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
Aug 1, 2017	2017_617148_0023	000440-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

AMANDA NIXON (148), SUSAN LUI (178)

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): July 13, 14, 17, 18, 19, 24, 25, 26, 2017

This inspection included one complaint related to several issues including weight loss, continence and bowel care, medication administration and care related to sleep preferences.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Managers of Resident Care, Registered Dietitian, Food Services Supervisor, Registered Nursing Staff and Personal Support Workers (PSW).

In addition, the Inspectors reviewed the identified resident's health care record including plans of care, medication administration records, shift reports and relevant policies and protocols and observed the care environment including a medication pass.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

In accordance with O.Regulation 79/10, s.48 and s.51, the licensee is required to have a continence care and bowel management program which at a minimum, shall provide for treatments and interventions to prevent constipation, including nutritional and hydration protocols and toileting programs, including protocols for bowel management.

The licensee has the following Bowel Management Program, policy #355.13, in place in the home May 2015. The program describes the bowel protocol which includes:
-Review of the daily flow sheets and record any outstanding needs for interventions in the daily planner (communication book)
-On Day 1 and 2 of no bowel movements use nursing management/natural laxatives or already prescribed PRNs
-On Day 3 give 30cc Milk of Magnesia
-On Day 4 glycerine suppository, to be given early morning, night shift to check on effect
-On Day 5 do a rectal exam and assess for bowel sounds, if stool present, give fleet enema. If no result or no bowel sounds present, refer to physician
-Document on the daily planner all residents who are placed on a bowel management protocol and results of interventions.
-Document in progress notes all interventions and effectiveness of intervention
-PSW to document all bowel movements on flow sheets and into the bowel calculation form

Inspector #148 spoke with registered nursing staff and personal support workers who indicated that all known bowel movements are recorded on the flow sheet and bowel calculation form. The flow sheets and/or bowel calculation form are reviewed by registered nursing staff at the start of shift along with a review of the daily planner/communication book to ascertain residents that may require follow up or intervention related to bowel movements. In addition, to physician order PRNs, registered staff follow the medical directive/bowel protocol which directs staff to implement pharmaceutical intervention on day 3 of no bowel movement. Registered staff will document interventions and effectiveness in the communication book and progress notes.

The bowel management program was reviewed for resident #001 for three months.

The flow sheets, used by PSW staff to record bowel movements, for an identified month, indicated four instances where there were no bowel movements recorded for three or more days. The Inspector reviewed the resident's health care record including flow sheets, medication administrator records (MARs), physician notes, physician orders and progress notes (it was noted that the communication book for this month was no longer available in the home). For the month reviewed, the resident was provided with daily fruit spread as part of his/her constipation management; the resident also had a PRN laxative (PRN not administered in this month). There was no documentation to support that the resident was assessed or bowel management interventions implemented for the four instances noted above during this identified month.

The flow sheets, used by PSW staff to record bowel movements, for an identified month, were reviewed by the Inspector. No bowel movement was recorded for a period of six days. There was no documentation to support that the bowel protocol was implemented on day 3. The earliest intervention was noted in the progress note and communication book on day 6. The resident has a recorded bowel movement on the following day. In a second instance, there was no bowel movement recorded for three days. On the third day, the communication book denotes this as day 5 with no bowel movement and for staff to follow up. On the fourth day, the communication book denotes it as day 3-4 without bowel movement and that a medication was administered with small bowel movement; a progress note on the same day indicates a medication was administered. Ongoing on the fifth, sixth, seventh and eighth day, there was no bowel movement recorded. On the eighth day, the communication book indicates a medication administered, effectiveness was not noted. On the ninth day, a progress note indicates day 9 with no bowel movement and medication administered with effect (also documented on the MARs). In a third instance, the flow sheets indicated no bowel movement for four days; the health care record does not support that any intervention was administered. During the identified month the resident was provided daily fruit spread and had an order for a PRN laxative (PRN not administered in this month);.

The flow sheets, used by PSW staff to record bowel movements, for an identified month, were reviewed by the Inspector. There was one instance whereby no bowel movement was recorded for five days. The Inspector reviewed the resident's health care record including flow sheets, medication administrator records (MARs), physician notes, physician orders, progress notes and the communication book. The following were the

notations found related to the above dates: on day 3, a notation in the communication book notes 4 days and on day 6, a notation in the communication book indicates large bowel movement.

In instances described above, the health care record does not support that the resident was provided with interventions as outlined by the bowel management protocol in addition to documentation practices not followed exampled by interventions and effectiveness not documented in progress notes. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident with a weight change of 5 per cent body weight, or more, over one month was assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated.

Resident #003 had multiple diagnosis and was high nutritional risk related to the need for total assistance at meals and later due to weight loss, changes in appetite and advancing dementia.

A progress note on a specified day, completed by the home's Registered Dietitian (RD), indicated that the resident's weight was stable and intake was good. Within this progress note the body weight referenced was that of the previous month.

The Inspector reviewed the weight record for resident #003 for nine consecutive months. It was noted that in this period, the resident's weight was stable for five months. The body weight of the sixth month, indicated a loss of 5% or more over one month, with continued weight loss in the seventh month.

The Inspector reviewed the resident's health care record and spoke with the home's RD, whereby it was demonstrated that the resident's weight had decreased by 5% or more over one month based on the recorded sixth month weight, in addition to further loss during the seventh month of 5% or more over one month. The weight loss was not assessed until the seventh month at which time nutritional interventions were implemented. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.