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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 17, 2016	2016_286547_0024	023948-16	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

LISA KLUKE (547)

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): September 13,14,19, 20 and 21, 2016

The purpose of this inspection was related to a complaint log #023948-16 related to concerns regarding the resident's urinary catheter care and cleaning procedures as well as, following resident's needs and preferences for personal care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Managers of Resident Care, a RAI Coordinator, one of the home's staff Educators, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family Members.

In addition, Inspector #547 observed aspects of resident care, staff to resident interactions, reviewed resident health care records, reviewed documents related to the home's investigation to this complaint and reviewed the home's policy and procedure related to catheter care and the reporting and complaints procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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).

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 :

1. The licensee has failed to ensure that the plan of care set out clear directions to nursing staff that provided direct care to resident #001 related to personal care and bathing.

Resident #001 was admitted to the home with several medical diagnoses. Inspector #547 reviewed the resident's health care records whereby it was noted that the home's Social Worker documented on the resident's chart on the date of admission that the home is to avoid having a male nursing staff provide personal care to resident #001. The Social Worker further documented that this information is to be shared with staff providing the resident personal care in order to be sensitive to the resident's needs.

Inspector #547 reviewed the resident's progress notes and RN #103 documented in the admission note that the family had indicated resident #001 had anxiety related to personal care and that they specifically requested no male nursing staff were to provide the resident personal care or bathing.

On September 13, 2016 PSW #102 indicated to Inspector #547 during an interview that PSWs refer to the kardex/bubble sheets and care plans on the unit as staff directions to the resident's plan of care. PSW #104 indicated to Inspector #547 during an interview that he was not made aware that resident #001 was not to have any male nursing staff for personal care and bathing and proceeded to give resident #001 a shower on a specified date, three months after the resident was admitted.

RN #103 indicated to Inspector #547 during an interview on September 13, 2016 that

she was made aware from the first day of admission that resident #001 should not have any male nursing staff members for personal care. She indicated that PSW #104 was assigned to provide personal care to resident #001 which included giving the resident a shower on this specified date. RN #103 recalled being called into the shower room and then realized that this male nursing staff member should not have been assigned resident #001's shower as per resident #001's needs and preferences. RN #103 indicated that she had forgotten to add this to the residents’ plan of care and indicated that PSW #104 did not have clear direction for the resident's personal care needs and preferences identified to the home at admission. The resident called his/her family after being showered on this specified date and was very upset about receiving personal care by a male nursing staff member. The resident's family reported this to the Manager of Resident Care #107.

Inspector #547 reviewed the home's complaint investigation package that included a paper copy of resident #001's bubble sheet/ kardex and care plan utilized on the unit on this specified date, and noted the resident's plan of care did not have any indication that no male nursing staff are to provide personal care and bathing.

The Manager of Resident Care #107 indicated during an interview with Inspector #547 that the home did not provide clear direction to PSW #104 in the plan of care regarding resident #001's needs and preferences for personal care and bathing at the time of this incident. [s. 6. (1) (c)]

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

Resident #001's health care records indicated the resident had several medical diagnoses such as a specified urinary condition and required an indwelling urinary catheter. Resident was known to have urinary tract infections and the resident's plan of care indicated the following regarding urinary catheter care:

a) Store catheter bags in blue basin, on the shelf above the toilet
b) Please stop using extension tubing for the leg bag. The catheter itself should connect directly to the leg bag.
c) Empty the leg bag frequently and more often as resident #001 requests.
d) Please ensure that the tips for the leg bag and night bag are used to cover the connectors of the bags that are not in use.
e) Catheter care and cleaning should not be done on the resident's sink counter, but use

the basin provided for storage. The nun's cap for emptying and the operation to be done on clean towels on the floor or outside the room for infection control purposes.

The Manager of Resident Care #107 provided the home's investigation into a complaint from resident #001's family regarding urinary catheter care for Inspector #547 to review on a specified date in September 2016. This investigation package included pictures of evidence the family took to validate concerns related to nursing staff not following the planned care for the resident's urinary catheter care such as:

-A picture identified the unsanitary storage of the resident's catheter bag and tubing on the resident's bathroom counter and inside the resident's sink
-A picture identified resident #001 was applied a catheter leg bag and connector tubing that were too long for the resident and kinked including her catheter bag was full of urine
-A picture identified that the catheter tubing tip was not covered and laying inside the resident's sink

The Manager of Resident Care #107 indicated to Inspector #547 that Personal Support workers (PSW) did not follow the resident's plan of care regarding catheter care and cleaning until it was brought to the home's attention by the resident's family and re-education was provided to PSW staff. [s. 6. (7)]

Issued on this 17th day of October, 2016

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

Original report signed by the inspector.