Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: September 26, 2024
Inspection Number: 2024-1550-0002
Inspection Type: Critical Incident
Licensee: The Regional Municipality of Niagara
Long Term Care Home and City: Gilmore Lodge, Fort Erie

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 13, 16, and 17, 2024.

The following intakes were inspected:

- Intake: #00120451 related to Infection Prevention and Control.
- Intake: #00120595 related to Falls Prevention and Management.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented related to the doffing of Personal Protective Equipment (PPE).

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) appropriate removal of PPE.

A resident required contact precautions and signage from Public Health Ontario was observed on their door regarding appropriate doffing of PPE. Specifically, the signage indicated that staff were to remove PPE in the following order: Remove gloves, remove gown, perform hand hygiene.

On a specified date, two staff provided personal care to the resident. They untied their gown, then removed their gown and gloves in one motion. They did not remove their gloves, then their gown as per the signage on the door.

The IPAC Program Manager acknowledged that the staff member did not follow best practice when removing their PPE.

There was potential for the spread of infection when the staff member did not remove their PPE appropriately.

Sources: Resident's clinical record; observations; interviews with staff.