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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2018	2018_617148_0004	012213-17, 015544-17, 020914-17, 021610-17, 025692-17, 027306-17	Critical Incident System

Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

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

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

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

AMANDA NIXON (148)

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 8, 9, 12, 13 and 20, 2018

This inspection included six critical incident reports; two related to alleged physical abuse of a resident by another resident (Logs 015544-17 and 020914-17) and four related to incidents that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health condition (Logs 021610-17, 027306-17, 025692-17 and 012213-17).

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Manager of Nursing Care Operations, Coordinator of Nursing Programs, Nursing Support Clerk, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector observed resident care and services, resident-staff interaction, resident-resident interaction and the care environment. The Inspector reviewed identified resident health care records, including plans of care, physician orders, geriatric outreach documentation and documents related to the fall prevention program.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. (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 :

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 the resident's care needs change or care set out in the plan is no longer necessary.

Prior to a specified date, resident #002 required various levels of assistance for activities of daily living; specifically the resident was independent for transfers, bed mobility and locomotion/ambulation, with toileting needs varying from independent to limited assist. The resident has a diagnosis that affects cognition with related responsive behaviours; the health care record supports the resident was predominately continent of bowel and bladder.

On a specified date, the Manager of Nursing Care Operations (MoNCO) submitted a critical incident report (CIR) to the Director describing that resident #002 had a fall five days prior to the CIR and was sent out to hospital. The CIR further indicates that the resident had falls on six and seven days prior to the CIR and that while in hospital the resident was diagnosed with a specified injury. The Inspector reviewed the falls identified in the CIR. Over the course of this time the resident's physician was involved and assessments completed. The progress notes support that staff implemented the use of various mobility equipment, personal alarms and medications to attempt to mitigate the fall risk. Prior to identified falls the resident was not at high risk for fall.

The resident returned from hospital three days after the CIR was submitted. As indicated by a progress note of the same date, the physiotherapist conducted an assessment and recommended the use of identified ambulation aides, personal alarms, two person transfer and mobility equipment as needed.

The plan of care was updated two days after the physiotherapist assessment to include a

restorative program for both walking and toileting and use of mobility equipment with additional physical device

The plan of care was updated two weeks later to include one person guidance and physical assist for transfers, use of mobility equipment with additional physical device and constant supervision.

Each of the above items were contained within the current plan of care that provides direction to direct care staff members. In addition the current plan of care also indicates hourly checks at night as part of the fall risk plan of care.

The resident was observed by the Inspector on several occasions during the time of the inspection. The resident was observed in bed with a personal alarm attached to the bed (not attached to resident) and a mobility device within reach at bedside. The resident was not able to participate in a discussion regarding the resident's history of falls and care plan.

The Inspector spoke with PSW #105 and RN #104 who are both regular staff members familiar with the resident's care. When asked about the resident's current care plan related to the resident's risk of falls, PSW #105 noted that the resident is monitored every 30 minutes which is documented in the electronic record Point of Care (POC). In review of the POC, there is a task indicating direct care staff conduct 30 minute checks, however the task is to be signed each shift and does not support that the resident is monitored every 30 minutes. As it relates to the constant monitoring intervention noted in the plan of care, it was determined by interview with PSW #105 and the Coordinator of Nursing Programs (CNP) that the resident has not been provided with constant monitoring as this would entail the provision of 1:1 services which has not been provided for this resident. As it relates to the hourly monitoring noted in the plan of care, the CNP indicated that all residents are monitored hourly as part of the PSW routines for resident care, which is not a documented process. She noted that when a care plan intervention is created for hourly monitoring it is referred to as hourly rounding and documentation is maintained on a hard copy form. Targeted Hourly Rounding Sheets for resident #002, for specified dates were reviewed by the Inspector and indicated the implementation of hourly rounding for all shifts; the rounding sheets had been discontinued prior to this inspection. The CNP indicated that given the resident's improvement it is suspected that nursing staff decided to discontinue this intervention.

In addition, staff noted the use of a personal alarm that is put on when the resident is in

bed. The Inspector noted the alarm to be disconnected from the resident clothing at the time of observations. PSW #105 noted that the resident takes it off regularly and that the resident does not usually keep the alarm attached. It was agreed that the resident may get out of bed without an alarm sounding in these instances. When asked about the use of other personal alarms, PSW #105 noted that there was another personal alarm in place but this is no longer used by day staff, the PSW #105 noted it may still be in the room and used by night staff. Upon observation of the room, no other personal alarm was found. The Inspector reviewed care documentation maintained by PSW staff in POC and noted that on four night shifts over the past 14 days, the use of another personal alarm was noted. The plan of care does not include direction to staff on the use of another personal alarm for this resident.

