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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2017	2017_617148_0032	013226-17	Complaint

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

AMANDA NIXON (148)

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): November 10, 14, 15, 16 and 17, 2017

This inspection included a complaint log related to the responsive behaviours of an identified resident and related resident safety concerns.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, VP of Nursing, Assistant VP of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Service Worker, family members and residents.

The Inspector reviewed the health care records of identified residents including assessments, plans of care and mental outreach consults. In addition, the Inspector observed the care and services provided to identified residents and the resident care environment.

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

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident that includes any potential behavioural triggers and variations in resident functioning at different times of day.

The health care record and staff interviews demonstrate that resident #001 has responsive behaviours including aggressive behaviours.

The regular day RPN #100, reported that the resident can be seen to become angry, move in an agitated manner and then become verbally aggressive with other residents. RPN #100 noted the resident #001 is often triggered by noise, including the noise of other resident's calling out or yelling. Regular day shift PSW #103 also reported, that when other resident's yell out resident #001 becomes angry sometimes becoming physically aggressive. FSW #105, who regularly works the breakfast and lunch meal service on the unit, indicated that the noise level in the dining room can trigger resident #001 to become angry. FSW #105 identified two residents who will yell out and that this can cause resident #001 to become verbally aggressive. Regular evening shift PSW #106 noted that the resident will become angry and verbally aggressive yelling at other co-residents when there is noise; specifically when co-resident's are yelling out. PSW #106 reported that the resident may bang his/her hands against the table or wall in anger or frustration related to the noise level.

The plan of care for resident #001 describes aggressive incidents including verbal and physical confrontations with co-residents. Staff are to monitor closely, intervene as necessary and remove or distract the resident from the situation. The plan of care does not include noise and/or co-resident's calling out as a trigger for resident #001's aggressive behaviours. [s. 26. (3) 5.]

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 any potential behavioural triggers are included in the plan of care for resident #001, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's responses and the effectiveness of the drugs appropriate to the risk level of the drug.

The health care record and staff interviews demonstrate that resident #001 has responsive behaviours including aggression. As part of the resident's interventions to manage responsive behaviours, resident #001 is ordered two antipsychotic PRN (as needed) medications.

Inspector #148 reviewed the Medication Administration Records (MAR) as available through eMeds, for three months in 2017. It was noted that one of the antipsychotic medications, was administered seven times and the other antipsychotic medication was administered once. In review of the health care record including progress notes and eMed notes, effectiveness for the use of either antipsychotic was not documented on four of the nine administrations.

As such the resident's responses and the effectiveness of administration of a PRN medication was not documented. [s. 134. (a)]

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 drugs, including the use of PRN medications, are monitored and that the resident's responses and effectiveness of the drugs are documented, to be implemented voluntarily.

Issued on this 22nd day of December, 2017

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

Original report signed by the inspector.