Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'Inspection
July 22, 2011	2011-159120-024	L-001122-11 Complaint

Licensee/Titulaire

Caressant Care Nursing And Retirement Homes Limited, 264 Norwich Avenue, Woodstock, Ontario N4S 3V9

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

Caressant Care Woodstock, 81 Fyfe Ave., Woodstock, ON N4S 8Y2

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

Bernadette Susnik, Environmental Health #120

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct a complaint inspection related to the prevention and management of heat-related illness during hot weather.

During the course of the inspection, the inspector spoke with the Administrator, Associate Director of Nursing, employees and several residents.

During the course of the inspection, the inspector conducted a walk-through of the home, took air temperature and humidity readings, reviewed resident clinical records, employee training attendance records and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:

- *Safe and Secure Home*
- *Personal Support Services*
- *Resident's Rights*

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: *The licensee has failed to comply with O. Reg. 79/10, s.20.(1).* *Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat*

Findings:

The home's policy and procedure NA111.35, titled "Hot Weather Plan – Residents" with an effective date of July 2007, was not written in accordance with prevailing practices. The Ministry of Health and Long term care released a document in 2006 titled "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care Homes". This document describes the necessary interventions necessary to manage heat stress in residents and how to manage the building environment during extreme heat episodes.

Policy NA111.35 directs staff to "open doors and windows" without first addressing how the Humidex values of outdoor air would impact the interior of the home. It directs staff to shut off lights in lounges and alternate lights in corridors, which is not permitted for health and safety reasons as well as to ensure compliance with lighting requirements of O. Reg. 79, s. 18. The policy does not offer any information to staff as to when to place residents in cooled or air conditioned common spaces. Only 1 high risk resident was noted to be sitting in the cooled dining room on the lower floor during the inspection. Residents on the upper level appeared to be managing well, however the residents in the lower level were heard to be complaining of the heat.

During the inspection, windows were open in many resident rooms, thermometers and hygrometers were found to be inaccurate, blinds were missing from windows in both the 1st and 2nd floor corridors (direct sun exposure), and only 9 staff received an in-service with respect to interventions prior to the summer season.

Interventions to reduce heat in the building environment were not effective. The air temperatures and humidity levels were measured throughout the building (both levels) and found to be between 28-30C with humidity levels between 43-47%. These values were very much similar to outdoor values which were 28-30.7C and 47-53% (as per Environment Canada's Hourly Report). These values equal a Humidex of 33-36 and in the uncomfortable range for residents and other occupants. Both floors had a corridor area filled with windows which were noted to be missing blinds to keep the heat out. The air temperature in this area was well above 30C and was contributing to the overall increase in indoor air temperature. Open windows contributed to increasing humidity and heat levels in the home, thereby negating the effect of the tempered air handling system which was operational at the time for the upper level.

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 in respect to ensuring that the written hot weather related illness prevention and management plan for the home meets the needs of the residents and is developed in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat.

WN #2: ***The licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.3(1).11.iv.*** *Every licensee of a long-term care shall ensure that the following residents rights are fully respected and promoted:*

11. Every resident has the right to,

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 *kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.*

Findings:

Identified on sheets of paper, posted on the wall at each nurse's station were residents' names with their heat risk diagnosis. This information is considered personal health information within the meaning of the Personal Health Information Protection Act, 2004 and must be kept confidential in accordance with the Health Information Protection Act, 2004.

Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

B. Smith

Date of Report: (if different from date(s) of inspection).

Aug. 2/11