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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2013	2013_208141_0008	H-001936-12	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

---

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 25, 29, 30, 31, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Directors of Care (ADOC), Registered Nurses (RN), and Registered Practical Nurses (RPN)

During the course of the inspection, the inspector(s) reviewed residents' medication records, home's investigation summary notes, and home policies and procedures and Drug Record Books

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. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee did not ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded in respect of every drug that was ordered and received in the home including the name, strength and quantity of the drug, the date the drug was received in the home, the signature of the person acknowledging receipt of the drug on behalf of the home.
In November, 2012 it was identified that 15 full tablets of a controlled substance were missing from the controlled drug destruct safe. The home's investigation identified the documentation in the Drug Record Book indicated the medication had been ordered in August, 2012 but the book did not identify the date the drug was received, the quantity received, or the signature of the person acknowledging receipt of the the drug on behalf of the home. The pharmacy receipt identified that 30 full tablets had been dispensed. Review of the Drug Record Books on two home areas during the inspection period identified inconsistent documentation in the Drug Record Books of prescriptions received including 3 controlled substances that did not have date or quantity received and signature of the staff person who received the prescription. Review of the bubble packages identified the medication had been received. The home's policy and procedure "Ordering and Receiving Medications From The Pharmacy" stated in the Drug Record Book the following information must be recorded for every drug order: Drug name, strength, duration , quantity and route, and signature and initials of person placing/receiving order, date order was placed/received. The ADOC confirmed the Drug Record Book should contain all the outlined information. [s. 133.]

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 a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home including the date the drug is ordered, the name, strength and quantity of the drug, the name of the place from which the drug is ordered, the name of the resident for whom the drug is prescribed, where applicable, the prescription number, where applicable, the date the drug is received in the home, the signature of the person acknowledging receipt of the drug on behalf of the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use. 2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and ii. the Administrator. 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. An identified resident was ordered a controlled drug in August, 2012 that was dispensed by the pharmacy in 2 separate blister packaged cards. The drug was discontinued in September, 2012 and the count at this time of the tablets remaining was accurate. The count was completed by totaling the number of 1/2 tablets remaining. The 2 drug cards remained in the locked cupboard of the medication cart until the next day but was not counted for the following 2 shifts. The drug was removed from the cart the day after it was discontinued and counted by 2 registered staff prior to placing it in the double locked cabinet in the pharmacy storage room, to await destruction. The count was completed by totaling the number of full tablets remaining and there was an identified differentiation in the count by one complete blister card for a total of 15 full tablets of the controlled substance. This differentiation was not identified to the home until 6 days later when destruction occurred with the pharmacist. The home completed an investigation but was unable to determine the cause of the missing medication. The ADOC, who completed the investigation to the missing drug, confirmed that the card went missing prior to being removed from the unit, that shift count should of occurred while the medication remained on the unit, staff had counted inconsistently the number of tablets remaining, and the home did not complete monthly audits of daily count sheets to determine if there are any discrepancies. [s. 130. 1.]

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

Issued on this 20th day of February, 2013

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