Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2020	2020_778563_0004	000599-20, 001632-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Middlesex
c/o Strathmere Lodge 599 Albert Street, P.O. Box 5000 STRATHROY ON N7G 3J3

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

Strathmere Lodge
599 Albert Street Box 5000 STRATHROY ON N7G 3J3

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

MELANIE NORTHEY (563)

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): January 27, 2020

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, a Registered Nurse and a Registered Practical Nurse.

The Inspector also made observations of medication storage areas. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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 :

The licensee has failed to ensure that the Medical Pharmacies Shift Change Monitored Drug Count Policy 6-6 and the Medical Pharmacies Individual Monitored Medication Record Policy 6-5 was complied with.

Ontario Regulation 79/10 s. 114 (2) states, "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."

The Nursing Manual "Controlled Substances - Counting - Narcotics" Policy NMC014 last revised June 7, 2017, stated "controlled substances will be counted on every shift in agreement with Medical Pharmacies Policy 6-6".

The Medical Pharmacies Shift Change Monitored Drug Count Policy 6-6 last revised November 2018, stated "the shift count must be reconciled with the actual amount of drug in the packaging (not just the last blister number or doses). If an individual count is used, the shift count should be reconciled with this as well to account for actual daily use." Two staff, leaving and arriving, were to count the actual quantity of medications remaining and confirm the actual quantity was the same as the amount recorded on the 'Individual Monitored Medication Record'.

A) The Critical Incident (CI) System Report documented a shift change narcotic count was completed and the registered staff noticed a controlled substance missing from the blister packaging. The shift count was correct at 0700 hours and the count was incorrect at 1500 hours, but the error was not noticed until the 2300 hour count on the same day. The Director of Resident Care (DRC) verified the shift count of controlled substances

was discovered missing at the 2300 hours count.

The Medical Pharmacies Shift Change Monitored Medication Count discrepancy was then noted during the 2300 hours shift count. The DRC stated to ensure the "7-day regular dose" remained consistent with the packaging, the registered staff borrowed from the resident’s PRN (as needed) order and administered the controlled substance as prescribed to the resident. The Individual Monitored Medication Record for the “Quantity Received from Pharmacy” had no documented initial for "Received by" or "Witnessed by".

The Medical Pharmacies Individual Monitored Medication Record Policy 6-5 last revised January 2018, stated to "initial 'received by' and 'witnessed by' on the 'Individual Monitored Medication Record' in appropriate section at top of page." The DRC verified the Individual Monitored Medication Record had a “Quantity Received from Pharmacy” section with no initial for "Received by" or "Witnessed by" for the resident’s controlled substance and stated the registered staff have never been instructed to initial this form related to quantity received from pharmacy. The DRC verified the home did not comply with the policy related to the individual record of monitored medications. Also, the registered staff did not sign the individual record to show that two separate blister numbers were used for the administration of two tablets of the controlled substance. Subsequent registered staff continued to incorrectly sign for the wrong blister number for three doses over 12 days. The Medical Pharmacies Individual Monitored Medication Record Policy stated each line on the record corresponds to one blister in the medication card for tablets and capsules.

The licensee failed to ensure that the Medical Pharmacies Shift Change Monitored Drug Count Policy 6-6 was complied with. The registered staff did not ensure the shift count was reconciled for the resident's controlled substance. The shift count was not reconciled to account for the actual daily use during the day shift. The two registered staff, leaving and arriving, were to count the actual quantity of routine controlled substance remaining and confirm the actual quantity was the same as the amount administered and this did not happen. The licensee failed to ensure the Medical Pharmacies Individual Monitored Medication Record Policy 6-5 was complied with related to the documentation of registered staff initials when receiving and witnessing the quantity of a controlled substance received from pharmacy.

B) The CI System Report related to a missing and/or accounted controlled substance for another resident. When the registered staff completed a shift change narcotic count it

was noted that a packaging blister was empty of any medication. The blister was not opened and remained sealed.

The Director of Resident Care (DRC) stated the home conducted an analysis of the incident and determined that it was a pharmacy and nursing error. The DRC stated the nurses should have noticed the controlled substance tablet was missing. The DRC verified the Shift Change Monitored Drug Count policy instructed the nurses to count the actual quantity of the medications remaining and they did not do that for several days.

The Medical Pharmacies Individual Monitored Medication Record for the resident's controlled substance documented that ten doses were administered as required over the course of a month. The registered staff, leaving and arriving, were to count the actual quantity of medications remaining and confirm the actual quantity was the same as the amount recorded on the Individual Monitored Medication Record and this did not happen. The Individual Monitored Medication Record had a "Quantity Received from Pharmacy" section that documented 30 tablets were received from pharmacy when there were only 29 received since one was empty. The quantity received from pharmacy was changed to 29 and that happened a month later. Also, the "Quantity Received from Pharmacy" section had no initial for "Received by" or "Witnessed by" for the resident's controlled substance.

The DRC verified the two registered staff, leaving and arriving, did not count the actual quantity of controlled substance tablets remaining when the medication was received from pharmacy and the registered staff continued to incorrectly count the controlled substance for approximately a month. The DRC also verified the Individual Monitored Medication Record had a "Quantity Received from Pharmacy" section with no initial for "Received by" or "Witnessed by" for the resident's controlled substance.

The Medical Pharmacies Shift Change Monitored Medication Count was documented incorrectly three times a day for approximately 28 days. The DRC stated it was the expectation of the registered staff to count the remaining controlled substances and narcotics and record that number on the resident's monitored shift count sheet and the administered dose on the individual monitored medication record to be crossed checked and verified as correct.

The licensee failed to ensure that the Medical Pharmacies Shift Change Monitored Drug Count Policy 6-6 and the Medical Pharmacies Individual Monitored Medication Record Policy 6-5 was complied with. The registered staff did not count the actual quantity of

controlled substance received from pharmacy and that continued for almost 28 days or 86 shifts. Also, the “Quantity Received from Pharmacy” section had no initial for "Received by" or "Witnessed by" for resident’s controlled substance.

C) To expand the resident sample as part of this critical incident medication inspection, the Inspector, accompanied by the Director of Resident Care (DRC), randomly selected a third resident from the controlled substance documentation binder in the locked medication room. The resident's Medical Pharmacies Individual Monitored Medication Record and the Medical Pharmacies Shift Change Monitored Medication Count was reviewed.

The Medical Pharmacies Individual Monitored Medication Record for the resident’s controlled substance had no initial for "Received by" or "Witnessed by" on the “Quantity Received from Pharmacy” portion of the form. There were no other discrepancies noted for the individual count or shift count for the resident’s controlled substance.

The DRC verified the Medical Pharmacies Individual Monitored Medication Record Policy 6-5 stated to initial 'received by' and 'witnessed by' on the 'Individual Monitored Medication Record' in the appropriate section at the top of page. The DRC acknowledged the Individual Monitored Medication Record had a “Quantity Received from Pharmacy” section with no initial for "Received by" or "Witnessed by" for the resident’s controlled substance.

The licensee failed to ensure the Medical Pharmacies Individual Monitored Medication Record Policy 6-5 was complied with related to the documentation of registered staff initials when receiving and witnessing the quantity of a controlled substance received from pharmacy. [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 instituted or otherwise put in place is complied with., to be implemented voluntarily.

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.