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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2013	2013_248509_0001	H-000183-13	Critical Incident System

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400, HAMILTON, ON, L8R-2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE, HAMILTON, ON, L8V-3M7

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

CATHY FEDIASH (509), LISA VINK (168)

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): November 19, 2013.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing.

During the course of the inspection, the inspector(s) observed medication storage rooms, reviewed clinical records of two residents, reviewed relevant policy's and procedures and investigative notes.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Pain

Findings of Non-Compliance were found during this inspection.

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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was: complied with.

The home had a policy "Shift Change Narcotic Count, NM 10-00-36, last updated September 27, 2010" which indicated when doing narcotic counts, "Two registered staff shall do the following: A) Count the actual quantity of medications remaining". On July 22, 2012, it was noted that seven ampoules of Hydromorphone 2mg/ml were missing during a narcotic count. Interview with Director of Nursing and the critical incident report identified that registered staff did not consistently count every box/pack of narcotics and instead recorded previous shift narcotic count numbers during their counts. Staff did not follow the home's policy. [s. 8. (1)]

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not inform the Director immediately of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The home suspected an enteric outbreak, involving residents on a unit of the home, on November 15, 2013. The staff put outbreak control measures in place, notified the physician and had the Public Health Unit declared the outbreak on November 15, 2013. The home did not notify the Director of the outbreak until November 19, 2013, when ministry staff made an unannounced visit and did not submit a critical incident until November 20, 2013. The outbreak was not reported to the Director immediately as required. [s. 107. (1)]

2. The licensee did not ensure that the Director was informed no later than one business day after the occurrence of a incident, followed by the report required of a missing or unaccounted for controlled substance.

The following incidents of missing/unaccounted for controlled substances were not reported to the Director no later than one business day after the occurrence of the incidents:
A. On July 22, 2012, it was identified that seven ampoules of Hydromorphone 2mg/ml were missing. The home did not report this incident until July 26, 2012.
B. On September 19, 2012, it was identified that five Fentanyl patches were missing. The home did not report this incident until September 28, 2012.
C. On October 10, 2012, it was identified that one 25 mcg Fentanyl patch had gone missing. The home did not report this incident until October 12, 2012.
D. On March 7, 2013, it was identified that 10 vials of Hydromorphone 10mg/ml were missing. The home did not report this incident until March 12, 2013.
E. On March 21, 2013, the home became aware by drug manufacturer testing of tampered Hydromorphone. The home did not report this incident until April 1, 2013.
F. On March 27, 2013, it was identified that 50 tablets of Hydromorphone 2mg were missing. The home did not report this incident until April 9, 2013.
The above instances of delayed reporting later than one business day to the Director were confirmed by the Director of Nursing. [s. 107. (3) 3.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A. On October 10, 2012, registered staff misplaced a controlled substance, a 25mcg Fentanyl patch, during the provision of care. The patch was not applied to the resident, nor stored in the double locked medication area for controlled substances. This missing controlled substance was not stored or monitored as required, as confirmed in an interview with the Director of Nursing.
B. On March 7, 2013, registered staff misplaced a controlled substance, a box of 10 vials of Hydromorphone 10mg/ml. This controlled substance was left in error in an area of the home that was accessible and not double-locked. This controlled substance was not located during a search of the home as confirmed by the Director of Nursing. [s. 129. (1) (b)]

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Issued on this 28th day of November, 2013

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