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
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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
Sep 16, 2013	2013_128138_0031	O-000732-13 O-000733-13	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

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

This inspection was conducted on the following date(s): September 11, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Coordinator of Nursing Projects, Manager of Nursing Care Operations, several Personal Care Workers, a Registered Practical Nurse, and a Registered Nurse.

During the course of the inspection, the inspector(s) reviewed several resident health care records, reviewed two Critical Incident Reports, reviewed the home's Falls Prevention and Management Program, and toured resident rooms.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

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

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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 :

1. The licensee failed to comply with O. Reg 79/10, s. 8. (1) (b) in that the licensee did not comply with its written system of post fall documentation for the Falls Prevention and Management Program.

In accordance with O.Reg 79/10 s 8., 30., 48., and 49. the licensee is required to have in place a falls prevention and management program in the home including a written description of the program. The home's Coordinator of Nursing Projects provided a copy of the home's Falls Prevention and Management Program including a supporting document entitled Documentation Systems. The Falls Prevention and Management Program states that it is the nurse's duty to document in the resident's chart under fall note when a resident has fallen. The specifics of the fall note are to be in accordance with the Documentation System which lists several items including safety measures in place.

On a date in July 2013, a resident had fallen from his/her bed, was found lying on the bathroom floor and was sent to hospital with a diagnosis of a fracture. The resident's care plan in effect at the time of the fall stated that the resident was to wear a posey alarm at all times as an intervention for falls management. The post fall note on the resident's chart did not capture the safety devices that where in place at the time of the fall including the use of the posey alarm.

On a date in July 2013, another resident climbed out of bed, fell to the floor and also sustained a fracture. The resident's care plan in effect at the time of the fall was reviewed and it stated that the resident was to have a motion sensor active when the resident was in bed as an intervention for falls management. The post fall note on the resident's chart did not capture the safety devices that where in place at the time of the fall including the use of the floor sensor.

Discussion was held with the Coordinator of Nursing Projects and she stated that it is expected that the documentation for the post fall notes be completed according to the documentation system so that as much information is available for monthly review of incidents of falls. [s. 8. (1)]

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 post fall documentation is completed according to the licensee's Fall Prevention and Management Program, to be implemented voluntarily.

WN #2: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 107. (3) 4. in that the licensee did not inform the Director no later than one business day after the occurrence of an incident of injury in which a person was taken to hospital.

The Director received a Critical Incident Report submitted by the home on a date in July 2013 in which a resident was taken to hospital as a result of an injury related to a fall. The Critical Incident Report was submitted ten days after the injury and transfer to hospital occurred.
The Director received another Critical Incident Report submitted by the home on a date in July 2013 in which another resident was taken to the hospital as a result of an injury related to a fall. The Critical Incident Report was submitted seventeen days after the injury and transfer to the hospital occurred.

Discussion was held with both the Director of Care and the Manager of Nursing Care Operations who both confirmed that the Critical Incident Report was used in both cases mentioned above to inform the Director of the the injuries and transfers to hospital. Both the Director of Care and Manager of Nursing Care Operations further stated that they were unaware of the requirement to inform the Director no later than one business day after the occurrence of an incident of injury in which a person was taken to hospital

The Manager of Nursing Care Operations confirmed an additional incident in which a resident was transferred to hospital with injury on a date in September 2013 and the Director was not informed until seven days later. [s. 107. (3) 4.]

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 the Director is informed no later than one business day after the occurrence of an incident of injury in which a person is taken to hospital, to be implemented voluntarily.

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Issued on this 16th day of September, 2013

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

Paula MacDonald RD