches that were removed were placed on a sheet of paper and stored in the narcotic bin but the sheets were not counted. The RPN explained that the patches stayed in the cart until the sheet was full and then it was put in the narcotic destruction bin.

During an observation of the cart on September 12, 2017, with another RPN, it was observed that there were three sheets of fentanyl patches. Two of the sheets were dated August 2017, and one of those was full. None of the pages were in zip lock bags.

The RPN stated that they did not count these sheets at shift change, and once the sheet was full they were to be removed to destruction. The RPN stated that they did not count the wastage on the narcotic count sheet when they removed the patch, they only wrote on the fentanyl destruction sheet that they removed it.

Another RPN stated that new fentanyl patches were counted if they were in the box but the ones that were on the paper to be destroyed were not counted.

An RN acknowledged that there were three fentanyl sheets in the narcotic bin, and that they should have been placed in the narcotic destruction bin once completed. The RN stated that the pages were destroyed when the sheet was full and that they were not counted each shift.

The DOC stated that the fentanyl patches went on a narcotic destruction sheet and they were kept in the locked box. Once the sheet was full it went in to the destruction bin. The DOC stated that the sheets were not counted each shift. The DOC acknowledged they were not following the home's policy. [s. 8. (1) (b)]

4. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Section 114 (2) of the Ontario Regulation 79/10 states 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.

Review of the home's policy, "Medication Incident and Reporting," dated February 2017, stated under procedures to "take immediate action in the event of an incident/adverse drug event by notifying the physician/nurse practitioner for treatment directions."

Review of the Medical Pharmacies policy, "Medication Incident Reporting," dated February 2017, stated, "If the wrong medication is ingested by the resident, the nurse must notify the physician and pharmacy to obtain action plan to access and maintain resident's health."

The home's Medication Incident-Final Report document was reviewed, and showed that a resident received a medication on a specified date, and that he medication had been previously discontinued. Interventions listed were to monitor the resident regularly, and the reporter of the incident was an RN.

Review of the electronic charting by the RN stated that the medication was given to the resident on a specified date, and that they would monitor the effect. The RN charted that the resident was checked on about three and a half hours later.

An RN charted in the progress notes that the medication incident was reported to pharmacy, and that the doctor was contacted regarding the medication administration

error the following day, and consulted regarding possible adverse effects for staff to monitor. The progress note continued that the physician instructed staff that this was not the first instance of the resident this medication being taken, and instructed the staff to monitor the resident for specific adverse effects.

During an interview with an RN, they stated that they did not call the physician on immediately on nights unless they had a life or death issue; otherwise, they would leave it for day shift to call the doctor. The RN stated that they did not monitor the resident as per the incident report but that they were constantly in the resident's room but that they did not do the checks that they should have done.

The DOC stated that the expectation for that medication error would have been that they notified the doctor. The DOC stated that they should have notified the doctor.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home did not have a history of related non-compliance with this section of legislation. [s. 8. (1) (b)]

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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

The home's policy, "Contact Precautions," dated September 2016, was reviewed on September 8, 2017. The policy stated the following under the procedures section:

4. Place contact precautions on the resident's room door that includes the personal protective equipment (PPE) required by staff providing care for the resident.
5. Place an isolate caddy/cart outside the door or at the doorway to the resident's room with all of the required PPE supplies as well as a container of alcohol-based hand sanitizer.
6. Place a hands-free garbage receptacle inside the resident room for easy disposal of PPE.

The home's policy, "Vancomycin-resistant Enterococcus (VRE)," dated September 2016, was reviewed on September 8, 2017. The policy stated the following under the procedures section:

7. Transport laundry from residents with VRE to the laundry room separately from other laundry in the home. Ensure usage of the coloured bag that specifically indicates isolation.
8. Wear PPE in accordance with contact precautions. Wear gloves and gowns when providing care or coming in contact with bodily fluids.

The home's policy, "Methicillin-Resistant Staphylococcus Aureus (MRSA) Infection," dated September 2016, was reviewed on September 8, 2017. The policy stated, "Methicillin-Resistant Staphylococcus Aureus (MRSA) is a highly contagious infection spread through touch that, once detected in the home, requires rigorous attention and precautions to the take to stop the spread of infection to other residents and/or staff. Most MRSA infections manifest in the community as skin infections. More severe or potentially life-threatening MRSA infections occur more frequently among residents in health care settings." Under the procedures section, it stated the following:

3. Transport laundry from residents with MRSA to the laundry room separately from other laundry in the home. Ensure usage of the coloured bag that specifically indicates isolation.

Under registered staff, the policy stated the following:
d. implement contact precautions and ensure the required PPE is available for staff providing care.
e. provide dedicated resident-care equipment where possible.
h. apply signage at the resident's doorway indicating the need for contact precautions.

The home's policy, "Personal Protective Equipment," dated September 2016, was reviewed. Under the procedures section, it stated the following:

b. Gowns are to be changed when they become contaminated/wet with bodily secretions and must be removed before you leave the resident's room.

