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
Apr 15, 2015	2015_362138_0011	O-001877-15, O-001889-15	Critical Incident System

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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): April 13 and 14, 2015.

This inspection was completed concurrently with Complaint Inspection O-001467-15

During the course of the inspection, the inspector(s) spoke with a Resident, several Personal Support Workers (PSWs), several Registered Practical Nurses (RPNs), the Vice President Resident Care, the Vice President Resident Care, and the Assistant to the Human Resources Manager.
The inspector also reviewed several health care records, observed a demonstration of the use of a mechanical lift, reviewed internal investigation documents, reviewed a disciplinary documentation from an employee file, and reviewed documentation for employee training. Three Critical Incident Reports were reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
2 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1. On a day in March 2015, Resident #001's family reported concerns with Resident #001 indicating that the resident had reported that s/he was banged during a transfer

with a staff member the previous evening. The resident was monitored by the home and ten days later the resident received a diagnosis of a fracture.

The inspector spoke with Resident #001 who reported to the inspector that s/he was bumped when s/he lost his/her balance transferring with a staff member. The resident was not able to communicate any other details about the incident. Resident #001's plan of care, as defined by the home, was reviewed and it was noted by the inspector that the plan of care indicates that the resident was a two person transfer at the time of the incident.

The inspector spoke with the Vice President Clinical Services and the Vice President of Resident Services regarding the home's internal investigation into the incident. The Vice President of Clinical Services conducted the investigation and stated that it was discovered that a PSW, Staff #101, was transferring Resident #001 as a single person transfer. The inspector reviewed the internal investigation documents which demonstrate that Staff #101 was transferring Resident #001 as a single person transfer while the plan of care directed staff to transfer Resident #001 using a two person transfer.

The inspector partially reviewed Staff #101's employee record which included a letter of discipline for improperly transferring a resident.
(O-001955-15)

2. On a day in March 2015, Resident #003 was struck by the bar of the mechanical lift as a PSW, Staff #103 was setting up the lift to transfer the resident from the bed to the wheelchair. Staff #103 demonstrated to the inspector how that the bar of the Tempo lift was lowered and pushed against the resident as it was lowered. It was noted from a review of the resident's health record that the Resident #003 has a contributing diagnosis.

The resident was assessed by the RPN and no injury was noted. Resident #003 was later sent to the hospital related to pain from the injury and was diagnosed with a fracture.
(O-001889-15) [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that retraining on safe and correct use of equipment including mechanical lifts is conducted annually.

In accordance with this section, section 218. 2. of the regulation, and sections 76(2) and 76(4) of the Act, the licensee is required to provide annual retraining on safe and correct use of equipment including mechanical lifts.

The inspector spoke with several PSWs and two RPNs regarding annual training relating to mechanical lifts and staff could not recall any recent training, all citing that training had occurred in December 2013 when the home moved into a new building.

The inspector reviewed the training package for Staff #101 and noted that there was no indication that training for mechanical lifts had been completed in 2014. The inspector spoke with the VP of Clinical Services and the VP of Resident Services and both stated that the training for mechanical lifts was missed for 2014. [s. 219. (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 nursing staff receive annual training on mechanical lifts, to be implemented voluntarily.

Issued on this 15th day of April, 2015

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

Original report signed by the inspector.