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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 22, 2015	2015_450138_0014	O-001023-14, O-001910-15	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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): September 14 and 15, 2015.

Off-site inspection activities were conducted on September 14, 15 and 16, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, both Program Managers, Resident Care, the RAI-MDS Application and Support Specialist, the Scheduling Coordinator, the Training Coordinator, several Personal Support Workers (PSW), several Registered Nurses, and a Registered Practical Nurse.

The inspector also reviewed Critical Incident Reports, reviewed the home's internal investigation documents, reviewed resident health care records, reviewed several partial employee files including discipline letters and education history, reviewed an employee's work schedule, and reviewed the home's Least Restraint policy (No. 335.10, revision date January 2011).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 29. (1) in that the licensee failed to ensure that its written policy to minimize the restraining of residents was complied with.

Inspector #138 reviewed a Critical Incident Report which outlined that Resident #001 was found early in the morning in September 2014 with his/her night clothing tied behind the resident's knees by PSW #103 in an attempt to prevent the resident from pulling off his/her incontinence product.

The inspector interviewed Program Manager, Resident Care #104 on September 14, 2015 regarding the incident. The Program Manager, Resident Care confirmed to the inspector that a PSW (although at the time of the interview the Program Manager, Resident Care could not recall the exact PSW involved in the incident) had tied the night clothing of Resident #001 behind the resident's knees to prevent the resident from getting to his/her incontinence product as the resident would often take the incontinent product off. The Program Manager, Resident Care stated that this action by the PSW was not appropriate as the action of tying the night clothing restrained the resident and prevented the resident's freedom of movement. She further stated that the PSW involved in the incident had been disciplined for her actions.

The inspector spoke with the other Program Manager, Resident Care #105 and she was able to confirm that PSW #103 was the staff member who had tied the night clothing of Resident #001 that was discovered on a specific day in September 2014. She provided the inspector with a document outlining disciplinary action for PSW #103's actions in the incident.

On September 14, 2015, the inspector spoke with PSW #100 and on September 15, 2015, the inspector spoke with PSW #101. Both PSW #100 and PSW #101 confirmed that they witnessed Resident #001's night clothing tied behind his/her knees early in the morning on a specific day in September 2014. Both PSWs stated that the resident's night clothing was tied in a tight knot behind the resident's knees and that the knot was very difficult for the staff to undo.

On September 17, 2015, the inspector also spoke with the PSW #103 who was involved in the incident. PSW #103 stated that she tied Resident #001's night clothing behind the resident and confirmed that she did this to prevent the resident from getting to his/her incontinence product.

The inspector reviewed the home's Least Restraint policy as provided by the home. The

home's policy defines a physical restraint as "any manual method, or any physical or mechanical device, material or equipment that is attached or adjacent to the resident's body, that the resident cannot remove easily, and that restricts the resident's freedom of movement or normal access to his or her body". As such, the tied night clothing behind the knees for the purpose of restricting Resident #001's access to his/her incontinence product meets the home's definition of a restraint. Further, the policy also outlines that only approved, commercially made restraints may be used in restraining a resident. The policy outlined the specific approved restraints and tying of a clothing was not included in the list of approved restraints.

As such, the home failed to follow its policy on Least Restraint when PSW #103 tied the night clothing of Resident #001 for the purpose of preventing resident access to his/her incontinence product. [s. 29. (1) (b)]

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 home's Least Restraint policy is followed by all staff, to be implemented voluntarily.

Issued on this 22nd day of September, 2015

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

Original report signed by the inspector.