Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 10, 26, 2010	2011_132_2905_10Jan123311	Critical Incident T3268 -10

Licensee/Titulaire
Specialty Care – Bradford Inc.

Long-Term Care Home/Foyer de soins de longue durée
Bradford Valley, 2656, Line 6, Bradford, ON L3Z 3H5

Name of Inspector(s)/Nom de l'inspecteur(s)
Rosemary Lam (#132)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection regarding resident injury.

During the course of the inspection, the inspector spoke with: The Administrator, Director and Assistant Directors of care, Medical Director (also the attending physician), Nurse Practitioner.

During the course of the inspection, the inspector reviewed: The resident's health record, policies and procedures around "End of life care", Pain assessment and management program, nurse practitioner job description and medical directives on PRN orders were completed.

The following Inspection Protocols were used during this inspection:
Pain Inspection Protocol
Hospitalization and Death Inspection Protocol
Critical incident and Response Inspection Protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, c.8, s.24(1)1
A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Findings:
Critical incident of improper or incompetent treatment or care of a resident that resulted in harm, was not reported immediately using the after hour pager as required.

- Registered Practical Nurse (RPN) used inappropriate equipment and caused harm to an identified resident. The incident was not reported to the Ministry until the next day using the electronic Critical Incident Report.

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 with ensuring staff are aware of the reporting requirement to immediately report to the Director on incompetent Treatment and Improper care, as per Tim Burn's August 4, 2010 memo to Licensees of Long-Term Care Homes on "Clarification of Mandatory and Critical Incident Reporting Requirements". This plan of correction is to be implemented voluntarily.

WN #2 : The Licensee has failed to comply with O.Reg 78/10. s30(1).2
Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

Findings:
Registered Practical Nurse (RPN) **did not ensure that appropriate and safe equipment was used for heat therapy.**

Since this incident, the licensee issued a memo instructing staff not to use equipment that is not approved by the home. A disciplinary letter was also sent to RPN and kept on her file.

Additional Required Actions: None required.

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented

Findings:

The Licensee did not ensure the assessments, reassessments and interventions to address a resident's changed condition, were documented

1. There was no documentation to indicate a discussion took place between the physician and staff regarding proposed care strategies and the reasons for not proposing any further treatment to manage a resident's presenting symptoms. .

2. A palliative care decision was made, however, both staff's and physician's assessments and /or discussion to rule out possible actual illness were not available. During Inspector's telephone interview with the attending physician, the attending physician agreed that better documentation could be made with regards to the decision process regarding palliative care for the resident. .

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 with ensuring interdisciplinary assessment of all presenting symptoms & their related interventions are documented. This plan of correction is to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg. 79/10 s.80
Every licensee of a long-term care home shall ensure that residents have access to medical services in the home 24 hours a day.

Findings:

Medical service was not available 24 hours a day when staff could not reach the on call physician on a specific date.

1) RPN staff documented on the progress note that as of end of shift at 11:00pm, the on call physician had not returned call. Staff accessed medical service by re-paging the on-call physician the next day.

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 with ensuring a system is developed to ensure staff have access to medical services 24 hr a day, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

	Rosemary Lam
Title: Date:	Date of Report: (if different from date(s) of inspection). Aug 4, 2011