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_0020	006083-17, 006793-17	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)

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 6, 7, 10, 11,12, 13 and 25, 2017

This inspection included two complaints, one related to the care of a skin wound, a fall and communication with a substitute decision maker and the other related to the monitoring and assessment of a resident's change in health status.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, both Managers of Resident Care, Registered Nurses (RN) , Registered Practical Nurses and Personal Support Workers (PSW).

In addition, the Inspector reviewed the identified resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The SDM for resident #001, reported to Inspector #148 that he/she was not informed of a skin wound until a specified date, after the wound had existed for some time.

The Wound Assessment Tool, completed on three separate dates, for resident #001 indicated that a wound existed on a specified area of the body. On a specified date, resident #001 was assessed by the enterostomal therapy (ET) nurse related to the wound; treatment was recommended and implemented for the wound. RN #101 reported that at the time of the ET nurse's assessment, the resident was provided with therapeutic equipment, along with the prescribed wound treatment.

In review of the health care record, the resident's skin condition and need for interventions, were discussed with the SDM 10 days after the onset. There was no supporting documentation to indicate that the SDM had been given the opportunity to participate in the development and implementation of the skin and wound plan of care prior to this date. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required; and (iv), is reassess at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 required assistance with activities of daily living including repositioning, bed mobility, hygiene and continence care. The resident was at risk of skin breakdown and over time developed skin wounds.

The Inspector discussed the licensee's skin and wound care program with the home's Manager of Resident Care and registered nursing staff who implement the program. The program was described to include the monitoring of skin during the provision of care, the use of a Wound Assessment tool (WAT), communication/shift reports, progress notes and medication administration records (MAR). The Manager of Resident Care reported that skin is monitored daily with care, wound assessments are conducted at least weekly (more frequently as required), assessments are documented on the WAT or progress notes and treatments provided to residents are documented on the MARs. Personal

support workers reported to the Inspector that resident skin is monitored during care and any changes in skin are reported to the registered nursing staff. Registered nursing staff reported that when changes in skin are communicated to them, an assessment is completed and treatment is initiated as required. Skin changes are communicated shift to shift by use of the shift report, MARs and the WATs.

In review of resident #001's health care record, including wound assessment tools, progress notes, medication administration records (MAR) and communication/shift reports, it was found that on a specified date a WAT was initiated for a wound on a specified area of the body. The WAT was completed on four specified dates, which describe the progress and treatment of the wound. On a specified date the enterostomal therapy (ET) nurse assessed the wound and treatment for the wound was changed. Sixteen days after the ET assessment, on a specified date, a WAT was completed noting the worsening of the wound.

As it relates to the assessment of the wound, the licensee failed to ensure that weekly assessments were completed.

As it relates to the provision of treatment to the wound, the licensee failed to ensure that treatment to the wound was provided as ordered between specified dates. In addition, it could not be demonstrated within the health care record that daily monitoring of the wound, as outlined by the treatment regime was completed for a specified period of time.

In addition to the wound indicated above, the health care record of resident #001 supports the development of wounds on two other areas of the body. On a specified date, a progress note was written noting wounds on a second area of the body. A WAT was initiated for one of the wounds; treatment was indicated. On a subsequent date, a progress note describes the second area wound and notes interventions to relieve pressure and monitor. On a specified date, a progress note describes the second area and a third area of the body to have areas of redness and directs staff in interventions for pressure relief as needed. A notation within the communication/shift report three days later, indicates that interventions are in use to protect both the second and third area of the body. Four days later, a WAT was initiated for multiple areas including the second are of the body, noting the treatment was to relieve pressure and reposition. Five days later, a WAT was initiated for a worsening wound on the third area with treatment changes.

The MARs in place at the time of the wounds were reviewed. A treatment is noted for the

second area of the body. The MAR documentation does not support the application of this treatment at any time, it is noted as discontinued, however, the date discontinued is not recorded within the health care record. In addition, another treatment is noted for the second area of the body; the health care record does not support the application of this treatment.

The Inspector spoke with two RNs and two RPNs that were involved with the resident's care and participated in the assessments noted above. Staff could not recall the evolution or status of the wounds on the second and third areas of the body, conclusively.

As it relates to the wounds on the second area of the body, an assessment with a clinically appropriate tool, was not initially completed. The documentation maintained within the health care record does not support the monitoring, application and/or changes in treatment during the time frame noted, as it relates to these wounds.

As it relates to the wound on the third area of the body, an assessment with a clinically appropriate tool was not completed until 11 days after the wound was first noted. Further assessments or documented monitoring of the third area was not demonstrated between that time. [s. 50. (2) (b)]

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.