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
Sep 2, 2016	2016_294623_0026	024505-16	Complaint

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

FROST MANOR
225 MARY STREET WEST LINDSAY ON K9V 5K3

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

SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 25 and 26, 2016

The following was inspected: Log#024505-16 complaint related to medication administration

During the course of the inspection, the inspector(s) spoke with family members, Registered Nurses (RN), Registered Practical Nurses (RPN), Director of Care (DOC) and the Administrator.

The inspector also observed interactions between staff and residents during the provision of care, toured the home, observed medication administration practices, reviewed the drug record book, reviewed pharmacy order records, reviewed medication incident reports, reviewed clinical health records, reviewed complaint investigation records, and the licensee's policies: complaints procedure, medication policies

The following Inspection Protocols were used during this inspection:
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to establishing and maintaining and keeping of a record for every drug ordered and received in the home.

O.Reg. 79/10, s.133 states; Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section 136(4)

The licensee's policy 2.4 – Ordering and receiving medication – Drug Record Book Procedure (revision November 2015) states;

Policy:
- The Drug record Book contains a record of all medications ordered and received by the Home.
- Orders requested and received from the Satellite Pharmacy or any other location under exceptional circumstances must be entered in the Drug Record Book specifying the name of the place from which the drug was ordered and received (see policies 1.6 and 2.9)
- The Drug Record Book is a permanent record that is stored within the Home for at least 2 years.

Procedure:
1. Ordering medication:

a. New and repeat orders are entered in the next available space in the Drug Record Book by the "ordering nurse" as discussed in Policies 2.1 and 2.2 ensuring that the Resident's name, medication name and medication strength is indicated.
b. The entry is signed and dated by the "ordering nurse".
c. The Drug Record Book page is faxed to Classic Care Pharmacy.
2. Receiving Medications:
a. The "receiving nurse" confirms receipt of the correct medication and documents the following information in the appropriate spaces in the Drug Record Book:
i. Signature of the "receiving nurse".
ii. Date of receipt of the medication.
iii. Prescription number of the medication.
iv. Quantity of medication received.
b. The medication is subsequently stored safely in the correct location according to the Home preference.

The licensee's policy 1.6 – Satellite Pharmacy Procedure (revision July 2014) states;
Notes:
- All medications that are received from the satellite pharmacy are recorded in the Drug Record Book.

Resident #001 was admitted to the home on a specified date with a specified diagnosis. In an interview with SDM#100 on a specific date, it was indicated that resident #001 was prescribed a specific medication that was to be administered three days a week. Review of the physician's order confirmed that specific medication was prescribed. SDM#100 indicated that this prescription was filled at the Satellite Pharmacy for the home, as prearranged by SDM#100 when resident #001 was admitted to the long-term care home. The registered nurse was to notify the SDM when the supply was low and the SDM would pick up the medication. On a specific date SDM#100 provided a 1 month supply of the medication to the home. Five months later SDM#100 received a call from the home indicating that they had run out of the medication. SDM indicated that when he/she went to the pharmacy to fill the prescription he was informed that the medication order had not been filled for five months. SDM#100 informed the Administrator of the home and requested that an investigation be completed to find out what medication had been given

after the 1 month supply that was brought to the home was exhausted.

Review of the dispensing record from the satellite pharmacy for resident #001 indicated the prescription was filled on three specific dates. On each occasion a quantity of 6ml was dispensed for a four week supply.

Review of the Drug Record Book revealed that on page No. 047 the medication was hand written in the order book on a specific date for resident #001 indicating that the medication was ordered. The entry for aforementioned date was not marked as received. A note in the drug directions section of the order box indicates "family will get". There are no other entries recorded in the Drug Record Book for an identified six month time period, for the specific medication for resident #001.

During an interview on August 26, 2016 RN#101 stated that he/she received the specific medication on a specific date in when the family brought it in to the facility. RN#101 indicated that the bag of medications was placed unopened, into the refrigerator. RN#101 confirmed that he/she did not write the medication in the drug record book because there was a resident emergency and then he/she forgot to sign in the book that the medication was received. RN#101 confirmed that it is the homes expectation that all medications are written in the drug record book when they are ordered and signed in when they are received, including the quantity of medication received. RN#101 confirms the satellite pharmacy for the home and it was set up through the SDM for resident #001 that the specific medication was to be ordered from there rather than the main pharmacy provider.

During an interview on August 26, 2016 DOC indicated that as part of the investigation into the concerns brought forward by SDM#100, a meeting was held with a representative at the satellite pharmacy. Copies of the dispensing record were provided to the DOC which indicated the specified prescription was filled on three specific dates. On each occasion there was four weeks supply of medication dispensed. The DOC confirmed the outcome of the homes internal investigation indicated that the DOC was unable to validate how much of the specified medication was on hand in the home, as it was never signed in and recorded in the Drug Record Book as is per policy. Therefore the DOC was unable to say at any given time how much of the medication was in the home.

Therefore the licensee failed to ensure that the policy 2.4 – Ordering and receiving medication – Drug Record Book Procedure was complied with. [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 related to establishing and maintaining and keeping of a record for every drug ordered and received in the home., to be implemented voluntarily.

WN #2: 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 has a specific diagnosis. Review of the clinical records including the physician orders indicated a specific medication was prescribed;

Review of the medication administration records (MAR) for a four month period indicted that the specific medication was signed as administered every Monday, Wednesday and Friday. There is no indication that any doses were missed.

Review of the licensee's internal investigation for the complaint brought forward by SDM#100 indicated that there were eight registered nurses that signed the MAR as having administered the specific medication to resident #001. Each nurse was interviewed by the DOC and a written statement was completed indicating that the medication was administered correctly. During the investigation it was revealed that RN#102 administered the medication incorrectly six times unknowingly. It was discovered that he/she administered 0.05ml instead of 0.5ml on six specific dates over a four month period. In a written statement RN#102 indicates that he/she administered 0.05ml of the specific medication to resident #001 and on each occasion felt that he/she was administering the medication correctly.

August 25, 2016 at 11:00 during an interview DOC confirmed that the outcome of the internal investigation indicated RN#102 administered the incorrect dose of a specific medication to resident #001 on six occasions over a four month period. RN#102 was provided re-education following the discovery of the error.

Therefore the licensee failed to ensure that the specific medication was administered to resident #001 in accordance with the directions for use specified by the prescriber. [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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

Issued on this 2nd day of September, 2016

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

Original report signed by the inspector.