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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 5, 6, 2017	2017_548592_0007	005484-17	Critical Incident System

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

MELANIE SARRAZIN (592)

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): March 10, 13 and 14, 2017

The following Critical Incident was inspected during this inspection:

Log #005484-17 related to a medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPN), Registered Nurses (RN), one Nurse Practitioner, one Pharmacy Consultant, one Pharmacy Manager and the Executive Director.

During the course of the inspection, the inspector reviewed residents' health care records, relevant licensee policies and procedures on medication management and administration, staff work routines and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 home's Medication Management System procedures in place during this inspection were complied with.

In accordance with O.Regulation 79/10, s.114 (2) and (3) (a), the home shall develop a medication management system and ensure that there are written policies and protocols developed to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home. The written policies and protocols must be implemented.

The home has medication administration policies related to the Drug Distribution-Delivery, Receipt of Medications and on Digital MAR/TAR and Electronic Medication Administration Systems and on Medication Incidents.

Inspector #592 reviewed the home's Administration policy titled MAR/TAR Sheets dated October 2012 and reviewed in January 2017 and observed the following documented under "Checking New digiMAR/digiTAR Sheets:

Under tab:
6. Upon receipt of the digiMAR/digiTAR sheet, two nurses or facility authorized care providers are to check all printed information for correctness, make appropriate corrections and inform pharmacy of any changes.
7. To ensure accuracy, each new sheet must be double checked against the Physician's Order Review, as well as the previous month's digiMAR/digiTAR sheets before being used.
9. The two nurses or care providers who double check the digiMAR/digiTAR sheets must sign in the appropriate spaces at the bottom of the sheets.

Inspector #592 also reviewed the home's Medication Administration policy titled MAR/TAR Sheets dated October 2012 and reviewed in January 2017 and observed the following documented under " Digital Medication Administration Record/Treatment Administration Record Sheets (DidiMAR/digiTAR):

Under tab:
3. DigiMAR/digiTAR sheets are only prepared for residents receiving medications from Medisystem Pharmacy.

The home submitted a Critical Incident Report (CIR) to the Director under LTCHA on a specific date , for an incident involving resident #001 and a medication incident.

A review of resident #001 health care records was done by Inspector #592.

The progress notes indicated that resident #001 was admitted to the home on a specified date with several diagnosis and was treated with antibiotics for the presence of an infection. The progress notes further indicated that resident #001 was also receiving specific interventions from the home as part of his/her treatments and that prior to the admission to the home, the resident was followed by an identified Hospital who were working in collaboration with the home. The progress notes further indicated that resident #001 was monitored closely throughout the days for poor food and fluid intake since the day of his admission to the home, due to health care problems and the presence of an infection.

Eight days after resident #001 was admitted to the home, the resident's progress notes indicated that the resident's condition had deteriorated and that the resident was observed with generalized weakness, having ongoing poor food and fluid intake with a low blood pressure and a low pulse. The progress notes further indicated that the registered staff had contacted the physician and that at the request of the resident's family member, the resident would not be sent to the hospital. Orders were given to the registered staff to put on-hold several identified anti-hypertensive medications if the blood pressure and pulse range of resident #001 were below specific parameters.

On the next day, the resident #001's progress notes indicated that at a specified time, the resident's blood pressure was below the recommendation range specified by the physician. The registered nurse had contacted the identified Hospital and instructions were received to make sure that the anti-hypertensive medications were still on hold and that the identified Hospital would call back later for a re-assessment of resident #001.

Approximately five hours later, the resident #001's progress notes indicated that the resident was sent to the hospital by the LTC Home due to drowsiness and not responding to stimulus. Resident #001's blood pressure and pulse at that time were documented to be below the recommended range specified by the physician. The progress notes further indicated that the resident was admitted to an indentified hospital.

The home's Critical Incident Report submitted to the Director three days after the resident was sent to the hospital indicated that the hospital contacted the home on that

day to notify them of a medication error involving resident #001. The Critical Incident Report indicated that since resident #001's admission to the home, the resident was administered one dose of a specific medication daily, for eight consecutive days. The Physician orders dated on the day that the resident was admitted to the home were to administrate the specific medication once every three weeks. The next dose was to be administrated on a specific day.

In a review of the Medication Administration Records (MARS) provided electronically by the home's pharmacy for resident #001, the EMAR documentation indicated that the medication was signed by Registered Staff as being administered once daily for nine consecutive days.

Although CI indicated eight dosages were administrated to the resident, however during the Inspection, Inspector #592 observed that there was nine documented dosage recorded in the EMAR as being administered.

