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 soins 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
Oct 6, 2016	2016_384161_0043	005176-14, 005209-14, 005525-14, 009578-14, 022038-15, 028305-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

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): September 22, 23, 27, 28, 2016 and October 3, 4, 2016.

During the course of the inspection, the inspector(s) conducted the following critical incident system inspections:
- log #005176-14 related to medication administration
- log #005209-14 related to a fall with injury
- log #005525-14 related to a fall with injury
- log #009578-14 related to a fall with injury
- log #022038-15 related to a fall with injury
- log #028305-16 related to wound care

During the course of the inspection, the inspector(s) observed identified residents and care provided, reviewed identified residents health care records, home's investigation notes, and reviewed the homes policies titled "Medication Administration – #345.3" dated June 2016; policy titled "Medication Administration Record/Treatment Administration Record Sheet - #04-02-10" dated June 23, 2014, policy titled "Health Record: Downtime of Electronic Record - #750-106" dated August 2014; and policy titled "Skin and Wound Care Program" dated March 2016.

During the course of the inspection, the inspector(s) spoke with identified residents, Registered Practical Nurses (RPN), Registered Nurses (RN), RAI Coordinator, Program Manager of Personal Care, Manager Resident Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

The licensee has failed to ensure that the plan of care of resident #002 did not set out clear directions to staff and others who provide direct care to resident #002.

Resident #002 was admitted to the home in September 2015 with multiple medical diagnoses.

On an identified date in September 2016 the Program Manager Personal Care submitted a Critical Incident Report to the Director. The report indicated that on the previous day, RPN #103 reported that an incorrect treatment was applied to Resident #002 that led to increased skin irritation and pain.

On a following identified date in September 2016, Inspector #161 reviewed the health care records of resident #002. It was noted that a specialized registered nurse provided ongoing in-home consultative services regarding resident #002's plan of care related to specific treatment requirements, most recently on an earlier identified date in September 2016.

On an identified date in September 2016 resident #002's plan of care was reviewed with respect to the specialized registered nurse's detailed directions for the resident's specific treatment requirements. These directions consisted of eight distinct steps to effectively manage resident #002's specific treatment requirements. On an identified date in September 2016 during discussion with the Manager of Resident Care, he indicated to Inspector #161 that a resident's Medication/Treatment Record is used to identify, describe and direct a registered staff member regarding the provision of any specific treatment that a resident requires. Inspector #161 and the Manager of Resident Care reviewed resident #002's Medication/Treatment record and there was no information regarding the eight distinct steps to effectively manage resident #002's specific treatment requirements.
On an identified date in September 2016 discussion held with RPN #103 regarding the specialized registered nurse's detailed directions for resident #002's specific treatment. RPN #103 showed Inspector #161 in the Medication/Treatment binder, an undated photographic document accompanied by RPN#103's hand written directions for the eight steps required by registered staff to provide specific treatment to resident #002. RPN #103 indicated that she had created this photographic document to provide direction to any registered staff member required to provide specific treatment to resident #002. Inspector #161 reviewed the photographic document and noted on page two that there were written two of the eight directions for specific treatment of resident #002. These two directions were compared to the specialized registered nurse's directions for treatment. There were several discrepancies. On an identified date in September 2016 discussions held with RPN #103 and RN #104 who confirmed the discrepancies which in turn, were confirmed by the Program Manger of Personal Care. On an identified date in September 2016 discussion held with RN #105 who indicated that resident #002's plan of care related to specific treatment was confusing.

In summary, resident #002's plan of care related to specific treatment did not provide clear direction. There were discrepancies between the specialized registered nurse's directions, the photographic document accompanied by written directions as well as resident #002's Sept 2016 Medication/Treatment Administration Record. [log #028305-16] [s. 6. (1) (c)]

2. The licensee has failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan.

On an identified date in September 2016 RN #105 worked a day shift and provided a

specific treatment to resident #002. RN #105 wrote a note to RN #104 who was working the following day that she had not applied a specific treatment product to resident #002 but rather, had used a different treatment product. RN #105 further indicated in the note to RN #104, that she was unaware that the plan of care related to the resident's specific treatment had been changed the day before. On an identified date in September 2016 RN #104 reported to the Manager of Resident Care that RN #105 had used an incorrect specific treatment product on resident #002 earlier in the month. Inspector #161 reviewed the note written on an identified date in September 2016 by RN #105 to RN #104 which contained the above information. On September 23, 2016 Inspector #161 and RN #105 discussed the error. RN #105 indicated to Inspector #161 that resident #002's plan of care was confusing related to the specific treatment products used on the resident.

On an identified date in September 2016 RPN #103 reported to the Program Manger of Personal Care that on the previous evening, RN #106 provided specialized care to resident #002 and did not apply all of the required treatment products. On September 23, 2016 discussion held with RN #105 who indicated to Inspector #161 that she had provided specialized care treatment to resident #002 on an identified date in September 2016. She indicated to Inspector #161 that she did not apply one of the required treatment products as specified in the plan of care. [log #028305-16] [s. 6. (7)]

3. The licensee failed to ensure that the provision of care to resident #002 as set out in the plan of care was documented.

On an identified date in September 2016 it was reported to the Manager of Resident Care, that on the previous day, RN #105 provided specific treatments to resident #002 and did not document these treatments on the resident's September 2016 Medication/Treatment Record. Inspector #161 reviewed resident #002's Medication/Treatment Record for an identified date in September 2016 and observed that there was no documentation regarding any specific treatments provided to the resident on that date. On September 23, 2016 discussion held with RN #105 who indicated to Inspector #161 that although she had provided specific treatments to resident #002 on the identified date in September 2016, she had not documented these treatments.

On another specified date in September 2016 it was reported to the Program Manger of Personal Care that on the previous day, RN #106 provided specific treatments to resident #002 and did not document these treatments on the resident's September 2016 Medication/Treatment Record. Inspector #161 reviewed resident #002's

Medication/Treatment Record for an identified date in September 2016 and observed that there was no documentation regarding any specific treatments provided to the resident on that date. On September 23, 2016 discussion held with RN #106 who indicated to Inspector #161 that although she had provided specific treatments to resident #002 on the identified date in September 2016, she had not documented these treatments. [log #028305-16]

Written Notification #1 related to LTCHA 2007 S.O. 2007, c.8, s. 6(1)(c) related to a previously identified resident's plan of care was issued on June 14, 2016 by inspector #211 in Inspection Report #2016_219211_0013.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

On an identified date in September 2014, the attending physician of resident #001 prescribed an injection four times daily, the dose of which was according to the resident's blood work results. In the evening of an identified date in September 2014 RPN #100 checked resident #001's blood work results. As per the attending physician's orders, the resident was to be administered a prescribed injection subcutaneously. RPN #100 used an incorrect type of syringe to draw up the prescribed injection and as a result, RPN #100 administered the wrong dose of medication rather than the dose prescribed. RPN #100 immediately realized her error, notified the physician, treated the resident on-site and called an ambulance for immediate transfer of resident #001 to the hospital. Several hours later the resident was transferred from the hospital back to the home. [log #005176 -14]

Issued on this 6th day of October, 2016

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

Original report signed by the inspector.