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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2015	2015_349590_0037	021204-15, 019328-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

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

MARSHALL GOWLAND MANOR
749 DEVINE STREET SARNIA ON N7T 1X3

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

ALICIA MARLATT (590)

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): August 14, 2015.

This inspection was related to prevention of abuse and neglect and a medication incident.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, the Director of Nursing and Personal Care, two Registered Nurses, one Registered Practical Nurse and two Personal Support Workers.

During the course of the inspection, the inspector(s) observed staff and resident interactions.

During the course of the inspection, the inspector(s) reviewed two Critical Incident Reports, two resident clinical records and relevant policies related to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication

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

- **1 WN(s)**
- **0 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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary medication management

system provided safe medication management and optimized effective drug therapy outcomes for residents.

Resident #002 was diagnosed with a health condition. The resident was sent to the hospital for assessment after having an episode at the home. The resident had returned to the home later that day with a prescription for a specific medication for four weeks.

A medication review was completed and indicated resident #002 was on the specific medication daily and it needed to be reassessed; the resident was still on the medication at the time of the review so the administration of the medication had continued. The medication's four week therapy was completed the following month; the medication was not reassessed at that time. In the next quarter, another medication review had been completed and the specific medication was not listed as a medication that still needed to be reassessed. The resident had several documented episodes during the time period when the medication was stopped until the error was found five months later. The error was found during a care conference when medications were being reviewed with the family and resident. The medication was subsequently ordered again after the care conference.

Interviews with three registered staff members revealed that medications that need to be reassessed were noted on the calendar or on a whiteboard at the nursing station desk. The calendar or whiteboard was reviewed at each shift change and concerns were addressed by each shift. They all shared that the Pharmacist was responsible for processing orders during the day shift and the registered staff were responsible for processing orders on the evening and night shift. The eMAR (electronic Medication Administration Record) would provide an alert for reassessment for antibiotics and high risk medications; the ordered medication was not listed as a high risk medication so was not alerted in the eMAR system for staff to reassess.
They also shared that the Physician, Pharmacist, and a Registered Nurse were responsible for completing quarterly medication reviews.

The homes policy titled Inter-Disciplinary Team, dated September 1, 2013, with a policy number of 2.2, indicated in the procedure section that:

"Remedy's Rx understands the importance of keeping all members of the health care team informed. Constant communication between the inter-disciplinary health care team members is crucial to optimizing resident care delivered" and that "The Pharmacist is a recognized member of the inter-disciplinary care team and contributes to the team by

reviewing residents' drug therapy, evaluating medication management processes, establishing best-practice initiatives, providing education to staff, residents and family related to clinical disease management/drug therapy and conducting continuous quality improvement activities".

In an interview with the Interim Administrator she confirmed that the home had failed in communicating and completing an inter-disciplinary assessment to ensure resident #002's medications were reassessed appropriately to optimize drug therapy outcomes. In an interview with the Director of Nursing and Personal Care she indicated that she has been in contact with their Pharmacy Service Provider and the home has made improvements to their electronic medication management system called Point Click Care to alert staff of every short term medication order that would need to be reassessed so this type of incident does not occur again. [s. 114. (1)]

Issued on this 3rd day of September, 2015

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

Original report signed by the inspector.