Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 23, 2019	2019_777731_0024	015160-19	Complaint

Licensee/Titulaire de permis

Meritas Care Corporation
567 Victoria Avenue WINDSOR ON N9A 4N1

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

Regency Park Long Term Care Home
567 Victoria Avenue WINDSOR ON N9A 4N1

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

KRISTEN MURRAY (731)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Aug 7, 8, 9, 12, and 13, 2019

The following Complaint intake was completed within this inspection:

Complaint IL-68954-LO/ Log #015160-19 related to restraints, monitoring and resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurses (RPNs), and Health Care Aides (HCAs)/Personal Support Workers (PSWs).

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Personal Support Services

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	Légende 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 has failed to ensure that the written policy to minimize the restraining of residents was complied with.

The Ministry of Long Term Care (MOLTC) received complaint IL-68954-LO/ Log #015160 -19 related to the consent and use of assistive devices for resident #001, the monitoring of the resident, and care provided to resident #001.

According to the progress notes and the orders for resident #001, on a specified date the Physician was phoned, an order was placed for a specific assistive device to be used at identified times for safety and the device was applied the same day. On a specific day in the following month, the Physician placed an order for a second assistive device to be used for safety and it was first applied to resident #001 a couple days after it was ordered. The order for the original assistive device was then discontinued.

A) A review of the home's policy "RESTRAINT PROGRAM (MINIMIZING)" last reviewed May 2018 stated in part that "A physical restraint restricts or controls movement. It may be attached to a person or create a physical barrier". The policy stated in part "Discuss with the resident/Substitute Decision-Maker (SDM) goals such as elimination of the restraint, reduction of the severity, duration and/or frequency of use, period of day when the restraint is required, frequency that the resident will be checked, frequency of evaluation of the side effects of restraints on resident behaviour, deadline for re-evaluation of the need for the restraint". The policy also stated staff were to "Obtain and record informed consent including risks and benefits of alternative treatment options and risks and benefits related to use of the restraint have been outlined to the resident/SDM. See forms for restraint assessment and consent" and "Complete assessment and file on resident's chart under consent section".

A review of two assessment and consent forms for resident #001 on specific dates in PointClickCare (PCC) indicated a section at the bottom of each assessment form that the SDM was to have signed for consent of the use of both ordered assistive devices. A review of resident #001's paper chart indicated that both of the forms had not been printed or signed by the SDM, as there were no assessment and consent forms filed in resident #001's paper chart.

A progress note indicated that a telephone order was received by the Physician to apply the second assistive device as needed for resident #001's and a message was left to the

SDM. According to the progress notes, the assistive device was first applied for resident #001 on a specified date after it was ordered. There was no documented consent by the SDM for the use of the device.

In separate interviews with Registered Practical Nurse (RPN) #103 and RPN #104, when asked what the process was for obtaining and documenting informed consent for the use of assistive devices, they each indicated that consent would be documented in progress notes and in the bottom section of the assessment tool for the devices, which was printed and signed for the resident's paper chart. When asked if leaving a voice message for the SDM would be considered consent for the use of an assistive device, RPN #104 stated it would not.

In an interview with the Director of Care (DOC) #101, when asked if there was a form that the home uses to document the SDM consent for the use of assistive devices, DOC #101 stated the form should have been in the resident's chart. When asked if they could locate the consent forms for both of the devices, DOC #101 was unable to locate the consent forms, and stated the expectation in the home would be that the consent forms were signed as per the home's policy.

B) The home's policy "RESTRAINT PROGRAM (MINIMIZING)" last reviewed May 2018 stated in part that a "Restraint Assessment must be completed prior to applying a restraint that is being considered as an intervention". The policy stated under assessment and evaluation, staff were to "Include any and all alternatives that were tried/considered and why they were not suitable, Restraint Assessment/Consent". The policy stated in part that "Nursing RN/RPN conducts and documents restraint assessments".

In a review of resident #001's clinical records, under the assessment tab in PCC, the only assistive device assessment that was completed for the use of the second device was documented on a specified date, nearly one month after that device was ordered and applied to resident #001. No assistive device assessment was noted to be completed for resident #001 prior to applying the second assistive device.

