Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: June 26, 2024	
Inspection Number: 2024-1417-0002	
Inspection Type: Critical Incident	
Licensee: Royal Ottawa Health Care Group	
Long Term Care Home and City: Royal Ottawa Place, Ottawa	
Lead Inspector Gurpreet Gill (705004)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22, 24, 2024

The following intake(s) were inspected:

- Intake: #00112126 [CI:2933-000001-24] related to a fall incident that caused injury to a resident

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard issued by the Director was followed by staff related to hand hygiene as required by Routine Practices after removing gloves.

Rationale and Summary

On a day in May 2024, upon entering a specified home area, Inspector observed a Personal Care Assistance (PCA) walking with gloves on. The PCA asked another PCA for help to assist a resident who was in their wheelchair in a specified home area's hallway. Both assisted the resident with sit and stand restorative activity. After completing the restorative activity, the second PCA did not take off their gloves and took the resident in their wheelchair to the lounge area.

After completing the restorative activity with the resident, the first PCA wrote on a piece of paper with gloved hands. They then took off the gloves, proceeded to another resident's room, talked with the resident, and grabbed a new pair of gloves

from the box mounted on the wall. The PCA did not perform hand hygiene after taking off their gloves and before putting on a new pair of gloves.

The PCA then proceeded to the resident's room, brought resident in their wheelchair in the hallways, positioned the resident's wheelchair facing the wall, adjusted their footrest, and assisted them with the restorative activity.
After completing the restorative activity with the resident, the PCA took the resident in their wheelchair to the lounge area with gloved hands. Upon returning, they were still wearing gloves, wrote on a piece of paper, and then took off their gloves. Once again, the PCA did not perform hand hygiene after taking off their gloves and between residents.

The PCA then went into the third resident's room, talked with the resident, grabbed gloves from the box, held them in their hands, and walked down the hall, As they were proceeding into the resident's room, Inspector stopped them and conducted an interview.

The PCA indicated that they forgot to sanitize their hands after removing the gloves. They are supposed sanitize their hands before putting on gloves and after removing gloves.

As such, a lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Observation and interview with the identified staff member. [705004]