On March 10, 2017, during an interview with the RN #100 in charge of the unit, she indicated to the Inspector that when a resident is admitted to the home, the Nurse Practitioner or the Registered Nurse will do the reconciliation of the medications and have them authorized by the physician. She further indicated that once the medications were authorized by the physician, the orders would be sent to the pharmacist on a specific form and that a temporary MARS would be used for registered staff until the permanent MARS is updated by the pharmacy and made available electronically. RN #100 further indicated that once the medications are received in the home, the medications are checked for the accuracy and their receipt recorded in the drug record book.

During an interview with RN #100, the RN showed to the Inspector a form titled "New admission order" dated on the day that resident #001 was admitted to the home. The form indicated that resident #001 was to receive a specific medication every three weeks, was authorized and signed by the nurse practitioner and the physician with the specification that the next dose would be due on a specified day. This was faxed to the home's pharmacy. The RN further indicated to the Inspector that the specific medication was not provided by the home's pharmacy but by an outside Pharmacy in order to have the specific medication covered. She further told the Inspector that this was the only medication provided to the home by that outside Pharmacy. RN #100 further indicated that all of the other resident's medications are provided by the home's regular Pharmacy. RN #100 further indicated to the Inspector that she was made aware by the identified

Hospital three days after resident #001 was sent to the hospital, that the resident had received a daily dose of the specific medication. Following the home's internal investigation, the home discovered that the MARS received electronically from the home's pharmacy were not accurate. They did not match the faxed order for the specific medication.

On March 10, 2017, during an interview with the home's pharmacy Supervisor/Manager, she indicated to the Inspector that she has immediately initiate an internal investigation as soon as she was made aware of the medication incident with resident #001. She further indicated that following the investigation, it was found that a pharmacy technician had entered the orders, received by the home for the specific medication, in the MARS with the wrong dosage. She further indicated that it was not part of the technician's task to enter the specific medication in the home's MARS as it was not the pharmacy's responsibility to enter the information related to a medication that was not dispensed by them.

In a review of the MARS provided electronically by the home's pharmacy for resident #001, Inspector #592 observed that there was a space at the bottom of the sheets indicating name/signature with a checked by 1st, 2nd and 3rd Registered staff member. There was no signature observed on that space.

On March 14, 2017, during an interview with RN #106, she indicated to Inspector #592 that there was no verification signature on the resident's MARS. The nurses are no longer doing MARS verification since the home has changed pharmacy systems to an electronic MAR. She further indicated that in the past, before the electronic MAR was first introduced to the home, the process in place was to have two nurses verify all the printed information for accuracy. Once verified for accuracy, the two nurses would sign the MARS at the bottom of the sheets or would notify the pharmacy of any discrepancies identified. RN #106 further indicated that as per her understanding the electronic MAR was introduced to eliminate this verification task from the nurses and that the pharmacy would be responsible for the accuracy of the electronic MAR. RN #106 indicated that the Registered staff are not doing the verification of the MARS since the start of the EMAR.

In a discussion with the Executive Director, she indicated to Inspector #592 that the electronic MAR was introduced in the home since February 2016.

Therefore the home did not comply with their medication administration written policy related to the Drug Distribution-Delivery, Receipt of Medications and on Digital MAR/TAR

and Electronic Medication Administration Systems. [s. 8. (1) (b)]

2. Inspector #592 reviewed the home's Medication Administration policy titled "Medication Incidents-Definition & Policy" dated October 2012 and reviewed on January 2017 and observed the following documented under Policy:

Under tab:
1. All medication incidents, including near misses or close calls that are identified, are reported immediately to the nurse or designate and to the Director of Nursing/Care or Resident Services Manager.

Eight days after resident #001 was admitted to the home, the resident's progress notes indicated that the resident's condition had deteriorated and that the resident was observed with generalized weakness, having ongoing poor food and fluid intake with a low blood pressure and a low pulse. The progress notes further indicated that the registered staff had contacted the physician and that at the request of the resident's family member, the resident would not be sent to the hospital. Orders were given to the registered staff to put on hold several identified anti-hypertensive medications if the blood pressure and pulse range for resident #001 were below specific parameters.

On the next day, the resident #001's progress notes indicated that at a specific time, the resident's blood pressure was below the recommended range specified by the physician. The registered nurse had contacted the identified Hospital and instructions were received to make sure that the anti-hypertensive medications were still on hold and the identified Hospital would call back later for a re-assessment of resident #001.

Approximately five hours later, the resident #001's progress notes indicated that the resident was sent to the hospital by the LTC Home due to drowsiness and not responding to stimulus. Resident #001's blood pressure and pulse at that time were documented to be below the recommended range specified by the physician. The progress notes further indicated that the resident was admitted to the identified Hospital on the same day.