In separate interviews with RPN #103 and RPN #104, when asked what the process was for completing and documenting assistive device assessments, they each indicated that the assessments were completed in PCC, under the assessment tab, with the interdisciplinary team prior to the implementation of the device, they were printed and placed in the resident's paper chart.

In an interview with DOC #101, when asked if an assistive device assessment was completed for resident #001 prior to applying the second device, DOC #101 stated it was not and should have been completed.

C) The home's policy "RESTRAINT PROGRAM (MINIMIZING)" last reviewed May 2018 stated in part, that after the assessment was completed, staff were to "complete documentation requirements for progress notes and adjust applicable care plans". The policy stated "Nursing RN/RPN initiates, communicates, and reviews the plan of care with the interdisciplinary team to address each individual interventions and ensuring we are using the LEAST restraint possible, and evaluates the plan of care and updates as necessary".

In a review of resident #001's care plan, the assistive device intervention was initiated on a specific date, approximately two weeks after the device was ordered by the Physician and first applied to resident #001.

In separate interviews with RPN #103 and RPN #104, when asked where they would find information regarding assistive devices for a resident, they stated that the information would be in PCC and in the care plan of the resident. When asked the process for implementing an assistive device for a resident, both staff stated that the registered staff will enter the intervention into the care plan.

In an interview with DOC #101, when asked if the intervention for the use of the second assistive device for resident #001 was added to the care plan prior to applying the device, DOC #101 stated it was not.

D) The home's policy "RESTRAINT PROGRAM (MINIMIZING)" last reviewed May 2018 stated in part that "Registered staff are to document on the electronic Medication Administration Record (eMAR), Q shift for the restraint order while the restraint is required, even when not in use as an assessment of the need or continuation of the intervention is still required". The policy stated "Nursing RN/RPN initiates restraint documentation in eMAR and POC for registered staff and PSW's when restraint is in place".

In a clinical record review of the eMAR and eTAR for resident #001, registered staff had documented for each assistive device order on the evening shifts of a number of specified dates, with the remainder of the documentation in the eMAR for the device

orders not completed.

In an interview with RPN #103, when asked how often a resident with an assistive device is assessed, RPN #103 stated although the major assessment is completed quarterly, registered staff assess the resident every shift and document in the eMAR.

In an interview with DOC #101, when asked if staff were to document in the eMAR every shift, even when the assistive device is not in use, DOC #101 stated yes, according to the home's policy staff were to document in the eMAR every shift for the device. When asked if documentation was completed in the eMAR for both devices ordered for resident #001, DOC #101 stated they were missed being recorded on a number of days.

E) The home's policy "RESTRAINT PROGRAM (MINIMIZING)" last reviewed May 2018 stated in part that "The registered staff are required to add the restraint task to each resident that utilizes a Restraint, in doing this step it will populate for [the] month to come, and the tasks will then populate into Point of Care which will allow the HCA/PSW to begin their documentation on the Restraint". The policy stated in part that "Registered staff shall delegate the responsibility for assessing/checking the resident every hour for safety, comfort and to evaluate resident's response whenever the restraint is in use, and this document will remain in Point of Care at all times until completed".

In a clinical record review of the task records and follow up questions for resident #001 for three consecutive months, it was noted that there was no documentation in the records regarding the monitoring of resident #001 related to the use of both assistive device between specific dates during this time.

In separate interviews with Health Care Aide (HCA) #102, RPN #103 and RPN #104, when asked how often residents with assistive devices are monitored, they stated that the resident is monitored hourly, usually by the HCA or Personal Support Worker (PSW), and the monitoring is documented in the tasks.

In an interview with DOC #101, when asked how often staff were to monitor resident #001 when the assistive devices were in use, DOC #101 stated staff were to check the resident every hour and reposition every two hours. The DOC #101 stated that documentation for the monitoring every hour was to be completed in Point of Care (POC) tasks. When asked if documentation was completed in the POC for both assistive devices for resident #001, DOC #101 stated there was not the appropriate documentation in POC for monitoring of the resident.

The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with. [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 written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

Issued on this 28th day of August, 2019

[redacted]

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

Original report signed by the inspector.