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
Apr 16, 2013	2013_029134_0009	O-002041-12	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

COLETTE ASSELIN (134)

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): April 4 and 5, 2013

During the course of the inspection, the inspector(s) spoke with the Vice President of the Nursing Program, a Registered Nurse, the Pharmacy Manager and with Resident #1's Attending Physician.

During the course of the inspection, the inspector(s) reviewed Resident #1's Health Records, the Licensee's Policy and Procedure # PRO-N39 as it relates to the "Three Month Medication Review".

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Medication

Personal Support Services

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. 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 failed to comply with O. Reg. 79/10 s. 134 (c) in that the licensee failed to reassess Resident #1's drug regime at least quarterly between March and September 2012.

Resident #1 was admitted at the Home in March 2012. The first "Three Month Medication Review" was due to be completed at the end of July 2012.

Resident #1's E-Meds sheets between July and September 2012 were reviewed. There is an indication that three different medications were not administered as per the physician's order, in the months of July, August and September, 2012.

Resident #1's "Three Month Medication Review" sheet was reviewed by the Inspector. The form had been send to the Nursing Home by Pharmacy in July, 2012 as per requirement of the Licensee's Policy and Procedure # PRO-N39.

Resident #1's medication regime had not been reassessed until September, 2012, where it was noted that several medications, which required close monitoring, had been blocked from the electronic medication system. Those medications had not been discontinued by the attending physician.

The Pharmacy Manager was interviewed April 5, 2013 and reported that the "Three Month Medication Review" is treated as new orders and indicated that prior to September 2012, the Physicians were not all completing the Quarterly Medication Reviews in a timely manner as per the Licensee's Policy and Procedure #PRO-N39.

The Pharmacy Manager indicated that in September 2012, a Medical Advisory Committee meeting was held where the decision was made that all physicians were to review the residents' "Three Month Medication Review" sheets within a week of receiving them from Pharmacy. Further direction had been given to ensure that the physicians write the time line and or quantities of medication to be given to the residents until the next "Three Month Review". The Pharmacist indicated that according to legislation every prescription has to have a time duration. The Pharmacist reported that certain medications are administered based on lab work and would normally be given for only a short period; that in the case of any new medication therapy, the same thing would occur; if the medication was not renewed via the "Three Month Medication Review" sheet, the medication would not be dispensed. [s. 134. (c)]

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 "Three Month Medication Review" is completed in a timely manner, 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 failed to comply with the O. Reg. 79/10 s. 131 (2), in that the Licensee failed to ensure that drugs were administered to Resident #1 in accordance with the directions for use provided by the Prescriber.

Resident #1's E-Meds sheets between July and September 2012 were reviewed. There is an indication that three different medications were not administered as per the physician's order between July and September 2012.

Resident #1's "Three Month Medication Review" Sheet was reviewed by the Inspector. There is an indication that the "Three Month Medication Review" sheet for July 2012 was not completed as per the date stamped by pharmacy. The review was completed in September, 2012, which was six months post admission.

The Registered Nurse in charge of the unit was interviewed and reported that the pharmacy's electronic system had automatically stopped several medications from the electronic system because the medication quantities ordered, had been totally dispensed and pharmacy could not provide any more without a physician's order renewal. The attending physician had not discontinued these medications, but since the "Three Month Medication Review" sheet had not been completed as per requirement, the pharmacy could not dispense those medications.

The Pharmacy Manager was interviewed and indicated that in the case of certain medications, they are normally given for a short period and are followed by lab work. The Pharmacist added that in the case of any new pharmaceutical therapy, the same thing would occur, if the medication was not renewed via the "Three Month Medication Review" sheet, the medication would not be dispensed.

As such Resident #1 was not administered three of the prescribed medications in accordance with the directions for use specified by the Prescriber. [s. 131. (2)]

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

Issued on this 16th day of April, 2013

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

Colette Asselin, LTCH Inspector #134