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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 24, 2016	2016_226192_0026	020501-16	Critical Incident System

Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES
200 Boullee St. New Hamburg ON N3A 2K4

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

NITHVIEW HOME
200 Boullee Street New Hamburg ON N3A 2K4

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

DEBORA SAVILLE (192)

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): August 23, 2016.

This Critical Incident Inspection was completed in relation to Critical Incident C547-000005-16 related to Skin and Wound Care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Assistant Director of Care and a Registered Practical Nurse.

The inspector reviewed medical records, transfer records, and policy and procedure.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the skin and wound program required under section 48 of the regulation, there was a written description of the program that included protocols for referral of resident to specialized resources where required.

Review of the homes Skin and Wound Care Program dated as reviewed November 15, 2015, with the lead for the program, failed to identify protocols for the referral of residents to specialized resources. The program indicated that a referral to an Enterostomal Therapist or Wound Care Specialist would be initiated for residents with stage III, IV and unstageable ulcers.

During interview Assistant Director of Care #101 stated that the program did not provide direction to staff on when to make a referral, who to make the referral to or how the referral would be completed.

On a specified date in 2015, resident #001 sustained an injury, followed by an incident during transportation back to their bedroom. The resident was hospitalized and returned to the home with a medical device in place that resulted in the resident being dependent on staff for all mobility. Resident #001 developed altered skin integrity. Daily dressings were initiated. On a specified date in 2016, the physician started resident #001 on antibiotics in relation to an infection related to the area of altered skin integrity. Twelve weeks after the area of altered skin integrity was first assessed the area was noted to be larger in both length and width from the original measurements.

When questioned in regard to referral of the resident to a Wound Care Specialist, ADOC #001 indicated that no Wound Care Specialist was accessible at that time. The home used Cardinal Services for referral services and there was no Wound Care Specialist available. ADOC #001 stated that the Community Care Access Centre or other resources had not been approached to determine if Wound Care Specialists had been available from other sources.

Resident #001 continued with care of the area of altered skin integrity by staff in the home. Review of those assessments identified that the wound was not routinely assessed and wound measurements were not recorded consistently. At the time of a dressing change on a specified date it was documented that there were signs and symptoms of infection at the area of altered skin integrity. It was not recorded that interventions were initiated with this change.

On a specified date in 2016, an assessment was completed by a Wound Care Specialist. Specified suggestions for treatment of the resident were made. The assessment completed by the Wound Care Specialist demonstrated that the overall size of the area of altered skin integrity had increased, infection was present and further assessment of the resident was required.

The licensee failed to ensure that for the skin and wound program required under section 48 of the regulation, there was a written description of the program that included protocols for referral of residents to specialized resources where required. [s. 30. (1) 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 ensuring that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 was identified on a specified date in 2016 to have an identified area of altered skin integrity.

Review of the progress notes with Assistant Director of Care #101 confirmed that there was no weekly wound assessment of resident #001's area of altered skin integrity on specified dates in 2016.

Review of the home's policy on Skin and Wound, with ADOC #101 stated that registered staff were to complete the Wound Assessment Record weekly including the size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition, equipment being used, etc. Progress notes that indicated a dressing change had been completed but failed to identify the required items such as size, discharge from the wound, and appearance were not considered as assessments.

During interview ADOC #101 said that it would be the expectation that registered staff completed weekly wound assessments on the Skin/Wound Assessments, weekly and PRN (as necessary) progress notes on Point Click Care.

Review of the medical record identified that resident #001 sustained additional areas of altered skin integrity for which no weekly assessments were recorded.

The licensee failed to ensure that resident #001 who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds had been assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: 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 ensure that 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, is complied with.

The home's policy titled Skin and Wound Program dated as reviewed November 2015 stated;

A) Registered Staff were to make a referral to Enterostomal Therapist (ET) nurse or Wound Care Specialist if available (for Stage 3, 4 and unstageable ulcers only).

A specified resident was noted to have a stage III pressure area in 2016. No referral to an ET or Wound Care Specialist was made for the resident for a three month period in

spite of worsening of the area of altered skin integrity.

The Assistant Director of Care (ADOC) #101, responsible for the Skin and Wound Program stated that no Skin and Wound Specialist was available through the home's contracted service provider and confirmed that no attempt to reach out to a Skin and Wound Specialist from an alternative source was made.

B) Registered Staff were to participate in monthly high risk rounds and take photographs of the wound as necessary.

ADOC #101 stated that high risk rounds were not being completed in the home and that the home did not take photographs of wounds but was giving it consideration.

C) Registered Staff, after a dressing change were to complete the Pressure Ulcer/Wound Assessment Record (weekly) including size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition, equipment being used, etc.

Review of the medical record identified that resident #001 received an assessment of altered skin integrity on a specified date in 2016 that ADOC #101 confirmed failed to include the depth of the area of altered skin integrity. Dressing changes were to be done daily, however no assessment was documented for specified weeks in 2016 and specified notes failed to include measurements of the area of altered skin integrity.

ADOC #101 stated that weekly assessments were not documented as having been completed for resident #001 and that assessments completed did not contain all the information required in the policy and requested in the Wound Assessment progress note.

The licensee failed to ensure that registered staff in the home complied with the Skin and Wound Program when resident #001 who had a stage III pressure area was not referred to a Wound Care Specialist, failed to participate in high risk rounds and take photographs of the wound and failed to complete weekly wound assessments that included the size (circumference and depth) of the wound, discharge from the wound, appearance and progression of the wound. [s. 8. (1) (b)]

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Issued on this 20th day of September, 2016

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

Original report signed by the inspector.