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
Oct 16, 2019	2019_617148_0028	000809-19, 013032-19, 013543-19, 014643-19, 016273-19	Critical Incident System

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive 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 Critical Incident System inspection.

This inspection was conducted on the following date(s): September 24-26 and October 1-2, 2019

This inspection included five critical incident reports (CIR): Log 016273-19 (CIR #C569-000036-19); Log 014643-19 (CIR #C569-000032-19); Log 013543-19 (CIR #C569-000024-19); and Log 013032-19 (CIR #C569-000022-19, related to falls; and Log 000809-19 (CIR #C569-000001-19) related to a respiratory outbreak.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer, Vice President of Nursing, Assistant Vice President (AVP) of Nursing, Restorative Service Worker, Registered Nurses, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector also reviewed identified resident health care records, relevant falls prevention and infection control policies and documents related to a respiratory outbreak in 2019. In addition, the Inspector observed resident care and services and the resident care environment.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

A described by a critical incident report submitted to the Director, resident #001 was found by RPN #103, after having fall from bed; the resident sustained injuries. In an interview with RPN #103, the RPN indicated that no bed alarm was sounding upon the discovery of the resident. The RPN could not account for the placement or function of the bed alarm at the time of the fall.

The plan of care for resident #001 indicated the resident was at high risk of falls, in part due to the resident's attempts to self transfer. The resident was to have a bed alarm in place.

On September 24, 2019, at approximately 1415 hours, Inspector #148 observed resident #001 in bed sleeping without the bed alarm in place. Upon discussion with PSW #107, it was reported that the bed alarm was not applied when the resident was assisted to bed.

In this way, the licensee failed to ensure that the bed alarm for resident #001 was provide as specified by the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003, as specified in the plan.

As described by a critical incident report submitted to the Director, resident #003 had a fall whereby the resident was sent out to hospital for assessment and diagnosed with an injury. The day after the fall, the physician ordered a referral to rehabilitation (restorative care) for a supportive device. Nine days after the fall, the physician ordered a referral to physiotherapy for pain. Fourteen days after the fall, the physician requested implementation of a supportive device. On the same day, imaging was completed that confirmed the injury status.

In an interview with RPN #104, it was reported that the resident's pain was not controlled during the weeks following the fall. WN #2 describes the resident's continued pain and need for pharmaceutical intervention during that time.

In an interview with nursing staff, including the regular day RPN #104 and primary care giver PSW #106, it was indicated that the supportive device was not implemented until after the imaging was completed fourteen days after the fall. After review of the health care record and discussion with Restorative Service Worker #110 it was determined that

although the restorative referral was completed there was no assessment conducted by restorative until twenty days post fall. Although there was record of the physiotherapy referral, there had been no assessment conducted by physiotherapy at the time of this inspection.

In this way, care was not provided to resident #003 as specified by physician direction, including the application of sling and restorative and physiotherapy assessments.

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when resident #003's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
As described by a critical incident report submitted to the Director, resident #003 had a fall whereby the resident was sent out to hospital for assessment and diagnosed with an injury. The day after the fall, the resident complained of pain and the physician ordered a referral to rehabilitation (restorative care) for a supportive device, increased regular pain medication and ordered a new pain medication to be administered as needed (PRN). Nine days after the fall, the resident continued to complain of pain and the physician ordered imaging, increased dose of the PRN pain medication and a referral to physiotherapy for pain. Fourteen days after the fall, the physician requested implementation of a supportive device and to continue with medications as ordered. On the same day, imaging was completed that confirmed the injury status. A progress note, sixteen days after the fall, indicated that nursing communicated the results of imaging to the physician whereby direction was provided use the supportive device. Twenty-one days after the fall, due to continued pain, the physician ordered additional regular pain medication. Twenty-eight days after the fall, a physician note indicated that the resident's pain was better controlled.

In review of the electronic medication record the resident was provided PRN pain medication on nine occasions whereby the medication was noted to be ineffective. In an interview with RPN #104, it was reported that the resident's pain was not controlled during the weeks following the fall.

In discussion with RPN #104, AVP of Nursing and after review of the health care record, no pain assessment was completed when initial interventions for pain relief were ineffective, using a clinically appropriate assessment instrument specifically designed for this purpose.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

A critical incident report (CIR) was submitted to the Director on January 10, 2019, describing an acute respiratory outbreak. The CIR indicated that the Ottawa Public Health unit was contacted January 8, 2019 and that the outbreak was declared on January 10, 2019.

The Inspector reviewed the Ottawa Public Health Outbreak Report which described the outbreak as reported and declared on January 8, 2019. The line listings were reviewed and it was noted that there were two cases of suspected respiratory illness on January 8, 2019, on an identified unit. On January 9, 2019, a third suspected case on the same unit was identified. As per the home's policy two cases of respiratory illness is a suspected respiratory outbreak; three cases occurring within 48 hours is a confirmed respiratory outbreak.

In an interview with the AVP of Nursing, it was understood by their discussions with Ottawa Public Health that on January 8, 2019, the outbreak was suspected; therefore there was no need to report to the Director. The AVP of Nursing reported that on January 10, 2019, it was understood by their discussions with Ottawa Public Health that on January 10, 2019, the outbreak was confirmed and therefore declared. The AVP of Nursing proceeded to initiate the report to the Director.

The licensee failed to immediately inform the Director of an outbreak.

Issued on this 17th day of October, 2019

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

Original report signed by the inspector.