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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 12, 2013	2013_099188_0011	S-000038-13, S-001144-12	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4

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

CASSELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 19-21, 2013

The following logs were reviewed as part of this inspection: S-001926-11, S-001917-11, S-000366-12, S-000565-12, S-000788-12, S-000956-12, S-001144-12, S-001145-12, S-000019-13, S-000026-13, S-000033-13, S-000038-13

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nursing Staff, Personal Support Workers, Behavioural Support Staff and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Medication

Minimizing of Restraining

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. Inspector reviewed the home's policies relating to minimizing of restraining. Inspector noted the policy, under the procedures, directs the RN to "add the restraint task to the POC for the resident". Inspector reviewed the electronic care record for resident #038. Inspector noted this resident, who has a physician's order and consent for a physical restraint, does not have the restraint task within point of care (POC). Inspector noted no documentation to be available relating to this physical device within POC. Inspector spoke with staff #101 who confirmed that the task was missing and that it needed to be added. The licensee failed to ensure their restraint policy was complied with. [s. 29. (1) (b)]

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 ensuring the policy for minimizing the restraining of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. Inspector reviewed the home's policies relating to minimizing of restraining dated August 16, 2011. Inspector noted the policies identify some staff responsibilities and duties, however fails to identify who has the authority to apply and remove a physical device. Further, the policies fail to identify how all appropriate staff are aware at all times of when a resident is being restrained by a physical device. The licensee failed to ensure the policy deals with the duties and responsibilities of staff. [s. 109. (b) (ii)]

2. Inspector reviewed the home's policies relating to minimizing of restraining dated August 16, 2011. Inspector noted the policies identify that the emergency use of physical restraints may be permitted, however the policies fails to identify the need for continuous monitoring of a resident restrained under the common law duty and the need for the resident to be reassessed every 15 minutes. Further the policy does not address documentation requirements when a resident is restrained under the common law duty. The licensee failed to ensure the policy deals with restraining under the common law duty, pursuant to section 36(1) of the Act, when immediate action is necessary to prevent serious bodily harm to the person or others. [s. 109. (c)]

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 ensuring the policy for minimizing the restraining of residents addresses the duties and responsibilities of staff and provides direction related to restraining under the common law duty, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector reviewed resident #038's plan of care noting it identified the use of a physical restraint. Inspector reviewed the resident's health care record and noted documentation within the progress notes and the physician's notes which confirm this restraint was applied on two occasions for an unknown amount of time. Inspector further reviewed the restraint documentation to determine when the physical device was applied and noted there was no documentation other than the progress note entries identifying resident as being restrained. Inspector spoke with staff #101 who confirmed the documentation was not maintained and that it should have been recorded electronically within the point of care documentation. The licensee failed to ensure the documentation includes the person who applied the device and the time of the application. [s. 110. (7) 5.]

2. Inspector reviewed resident #038's plan of care noting it identified the use of a physical restraint. Inspector reviewed the resident's health care record and noted documentation within the progress notes and the physician's notes which confirm this restraint was applied on two occasions for an unknown amount of time. Inspector further reviewed the restraint documentation to determine when the physical device was removed and noted there was no documentation other than the progress note entries identifying resident as being restrained. Inspector spoke with staff #101 who confirmed the documentation was not maintained and that it should have been recorded electronically within the point of care documentation. The licensee failed to ensure the documentation includes the removal of the device, including the time of the removal and the post-restraining care. [s. 110. (7) 8.]

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 ensuring documentation when resident #038 is restrained includes the application and removal of the device, to be implemented voluntarily.

Issued on this 12th day of April, 2013

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