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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2013	2013_128138_0024	O-000546-13,O-000465-13	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

PAULA MACDONALD (138)

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): July 17 and 18, 2013

Two Critical Incident Inspections were conducted: O-000546-13 and O-000465-13

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Coordinator of Nursing Programs, a registered nurse (RN), a registered practical nurse (RPN), several personal support workers (PSW), a food services worker (FSW), and the Registered Dietitian.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, reviewed home's policy and procedure relating to skin and wound care, reviewed home's Falls Prevention and Management Program, reviewed Critical Incident Reports, observed a lunch meal service, and observed several resident rooms.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 S.O. 2007, c8, s. 6. (1) (b) in that the licensee failed to ensure that there is a written plan of care for each resident that sets out the goals the care is intended to achieve.

Resident #2 was reported by the home through a Critical Incident Report to have fallen on a day in May 2013 and was transferred to hospital. The resident was returned home, fell again the following day and was once again transferred to hospital where s/he was diagnosed with a urinary tract infection (UTI) and dehydration among other things.

The resident's health record was reviewed and it was noted that the resident has had recent and recurring UTI's and that the resident's anxiety increased around the time that a UTI is diagnosed. Discussion was held with the unit RPN, Staff #102, who confirmed that the resident's anxiety is more pronounced when s/he has a UTI. Staff #102 provided LTCH Inspector a copy of the resident's recent plan of care. The plan of care was reviewed and it was noted that there were no specific goals and interventions to guide staff in the management and prevention of UTI's including Staff #102's observation of increased anxiety as a link to a possible UTI. [s. 6. (1) (b)]

2. The licensee failed to comply with LTCHA 2007 S.O. 2007, c8, s. 6. (1) (c) in that the licensee failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Resident #2's care plan was further reviewed and it outlined that the resident was to wear a posey alarm at all times as an intervention to prevent falls. Discussion was held with several staff who reported otherwise. For instance: Staff #102 stated that the resident was to wear a posey alarm only when in bed and that it was not required when in his/her wheelchair. Staff #103 stated that the resident no longer wears a posey alarm at all as s/he now has a floor sensor in place while in bed and also stated that this has been the case for several weeks as the resident's condition has improved. Staff #105 stated that she responded to the resident in the morning July 18, 2013 when the floor sensor sounded as the resident was attempting to get out of bed and reported that she could not recall the resident wearing a posey alarm at the time. The care plan does not provide clear direction to staff on the use of a floor sensor or posey alarm as an intervention in the prevention of falls for Resident #2.

Resident #2's care plan was reviewed regarding interventions related to eating as it is

well documented that resident has poor oral intake. Discussion was held with several staff and Staff #102 stated that the resident has anxiety around mealtimes resulting in poor intake of food but will drink. Staff #102 further stated that the resident requires much verbal encouragement to eat and drink but will usually respond when staff tell the resident that the family or the doctor want him/her to eat/drink. Staff #104 also stated to LTCH Inspector that the technique of encouraging the resident to eat by telling him/her that his/her family and doctor want him/her to eat is usually successful. The resident's care plan does not outline this specific technique as an intervention to promote oral intake. [s. 6. (1) (c)]

3. The licensee failed to comply with LTCHA 2007 S.O. 2007, c8, s. 6. (4) (a) in that the licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Discussion was held with the Director of Care and the Coordinator of Nursing Programs regarding the home's Falls Prevention and Management Program. The Coordinator of the Nursing Program stated that dietary and nutritional care is not a component of the interdisciplinary Falls Prevention and Management Program. Discussion was also held with the home's Registered Dietitian who confirmed that dietary and nutritional care does not play a role in the Falls Prevention and Management Program. The home's dietitian further stated that she did not receive a referral or communication that Resident #2 was returned from the hospital with a diagnosis of UTI and dehydration and therefore only followed up with resident at the annual care conference which was a regularly scheduled event. The dietitian further stated that she would expect to receive a referral for a resident who was returned from hospital with a diagnosis of dehydration and UTI. [s. 6. (4) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 50 (2) (b) (ii) in that a resident exhibiting altered skin integrity did not receive immediate treatment and interventions.

A critical incident report submitted by the home was reviewed by LTCH Inspector #138. It outlined that Resident #1 had been transferred to hospital on a day in June 2013 after evening staff observed blood coming from an open area on the resident's right side of head. The resident was returned from the hospital with diagnoses of a small intracranial bleed.

LTCH Inspector spoke with the Director of Care regarding the investigation into the incident. The Director of Care stated that the home was not able to conclude the cause of the injury but did acknowledge that the bleeding was first identified by a PSW, Staff #100, who was providing Resident #1 with a bath in the morning on the day shift on the day the incident occurred. The Director of Care stated that the PSW reported that she observed that the resident was bleeding from the head while being bathed but that Staff #100 failed to report the observation to the Registered Nurse as is the home's practice on skin and wound care. The Director of Care further stated that the resident was again observed later in the afternoon by evening staff to be bleeding from the head and, at that time, was assessed by a Registered Nurse and transferred to hospital.

LTCH Inspector spoke with Staff #100 who stated that she bathed Resident #1 the morning of the day that the resident was transferred to hospital. Staff #100 stated she observed that the resident was bleeding from the head and also stated that she did not report the incident to anyone including the Registered Nurse.

LTCH Inspector spoke with the Registered Nurse, Staff #101, who was on during the day shift of the incident. Staff #101 stated that staff are to report any skin integrity issues including bleeding to the Registered Nurse so that the Registered Nurse can complete an assessment and take appropriate actions. Staff #101 stated that she did not assess Resident #1 or take any actions as she was not made aware that the resident had been observed to be bleeding during her bath on the morning of June 12, 2013.

The home's policy on Skin and Wound Care was reviewed and the policy outlined that PSW staff are responsible to report any open areas, blisters, bruises, tears and scratches and that the Registered Nursing Staff are to take actions. For Resident #1,

the bleeding observed by Staff #100 during morning bathing was not reported to the Registered Nurse which prevented the resident from the opportunity to be assessed and immediately receive treatment and/or interventions. The resident was not assessed until the afternoon when more bleeding was discovered by the evening staff. [s. 50. (2) (b) (ii)]

Issued on this 23rd day of July, 2013

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

Paula MacDonald RD
LTCH Inspector #158