On March 10, 2017, while conducting the inspection, Inspector #592 was informed by the home's Executive Director that during a discussion with the attending physician from the home and the physician from the hospital, concerns were brought forward about several identified medications that were administered on the day that resident #001 was sent to the hospital when blood pressure and pulse were outside parameters and were not to be

administered as per the physician orders.

In a review of the physician orders dated the day before resident #001 was sent to the hospital, it was indicated to put on hold several identified anti-hypertensive medications if systolic blood pressure and pulse range were below specific parameters.

In a review of the resident #001's MARS provided electronically by the home's pharmacy, it was indicated that the day that resident #001 was sent to the hospital, to take the blood pressure and pulse before administrating the identified anti-hypertensive medications and to not give the medications if the systolic and the pulse were below specific parameters. The MARS indicated that the identified anti-hypertensive medications were documented to be administrated approximately five hours before resident #001 was sent to the hospital, with the RPN #102 Digi signature. The MARS further indicated that a blood pressure was documented at the same time below the normal parameters specified by the physician by RN #102.

On March 13, 2017, during an interview with RPN #102 with the presence of the executive Director, he indicated that he was the nurse responsible for resident #001, the day that the resident was sent to the hospital. He further indicated that he was not aware of the new physician orders relating to the anti-hypertensive medications for resident #001 because he did not read all the prescription. RPN #102 further indicated that he took the resident's blood pressure and pulse after administrating the morning medications as part of the routine for resident #001. RPN #102 indicated that when the resident's condition had deteriorated and the paramedic contacted, he realized upon reviewing the MARS and the entire order that the identified anti-hypertensive medications should not have been administered if the blood pressure and the pulse were outside of the parameters as per the physician orders. When RPN #102 was asked by the Executive Director to which staff member he had reported the medication incident, the RPN indicated that he did not report the incident to anyone and thought that the paramedic and the Registered nurse present would have noticed the medication error and would have taken action to address the results of the adverse effect.

On March 13, 2017, during an interview with the Executive Director, she indicated to Inspector #592 that the employee should have reported immediately to the Registered Nurse immediately when he became aware of the medication incident on that day, as such, the employee did not followed the home's policy on Medication Incidents. [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 the home will comply with their written policies and protocols on their Medication Management System, to be implemented voluntarily.

WN #2: 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. (2) 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. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to have written policies and protocols developed for the medication management system to ensure the accurate acquisition and dispensing of medications from other pharmacies.

The home submitted a Critical Incident Report (CIR) to the Director under LTCHA on a specific date for an incident involving resident #001 and a medication incident.

A review of resident #001 health care records was done by Inspector #592.

As per WN #1, Resident #001 was administered one dose of a specific medication daily for a total of nine consecutive doses when the Physician orders and directions were to administrate the specific medication once every three weeks. Resident #001 was also administered several identified anti-hypertensive medications which were not to be administered when blood pressure and pulse were outside specific parameters.

On March 10, 2017, during an interview with the RN #100 in charge of the unit, she indicated to the Inspector that when a resident is admitted to the home, the Nurse Practitioner or the Registered Nurse will do the reconciliation of the medications and have them authorized by the physician. She further indicated that once the medications were authorized by the physician, the orders would be sent to the pharmacist on a specific form and that a temporary MARS would be used for registered staff until the permanent MARS is updated by the pharmacy and made available electronically. RN #100 further indicated that once the medications are received in the home, the medications are checked for the accuracy and their receipt recorded in the drug record book. The RN also indicated to the Inspector that the specific medication for resident #001 was not provided by the home's pharmacy but by an outside Pharmacy in order to have the specific medication covered. She further told the Inspector that this was the only medication provided to the home by that outside Pharmacy. RN #100 further indicated that all of the other resident's medications are provided by the home's regular Pharmacy. She further indicated that there was no process in place to check for the accuracy of the specific medication once delivered to the home. The specific medication is delivered by the outside Pharmacy and is given to the RN who will put the medication accessible for Registered staff. No documentation is required of the receipt of the medication in the drug record book as the medication is not dispensed from the home's Pharmacy.

On March 14, 2017, during an interview with the Executive Director, she indicated to the Inspector that the home does not have written policies for the delivery and the receipt of the medications that are dispensed from an outside Pharmacy. She further indicated that the home as a policy in place for "Patients' Own Medication" that applies for the Hospital but that she will need to develop one for the LTC.

It is to be noted that at the time of the Inspection, there was a total of seven residents who were provided with the specific medication dispensed from the outside Pharmacy. [s. 114. (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 a written policy will be developed and implemented regarding the distribution of a drug when dispensed from another pharmacy, to be implemented voluntarily.

