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

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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
Feb 22, 2013	2013_221124_0001	O-000124-13	Critical Incident System

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

LYNDA HAMILTON (124)

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 19-20, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses and the Corporate Regional Representative.

During the course of the inspection, the inspector(s) reviewed resident health records and the home's policies, "Ordering and Receiving Medication" and "Medication Disposal-Narcotics/LTCH's".

The following Inspection Protocols were used during this inspection:
Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 failed to comply with O.Reg. 79/10, s.8(1) in that the licensee did not ensure that policies regarding the medication management system, O.Reg. 79/10, s.114 were complied with.

--The home's Classic Care Pharmacy Policy 2.1, "Ordering New Prescriptions, Procedure step 2, directed staff to "transcribe the new physician order to the resident's MAR/TAR sheet, ensuring the following were documented; name and strength of the medication, route of administration, directions for use, indication for use, if applicable, order date, administration time(s), start date and stop date, if applicable."

On a specified date, there were new physician's orders for Resident #1, including a narcotic medication of specified strength and dose to be given by injection every four hours as needed for severe distress.

When transcribing the order, staff member #S100 documented the following on Resident #1's Medication Administration Record (MAR): the narcotic medication, the strength of the medication and that the medication was to be given by injection every four hours as needed. Staff member #S100 did not document the directions for use, the indication for use, the order date or the start date, as directed by the policy.

Staff member #S100 reported she was interrupted by a family with questions during the process of transcribing Resident #1's order and when she went back to the order she thought she had finished it.

--The home's Classic Care Pharmacy Policy 2.1, "Ordering New Prescriptions, Procedure, step 5 stated "A second nurse, within 24 hours, double-checks the order processing of the first nurse and documents that steps 1 and 2 have been completed and are correct."

On a specified date, there were new physician's orders for Resident #1, including a narcotic medication of specified strength and dose to be given by injection every four hours as needed for severe distress.

Staff member #S100 documented the following on Resident #1's MAR: the narcotic medication, the strength of the medication and that the medication was to be given by injection every four hours as needed. Staff member #S100 did not document the directions for use, the indication for use, the order date or the start date, as directed

by the policy.

Staff member #S101 signed the "Nurse #2" Box on the physician's orders of the specified date for Resident #1 to indicate that the orders had been double-checked. Staff member #S101 did not identify that staff member #S100 had not documented the directions for use, the indication for use, the order date or the start date.

Staff member #S101 reported to the inspector that there are a lot of interruptions when checking the orders because it is done when the staff are giving out medications.

Resident #1 was administered an incorrect dose of narcotic medication.

--The home's Classic Care Pharmacy Policy 5.8.1, "Medication Disposal-Narcotics/LTCH's Policy stated that all narcotic and controlled substances, which are to be destroyed are always stored in a designated area separate from any controlled substance that is available for the administration to a resident and maintained under double-lock until the destruction and disposal occurs.

On February 19, 2013, inspector 124 observed nine vials of Resident #1's narcotic medication and five vials of Resident #2's narcotic medication in the locked narcotic box on the medication cart.

Resident #1 and #2 were discharged from the home prior to February 19, 2013 and the narcotic medications were waiting for destruction and were not stored separate from the medication that was available for administration to a resident. [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 staff comply with the home's policies related to the transcription of physician orders and the storage of narcotics for destruction, 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 O.Reg. 79/10, s. 131. (2) in that drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date, there were new physician's orders for Resident #1, including a narcotic medication of specified strength and dose to be given by injection every four hours as needed for severe distress.

Resident #1's Medication Administration Record stated the narcotic medication was to be given by injection every four hours as needed. The prescribed dose of the narcotic medication was not recorded.
Staff member #S102 reported that a day later, Resident #1 was administered an incorrect dose of narcotic medication.

At this time, no further action is being taken because this non-compliance was noted during a November 2012 inspection and a Compliance Order was served that directed the licensee to:
Prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s. 131. (2) to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
This plan shall include:
1. Review and assessment of the process of medication administration by the multi-disciplinary team,
2. To educate and re-educate all registered nursing staff related to the home's medication policies and procedures and
3. A process for ongoing monitoring of medication administration practices to ensure compliance." This order must be complied with by March 31, 2013. [s. 131. (2)]

Issued on this 22nd day of February, 2013

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

Lynda Hamilton