When asked about the use of various mobility devices PSW #105 recalled the resident used several different devices since the occurrence of the falls identified, related to the resident's changing care needs but that the resident was only using one identified mobility device at this time. PSW #105 indicated that the resident uses this device to get around, although is sometimes non-compliant with use. In an interview, RN #104, indicated that the resident is using the device and walking well with this device at this time. In an interview with the home's Physiotherapist it was indicated that at the last assessment the resident was recommended the use of the one mobility device and that the second mobility device (currently in regular use) was to be used in the restorative walking program. The PT noted that it was possible that nursing had conducted their own assessment and determined the resident safe to use the second mobility device. In review of the health care record, no such documented assessment could be identified.

As indicated above the plan of care described a toileting plan that is currently in place for resident #002. During an interview with PSW #105 it was reported that the resident primarily self-toilets and the resident is independent for this care. PSW #105 further noted that the resident uses pull ups at this time, for occasional urinal incontinence as sometimes the resident is not able to get to the bathroom in time. Care sheets completed in POC were reviewed for the last 14 days and noted continence of bowel and occasional incontinence of bladder. The plan of care does not reflect the resident's ability or safety (as it may relate to falls) for self-toileting nor the use of pull ups.

The licensee was unable to demonstrate that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan is no longer necessary; specifically as it relates to the use of personal alarms, monitoring, mobility devices and continence care.

(Log 027306-17)

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 :

The licensee failed to ensure that where the Regulations require the licensee of a long-term care home to have, institute or otherwise put in place a plan, policy, protocol, procedure, strategy or system, the license is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

In accordance with section 49 (1) of the Regulation 79/10, the licensee is the have in place a falls prevention and management program that, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents. The home's falls prevention program includes a protocol for the monitoring of residents after a fall if there is head trauma or the resident hits his/her head. This protocol is the Neurological Flow sheet that directs staff to conduct an assessment at specified time intervals.

On an identified date, resident #001 sustained a witnessed fall whereby the resident sustained a head injury. RPN #112 initiated the Neurological Flow Sheet (NFS) in consultation with the charge RN, so as to monitor the resident for any changes that may indicate neurological injury.

In review of the NFS it was noted that there were four instances whereby the neurological check was incomplete for: level of consciousness, movement, hand grasps, pupil size/reaction and speech. Specifically, the evening RPN #112 noted "asleep" at two intervals and the night RN noted "sleeping" at another two intervals. In discussion with RPN #112, it was reported that it is possible that after having pain medication the resident was allowed to sleep and therefore the neurological check was not completed. As indicated by the NFS and the health care record the resident's neurological status changed some time after the fall and in consult with the physician the resident was sent out to hospital.

In discussion with both the Manager of Nursing Care Operations and the Coordinator of Nursing Programs it was determined that to perform neurological assessment the resident is to be woken to complete the assessment criteria, including level of consciousness, movement, hand grasps, pupil size/reaction and speech.

The protocol to monitor resident #001 for neurological symptoms after a fall was not complied with, whereby four intervals of assessment were not completed.
(Log 012213-17)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition for which the resident is taken to hospital (subject to subsection 3.1).

On a specified date, the Manager of Nursing Care Operations (MoNCO) submitted a critical incident report (CIR) to the Director describing that resident #002 had a fall five days prior to the CIR and was sent out to hospital for further assessment.

Inspector #148 reviewed the resident's health care record and noted that on the same day the resident was sent to hospital, the spouse of the resident was in contact with RPN #110 and the RPN was informed of an injury and significant change in health condition.

The Inspector spoke with the MoNCO who indicated that records demonstrated that the MoNCO was not informed of the resident's hospital transfer and significant change in health condition until five days after the fall, at which time the CIR was submitted. In discussion, the MoNCO shared that registered nursing staff are to communicate such instances through a hard copy internal incident report that is to be left for the MoNCO for follow up. The MoNCO could not indicate the date the internal incident form was completed or why the internal incident form was not provided to the MoNCO earlier.

In this way, the identified incident resulting in a hospital transfer and significant change in health condition for resident #002 was not reported to the Director within one business day.
(Log 027306-17)

Issued on this 12th day of March, 2018

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

Original report signed by the inspector.