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
Mar 19, 2015	2015_248214_0007	H-002055-15	Critical Incident System

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave HAMILTON ON L9C 7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue HAMILTON ON L9C 7W9

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

CATHY FEDIASH (214)

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 5, 2015.

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC); Coordinator of Continuing Quality Improvement and Education; Pharmacist; Registered Staff. The inspector also reviewed relevant clinical records, policies and procedures and the critical incident submitted by the home.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive days in February 2015. A review of the physician's orders indicated that on the identified date of this event the medication was discontinued and capillary blood glucose (CBG) testing was ordered to be completed twice daily for the next two days.

A review of the resident's Medication Administration Record (MAR) for February 2015 indicated that the CBG testing was to be completed at the 0800 hour and 1700 hour interval. A review of the MAR indicated that the CBG testing started on an identified date in February 2015 at the 1700 hour time frame; the next day it was completed at the 0800 hour and 1700 hour interval and the day following this, it had not been completed at the 0800 hour interval but at the 1700 hour interval. The DOC confirmed that the CBG testing was not completed at the 0800 hour interval on the identified date as specified on the MAR. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was prescribed a high- alert oral medication. The resident had received five doses of this newly prescribed medication over a period of five consecutive dates in February 2015. The day after receiving these five doses of newly prescribed medication, the resident was found in their bed, unresponsive. A review of the resident's current plan of care under interventions for this new diagnoses indicated that registered staff would check capillary blood glucose and give glucose or glucagon per protocol. An interview with the DOC confirmed that the plan of care was not reviewed and revised when the resident's care needs changed as these interventions had not been initiated until nine days after this new diagnosis. [s. 6. (10) (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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A) A review of the home's policy titled, "Management of Hypoglycemia" (15-3 with a revision date of February 6, 2015) indicated that registered staff would do the following:

i) If CBG (capillary blood glucose) is less than 4.0 mmol/L resident is experiencing a hypoglycemic event. It must be treated immediately. For the unconscious resident if the CBG is less than 4.0 mmol/L registered staff will administer glucagon as per prn order; position resident lying on their side; call physician; repeat CBG in 15 minutes.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive dates in February 2015. At the time of this

incident, a capillary blood glucose test (CBG) was performed with documented results of 1.6 Millimoles per Liter (mmol/L). The resident was immediately transferred to hospital. An interview with the DOC confirmed that registered staff did not administer glucagon and repeat the CBG 15 minutes later; that the resident did not have a prescription for glucagon and that the home did not comply with their policy.

B) A review of the home's pharmacy policy titled, "High Alert Medications" (4-009 with a reviewed date of January 2014) indicated the following under Procedure:

i) When a high-alert medication (ie. Anticoagulant, chemotherapeutic agent, hypoglycemic, narcotic, methotrexate for non-oncologic use) is dispensed by the pharmacy, extra precautions are taken to identify medication as "high risk". A list of high-alert medications was contained in this policy and did identify this resident's newly prescribed medication as a high risk medication.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive dates in February 2015. A telephone interview with the home's pharmacist confirmed that when this resident's high-alert prescription was dispensed, extra precautions were not taken as the pharmacy's computer system did not flag this medication as high risk.

ii) Additional, written information addressing safety concerns is included with medication to advise of potential risks such as side effects and potential drug interactions.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive days in February 2015. An interview with registered staff and a telephone interview with the home's pharmacist confirmed that no additional written information addressing safety concerns was included with the delivery of this new prescription.

iii) Education and In-service training is provided to staff regarding high-alert medications (ie. Hypoglycemic, fentanyl, warfarin, narcotic) with emphasis on optimal use of medication, potential side effects, and monitoring parameters.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive days in February 2015. An interview with the DOC and the Coordinator of Continuing Quality Improvement and Education confirmed that no training regarding this high-alert oral medication had been provided to the staff in 2014.

C) A review of the home's pharmacy policy titled, "Medication Incident/Near Incident Program" (6-001 with a reviewed date of January 2014) indicated the following under Procedure:

i) Complete the Incident/Near Incident report including the details of the incident and any corrective measures that were taken. Submit the report to the Director of Nursing and Personal Care.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive days in February 2015. An interview with the DOC confirmed that an Incident/Near Incident report had not been completed for this incident and that the home had not complied with the policy. [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 any plan, policy protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: 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 ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of resident #001's clinical record indicated that on an identified date in February 2015, the resident was found in their bed, unresponsive, following a medication related event. The resident had received five doses of a newly prescribed, high-alert oral medication over a period of five consecutive days in February 2015. A review of the home's investigation notes into this incident as well as an interview with the DOC confirmed that capillary blood glucose (CBG) testing had not been completed and that no monitoring and documentation of the resident's response and the effectiveness was done while taking this high risk medication. [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 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, to be implemented voluntarily.

WN #4: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

A review of the home's medication incidents from January 1 – December 31, 2014, was conducted. An interview with the Coordinator of Continuing Quality Improvement and Eduction indicated that during this time frame there was a total of 79 medication related incidents. An interview with the DOC and the Coordinator of Continuing Quality Improvement and Education confirmed that quarterly reviews of these medication incidents had only occurred for one out of the four quarters in 2014. [s. 135. (3)]

Issued on this 22nd day of March, 2015

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

Original report signed by the inspector.