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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Dec 29, 2016	2016_593573_0001	022921-16, 023961-16, 026593-16	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

ANANDRAJ NATARAJAN (573)

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): December 20, 21 and 22, 2016.

The purpose of this inspection was related to Log# 022921-16 and 026593-16 regarding resident to resident alleged abuse and Log# 023961-16 related to staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with identified Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Geriatric Psychiatry outreach Nurse/ Physician, the Assistant Vice President of Nursing, the Vice President of Nursing and the President and Chief Executive Officer (CEO).

The inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, assessments, progress notes, medication administration records, PSW flow sheets, BSO work sheets and Geriatric Psychiatry Outreach reports/progress notes) and documents associated with the licensee's investigation into the critical incident.

In addition the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003's written plan of care set out clear direction to staff and others who provide direct care to the resident, specifically in relation to resident #003's mood and behaviours.

A critical incident report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an incident of staff to resident alleged abuse that occurred on a specified date. The CIR indicated that resident #003 reported to RPN in the unit that a PSW staff was rough with the care while she was providing care to the resident.

A review of resident #003's health care records indicated that resident has a history of mood and behaviour problems. An recent assessment conducted by Geriatric Psychiatry Outreach on a specified date in 2016 indicated that "resident is vulnerable to increased anxiety and a sense of loss of control with changes in her/his routine and different care givers".

On December 22, 2016, during an interview with PSW #101, who indicated to Inspector #573 that resident #003 will trust certain PSW staff in the unit and will only receive care from PSWs familiar to the resident. Furthermore, PSW #101 indicated to inspector that even though resident #003 was not assigned to her that morning, she provided the care to the resident since resident would refuse care with the new or other PSW staff in the unit.

On December 22, 2016, Inspector #573 spoke with RPN #102 who indicated that resident #003 becomes more anxious and will refuse daily care with the new or other PSW staff and registered staff in the unit, who are not familiar to resident #003.

On December 22, 2016, Inspector #573 reviewed resident #005's current written plan of

care, which identified resident #003's mood disorders, but there was no information and interventions specifically related to resident's mood and behaviours towards new or unfamiliar staff. Furthermore, there was no information regarding the resident #003's refusals to the daily care with the new or other PSW staff with whom resident #003 is not familiar in the unit.

On December 22, 2016, Inspector #573 discussed the current written plan of care for resident #003, with the Vice President of Nursing. The VP of Nursing indicated to Inspector #573 that resident #003's written plan of care for mood and behaviours does not identify nor provide clear direction for staff specifically related to resident #003's mood and behaviours towards different care givers and increased anxiety related to any changes in the resident daily routine. (Log# 023961 -16) [s. 6. (1) (c)]

Issued on this 29th day of December, 2016

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

Original report signed by the inspector.