On September 8, 2017, Inspector #680 observed an HCA coming out of a resident's room. On the door there was a precaution sign. The HCA was bringing out dirty linen from the room and was not wearing a gown; they did have gloves on. On September 8, 2017, Inspector #680 observed a PSW coming out of another resident's room carrying a dirty product and linen out of the room; the PSW was not wearing a gown.

On September 8, 2017, a PSW was observed wearing gloves in the hallway and went from one end of the hallway to the other, and entered another resident's room with the gloves on.

On September 8, 2017, the PPE tool box was observed on the bottom shelf of the linen/care cart in the hallway. Inside the tool box were goggles, gowns and disposable towels. On top of the cart, a pile of gloves was observed; there was no glove box on the cart. Glove boxes were observed to be in the hallways in holders on the walls.

On September 6, 2017, two staff members were seen by Inspector #669 in a resident's room, which had a precaution sign. The two RPNs who exited the room were interviewed and explained that they were providing care to the resident. The RPNs acknowledged that they had not worn gowns during care. One of the RPNs explained that they would only wear a gown when working with a resident's bodily fluids, and did not require a gown for contact. The RPN said that they used gloves and practised hand hygiene when caring for the resident, and that they continued that gowns were in a toolbox on a cart that was located in each section of the home, and that gloves were located in the hallway.

Record review for a resident showed that the resident had an infection, and review of the

care plan showed that staff were to wear appropriate PPE and to follow contact precautions.

A resident who had a precaution sign on their door, was interviewed by Inspector #669 on September 6, 2017, and the resident stated that staff always wore gloves when providing care to them, but only wore gowns sometimes.

Record review for another resident showed that the resident had an infection. The resident's care plan stated that staff must "Wear appropriate Personal Protective Equipment (PPE) - follow contact precautions (gloves and gown), Designate resident equipment (red bag) when possible." A sign on the resident's door stated to "wear long sleeve gown for direct care." During observation of the room there was no red bag in the room for dirty linen, and a red bag was noted on the linen cart that was in the hallway.

In an interview with an HCA on September 8, 2017, they shared that they were not aware that precautions were required with the resident and that they had not seen the sign on the door. The HCA stated that they wore gloves when providing care to the resident, but did not wear a gown. The HCA acknowledged that they had completed personal care on the resident, but that they did not have time to wear the gown when getting residents up in the morning. The HCA recalled that they had training on infection control approximately three months ago. The HCA said that the PPE was available on the care cart in the hallway.

Record review for another resident showed that the resident had an infection, and their care plan stated that to wear appropriate PPE, and follow-contact precautions (gloves). The sign on the resident's door stated to "wear long sleeve gown for direct care." During observation of the room there was a red bag in the room for dirty linen.

In an interview with a PSW on September 8, 2017, they stated that they did not always wear a gown when going into the rooms with contact precautions. The PSW said that if they had a cold they would wear the PPE. The PSW explained that they put the linen and the dirty products in the regular dirty laundry cart. The PSW stated that they understood that it was universal precautions and that they could do this. The PSW stated that the resident had a red laundry bag in their room, but that they placed the linen in the regular laundry hampers.

An HCA was interviewed on September 6, 2017, and said that residents who were on contact precautions received the same universal precautions when providing care as

other residents, for example, hand hygiene and wearing gloves. The HCA acknowledged that they did not wear a gown when providing perineal care to residents on contact precautions, and would only wear a gown when a resident had for example, clostridium difficile, and the PPE was hung on the resident's door. The HCA recalled receiving education related to infection prevention and control on an annual basis.

An HCA was interviewed on September 6, 2017, and stated that they received education related to infection prevention and control within the last six months. The HCA explained that contact precaution signs meant that gowns, masks, and gloves were required when providing direct care to residents, which they defined as perineal care. The HCA showed the Inspector that gowns and other PPE were located in a black toolbox on a cart in each section of the home. The HCA admitted that they should wear a gown when providing perineal care to residents who were on contact precautions, but that they usually did not.

On September 8, 2017, during an interview with an RN, they shared that when staff were doing direct care they should be wearing gowns for residents with MRSA or VRE. The RN stated that each resident should have a red bag for linen, to be kept separate from the other laundry. The RN acknowledged that the plan of care did not direct staff to wear a gown for one of the residents with an infection, and acknowledged that there was no red linen bag in one of the rooms of a resident with an infection.

The ADOC, the home's infection control lead, was interviewed on September 8, 2017, and stated that when residents had MRSA or VRE, the staff should wear a gown when doing direct care, depending on where the virus was isolated from. A resident's plan of care was reviewed with the ADOC and DOC, who both acknowledged that the resident had an infection and that a gown should be worn. The ADOC and DOC also stated that this was in the plan of care and had been removed. The ADOC stated the expectation was that each resident with MRSA or VRE had a red bag for their dirty linen to keep it separate from the other laundry. The ADOC said that gowns should be worn when providing direct personal care to the identified residents. The ADOC and DOC stated that gloves were not to be worn in the hallway and the expectation was they were removed when staff exited the room.