WN #3: 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.

The home submitted a Critical Incident Report (CIR) to the Director under LTCHA on a specified date for an incident involving resident #001 and a medication incident.

As per WN #1, Resident #001 was administered one dose of a specific medication daily for nine consecutive days when the Physician orders and directions were to administrate the specific medication once every three weeks. Resident #001 was also administered several identified anti-hypertensive medications which were not to be administered when blood pressure and pulse were outside specific parameters.

During an interview on March 10, 2017 with RN #100, the RN showed to the Inspector a form titled "New admission order" dated on the day that resident #001 was admitted to the home. The form indicated that resident #001 was to receive a specific medication every three weeks, was authorized and signed by the nurse practitioner and the physician with the specification that the next dose would be due on a specific day. This was faxed to the home's pharmacy. The RN further indicated to the Inspector that the

specific medication was not provided by the home's pharmacy but by an outside Pharmacy in order to have the specific medication covered. She further told the Inspector that this was the only medication provided to the home by that outside Pharmacy. RN #100 further indicated that all of the other resident's other medications are provided by the home's regular Pharmacy. RN #100 further indicated to the Inspector that she was made aware by the identified Hospital three days after resident #001 was sent to the hospital, that the resident had received a daily dose of the specific medication. Following the home's internal investigation, the home discovered that the MARS received electronically from the home's pharmacy were not accurate. They did not match the faxed order for the specific medication.

When Inspector inquired about the medication packages, RN #100 indicated that the medication was discontinued, therefore was discarded in the medication box. She further indicated to the Inspector that a label was present on the medication packages and that the expectation would be that the nurse responsible to administer the medication would refer to the label for the accuracy of the order.

Later that day, upon asking the outside Pharmacy for the original label sent with the specific medication, a fax was received with the presence of RN #100 from the outside Pharmacy with the original label applied on the specific medication package indicating to administer the medication every 21 days or as directed.

In a review of the MARS for resident #001, it was indicated that, during the nine days that the specific medication was recorded as administered, the medication was administered three times by RPN #103 and twice by RPN #102.

On March 10, 2017, during an interview with RPN #103, she indicated to the Inspector that before administrating any medications to a resident she has to verify the directions on the MARS sheet and verify the medication on hand and compare to ensure of the accuracy. She further indicated that when the medication is not in the medication strips, she has to verify the label located on the medication box/container. RPN #103 indicated to the Inspector that she does recall the order of the specific medication for resident #001 but did not pay attention to the label on the package and had followed the directions on the MARS and thought that the directions were the same on the label. She further told the Inspector that she has questioned herself about the administration of the specific medication to resident #001, as it was not common to have that specific medication prescribed on a daily basis but because she was part time, she did not shared her

concerns.

On March 10, 2017, during an interview with RPN #102, he indicated to the Inspector that the process in place when administrating medications is to verify on the MARS for the accuracy of the medications on hand, for the right dosage, time, route, right person. He further told the Inspector that he has to be careful for specific instructions such as taking the blood pressure, pulse or blood sugar prior to the administration of certain medications. RPN #102 further indicated to the Inspector that if the medication is not in the medication strips, he would have to compare the label on the bottle or the box. When the Inspector inquired about the specific medication for resident #001, he indicated to the Inspector that he would have to ensure to read the label located on the box and that the resident was receiving the specific medication once a day as per the MARS. When Inspector showed RPN #102 the label provided by the outside Pharmacy, the RPN indicated that he does not recall if he did read all the label and that it was a mistake, that he should of read the entire label and pay more attention before administrating a medication.

On March 13, 2017, during an interview with RPN #102 with the presence of the executive Director, he indicated that he was the nurse responsible for resident #001 on the day that the resident was sent to the hospital. He further indicated that he was not aware of the new physician orders related to the anti-hypertensive medications for resident #001 because he did not read all the prescription. RPN #102 further indicated that he took the resident's blood pressure and pulse after administrating the morning medications as part of the routine for resident #001. RPN #102 indicated that when the resident's condition had deteriorated and the paramedic contacted, he realized upon reviewing the MARS and the entire physician order that the anti-hypertensive medications should of not being administrated if the blood pressure and pulse were outside of the parameters as per the physician orders. When RPN #102 was asked to who he has reported the medication error, he indicated that he did not report the incident to anyone and that he thought that the paramedic and the Registered nurse present would noticed it and would take care of it. Therefore resident #001 was not administered his drugs 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 administered to residents are in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 6th day of April, 2017

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

Original report signed by the inspector.