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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 8, 2016	2016_384161_0010	031525-15 X 008001-16	Critical Incident System

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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

KATHLEEN SMID (161)

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): on site March 21, 22, 2016

During the course of the inspection, the inspector(s) observed identified residents and reviewed their health care records.

During the course of the inspection, the inspector(s) spoke with a Personal Support Worker (PSW), a Registered Practical Nurse (RPN), a Registered Nurse (RN), a Manager of Resident Care and the Director of Nursing Operations.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

Resident #001was admitted to the home in November 2014 with multiple medical diagnoses that included dementia with cognitive impairment.

A review of resident #001's health care record indicated that a specific outreach team had provided ongoing consultative recommendations related to strategies and interventions to manage resident #001's ongoing responsive behaviours. Behaviour mapping was a strategy to be used to identify resident #001's behaviours on an hourly basis for seven days. These behaviours were to be documented on the Behaviour Mapping form which at the end of the seven days would be analyzed by a registered nurse. Based on this analysis, an individualized plan of care would be developed that promoted the well-being of the resident.

On a specified date in March 2016 behaviour mapping was initiated related to resident #001's responsive behaviours. This behavior map form was reviewed by inspector #161 who noted that there was no documentation of resident #001's behaviours on a specified dated in March 2016 from 07:00 AM to 23:00 PM; nor the following date in March 2016 from 07:00 AM to 14:00 PM.

On March 21, 2016 discussion held with RN #101 who indicated that the need for behaviour mapping for resident #001 was communicated to the nursing staff at shift to shift report as well as written in a communication book that nursing staff read on a daily basis. These communication tools were reviewed by inspector #161 and noted to contain the behaviour mapping strategy for resident #001. Discussion held with RPN #104 who indicated that she had informed PSW #105 of the requirement for behaviour mapping of resident #001. PSW #105 was unavailable to confirm that she was aware of the directive by RPN #104.

On March 22, 2016 discussions held with RN #101, Manager Resident Care #100 and the Director of Nursing Operations who indicated to inspector #161 that resident #001's behaviours on the specified dates and times, should have been documented on the resident's behaviour mapping form. [s. 6. (9) 1.]

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 to ensure that documentation is completed for all residents who require behaviour mapping, to be implemented voluntarily.

Issued on this 8th day of April, 2016

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

Original report signed by the inspector.