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 sions 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
Mar 9, 2017	2017_290551_0003	003763-17	Critical Incident System

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

MEGAN MACPHAIL (551)

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): February 16 and 17, 2017.

Critical Incident Report C569-000012-17 / log # 003763-17, related to an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status, was inspected.

During the course of the inspection, the inspector(s) spoke with Registered Nursing Staff, a Personal Support Worker, the Assistant Vice President of Nursing and the Vice President of Nursing.

During the course of the inspection, the inspector(s) reviewed a resident's health care record and the Medications - Security and Accountability policy.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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 a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

A Critical Incident Report (CIR) was submitted to the Director, under O. Reg 79/10, s. 107 (3) (4) outlining an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Resident #001 was admitted to the home on a specified date and had several medical diagnosis. The resident was ordered a specific medication at hs (bedtime) prn (as needed).

A review of resident #001's medication administration record (MAR) Sheet History and e-meds Patient Notes indicated that the resident was given numerous doses of the specific prn medication during a four and a half week period.

A review of resident #001's health care record indicated that on a specific date, a near miss occurred when the resident was given the prn medication at 0945 hours (not at hs as ordered). Upon verifying the order and realizing her error, the RPN who administered the medication was able to remove it from the resident's mouth before it was swallowed.

A review of the e-meds Patient Notes indicated that on seven different occasions, on different dates, resident #001 was given prn doses of the specific medication that were not in accordance with the directions for use specified by the prescriber, specifically:

On a specified date, resident #001 was given the specific prn medication at 0048 hours (not at hs as ordered).

On a specified date, resident #001 was given the specific prn medication 0216 hours (not at hs as ordered).

On a specified date, resident #001 was given the specific prn medication at 1400 hours (not at hs as ordered).

On a specified date, resident #001 was given the specific prn medication at 1101 hours (not at hs as ordered).

On a specified date, resident #001 was given the specific prn medication at 1044 hours (not at hs as ordered).

On a specified date, resident #001 was given the specific prn medication at 0409 hours (not at hs as ordered).

On a specified date, resident #001 was given the specific prn medication at 1239 hours (not at hs as ordered).

In an interview with RN #100 she indicated that on a specified date, she received a call from an agency RPN who reported that resident #001's condition had changed. RN #100 stated that the RPN reported to her that she had just given the resident a prn dose of the specific medication and that the resident was not answering her. RN #100 reported knowing that the resident did not have a prn order for the medication in the day time.

Following the resident's change in condition, staff were unable to make him/her comfortable, and the resident was sent to the hospital. Resident #001 passed away that evening. [s. 131. (2)]

2. On a specified date, resident #001 was ordered a specific medication to manage a medical issue. The time at which the order was obtained is not indicated on the physician's order sheet. A progress note was written by RN #101 indicating that the order had been obtained and consented to by the resident's SDM.

According to RN #101, a paper MAR was initiated. The times for administrating the specific medication were indicated as in the morning and the evening.

On the same date as the order was obtained, the specific medication was signed for then crossed out on the paper MAR. According to RPN #102, she had prepared the medication, and the resident was sleeping when she went to administer it, so she let him/her be.

According to the Assistant VP of Nursing who reviewed resident #001's MAR Sheet History, an agency nurse administered the resident's first dose of the specific medication the following day.

There was no documentation in the progress notes to indicate that the resident was not able to take the initial dose of the medication or to indicate that any subsequent attempts to administer the medication were made until the following day. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's response and the effectiveness of the drug was documented.

Resident #001 was ordered a specific medication prn at hs.

A review of resident #001's medication administration record (MAR) Sheet History and e-meds Patient Notes indicated that the resident was given numerous doses of the specific prn medication during a four and a half week period.

On February 17, 2017, the administration of the specific prn medication to resident #001, on three specific dates, was reviewed with the Assistant VP of Nursing, and it was identified that on two out of three occasions, the resident's response and the effectiveness of the drug was not documented.

On the two specific dates, the prn medication was signed for as given by RPN #102.

In both of these instances, there was no documentation as to why the medication was given, and the resident's response and the effectiveness of the drug was not documented. [s. 134. (a)]

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 residents' responses and the effectiveness of drugs are documented, to be implemented voluntarily.

WN #3: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented.

On a specified date at 1239 hours, resident #001 was administered a prn dose of a specific medication. The medication was ordered at hs (bedtime) prn (as needed).

In an interview with RN #100 she indicated that on a specified date, she received a call from an agency RPN who reported that resident #001's condition had changed. RN #100 stated that the RPN reported to her that she had just given the resident a prn does of the specific medication and that the resident was not answering her. RN #100 reported knowing that the resident did not have a prn order for the medication in the day time.

According to the home's VP of Nursing, following a medication administration error, a medication incident report is to be completed in the point click care risk management system. The VP of Nursing indicated that an incident report had not been completed following resident #001 being administered a prn dose of a specific medication during the day time, and not at bedtime as ordered, on a specified date.

According to the home's Assistant VP of Nursing, the medication incident report, for the medication administration error that occurred on a specific date, was completed until several weeks later [s. 135. (2)]

Issued on this 9th day of March, 2017

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

Original report signed by the inspector.