The licensee has failed to ensure that participated in the implementation of the infection prevention and control program. Staff were seen not using proper PPE for specific residents with MRSA and VRE infections.

The severity was determined to be a level two as there was potential for actual harm.

The scope of this issue was isolated during the course of this inspection. The home did not have a history of related non-compliance with this section of legislation. [s. 229. (4)]

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 that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

During the RQI, on September 5, 2017, the door to the spa area on Riverside across from room 1249 was observed to be slightly opened with no one present in the room. When the inspector went into the room, a bottle of disinfectant was noted on the floor by the sink. There were no staff available around the area.

The home's policy, "Potentially Harmful Substances," dated April 2017, was reviewed and stated the following under the procedures section:

5. "Ensure that staff are aware that the following areas are to be kept locked at all times:
a. housekeeping storage areas
b. dietary storage area

c. housekeeping closets and carts
d. medication and treatment carts
f. any other location that could be dangerous if a resident were to gain access to that area"

On September 5, 2017, it was observed that the hair salon door was open. There was no staff inside the room or near the room. Inside the salon, there was barbicide sitting on the counter, a curling iron that was on and hot, and scissors on the counter. Inspector #680 waited for the Hairdresser to return, and the Hairdresser acknowledged that there were chemicals, scissors and that the curling iron was on. The Hairdresser stated that they usually left the door open when they were going to get other residents.

On September 6, 2017, the door to the Riverside clean utility room was left slightly open, inside were oxygen storage tanks, and two containers of disinfectant wipes. An HCA stated that it must have not closed when they left the room.

On September 6, 2017, the spa door across from room 1249 on Riverside was observed to be ajar and a bottle of disinfectant was sitting by the sink inside the room. There were residents in their rooms directly across from the spa room.

On September 7, 2017, Inspector #680 walked by the hair salon and noted the door to be closed and locked. On further observation, it was noted that a resident was left alone inside the salon. On the counter was the barbicide, scissors and a curling that was left on. Inspector #669 also witnessed the area, and called for the DOC to come to the salon. The Hairdresser returned and opened the door, and acknowledged that they had locked the resident in the room to ensure the door was locked. The DOC arrived to the salon and acknowledged that there were chemicals and scissors on the counter.

On September 7, 2017, it was observed that storage room 1234 was slightly open, and had oxygen containers. A Housekeeper acknowledged that the door was open and that the door was supposed to close automatically. The Housekeeper stated the door was to be locked at all times.

During an interview, the Administrator stated that the doors were to be locked at all times when no one was in the room, and if a resident was in the room they could not be left alone.

The licensee has failed to ensure that all doors leading to non-residential areas were

kept closed and locked when they were not being supervised by staff.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home did not have a history of related non-compliance with this section of legislation. [s. 9. (1) 2.]

WN #4: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b).

Review of the home's policy, "Medication Incident and Reporting," dated February 2017, stated under the procedures section:

"review all medication incident/adverse drug events and corrective action plans at the home's Medical/Professional Advisory Committee" and "evaluate and audit the medication incident and reporting policy to ensure compliance and identify opportunities for quality improvement."

Review of the Medical Pharmacies policy, "Medication Incident Reporting," dated February 2017, stated, "All medication incidents are reviewed by the home 'interdisciplinary team' including the Administrator, Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist. Changes and improvements identified in the review are to be implemented and a written record kept on file at the home."

Review of the Professional Advisory Committee (PAC) Agenda, dated June 15, 2017, was completed on September 11, 2017, during the RQI. Under Medication Incident Reports, it showed from March to May 2017, there were eight incident reports: five administration incidents, two dispensing incidents, and one administration and dispensing incidents. It then stated, “No harm or ill effects from incidents" and "all reported to medical pharmacies.”

Review of the Clinical Consultant Pharmacist Quarterly Report, dated June 15, 2017, showed that follow-up for medication incidents was to be completed on June 26, which was added to the report in handwriting. The report also stated that there was discussion regarding the need of medication incidents and near misses to be forwarded to pharmacy, as they were issues which required follow-up.

The summary did not show any documentation of the strategies to be implemented to reduce and prevent medication incidents.

The DOC was interviewed on September 11, 2017, and shared that the discussions at the PAC meeting were far more intensive than what was documented. The DOC stated that they had a conversation with the pharmacist and, going forward, they would document their conversations in more detail. The DOC stated they did analyze them but it was not recorded on the form.

The Administrator acknowledged that the information provided and the meeting minutes supplied were what was available, and that the home reviewed the medications quarterly at the PAC meetings.

The licensee has failed to ensure that a written record was kept of the quarterly review for medication incidents and of any changes and improvements identified in the review.

The severity was determined to be a level one as there was minimum risk. The scope of

this issue was a isolated during the course of this inspection. The home did not have a history of related non-compliance with this section of legislation. [s. 135. (3)]

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.