Annual Resident Quality Inspection – July 24, 25, 26, 27, 28th, 2017

Finding	Type of Notification	What it means	How we resolved it
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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident□s health; and O. Reg. 79/10, s. 135 (1). (b) reported to the resident, the resident□s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident□s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s.135 1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident, the resident□s substitute decision-maker, if any, the prescriber of the drug, and the resident□s attending physician or the registered nurse in the extended class attending the resident. Medication incidents for the current year were reviewed. A medication incident involving an identified resident	Written Notification	As identified in the findings, through their review of 'medication incidents' at Wellington Terrace of the previous year, identified two incidents where the physician or POA was not notified when a medication was missed.	Although the severity of non-compliance was viewed as minimum risk, and not viewed as having a history of non-compliance in this area of the legislation, we took the notification seriously and changed our processes to comply with regulations. The Medical Director will be notified for any incidents involving medications. It had not been our practice to notify physician of medical incidents unless there was an adverse event related to the medication incident. In addition, our Safe Medication Practice Team continues to meet regularly to review incidents and identify ways to improve practices and avoid further incidents.

occurred on a specific date, where it was unsure if the resident received a dose of medication as it was not in the medication cart and staff questioned if it had been given at the wrong time, earlier in the day. The Medication Incident Report showed that the Registered Nurse was notified; however, the resident/POA, prescriber/attending physician were not checked off as notified, and on review of the residents progress notes, there was no documentation related to that medication incident. A medication incident involving another identified resident occurred on a specific date, where a resident's medication was found to have been administered on the wrong date. The Medication Incident Report showed that the Registered Nurse and the resident/POA was notified; however, the prescriber/attending physician was not checked off as notified. During interviews with the Director of Care and the Resident Care Manager both said that the attending physician/prescriber of the drug were not notified of the medication incidents, and that it has been the practice of the home, at the request of the physicians, that they are not notified of medication incidents unless there was risk or a negative outcome to the resident. The Resident Care Manager also agreed that after reviewing the medication incident and the resident's health record, the substitute decision maker for the resident was not notified of the medication incident that occurred on a specific date and should have been.			We are proud of our open and transparent culture of reporting medication incidents or near misses. This transparency allows us to develop quality improvement plans to address deficits.

The licensee failed to ensure that the substitute decision maker was notified of a medication incident involving a resident and the prescriber/attending physician was notified of medication incidents involving two residents. The severity of this non-compliance is minimum risk and the scope is a pattern. The home does not have a history of non-compliance in this subsection of the legislation. [s.135. (1)]			