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
Jun 14, 2016	2016_287548_0013	001755-16	Complaint

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 OVERLEA BLVD. TORONTO ON M4H 1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET OTTAWA ON K1Y 2Z3

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

RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): On May 19 and 20, 2016

Log#:001755-16- is related to care being provided

During the course of the inspection, the inspector reviewed the resident's health record, home policies and procedures, observed the resident and staff to resident interaction.

During the course of the inspection, the inspector(s) spoke with The resident, family members, Administrator, Acting Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW),Director of Activation and RAI Coordinator.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Pain
Personal Support Services
Reporting and Complaints
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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Related to Log #: log 001755-16

The resident requires assistance for activities of daily living due to several co-morbidities.

The resident's #017 health care record was reviewed. The progress notes were reviewed from specified times between March, 2016 to May, 2016 in addition to assessments and the Treatment Administration Record.

The resident's #017 care plan dated for a specified date in April, 2016 indicated that registered nursing staff are to assess the general condition of the resident's skin and to document on the flow sheet if the skin is intact. In addition, it specifies that PSWs are to report any reddened or open areas to registered nursing staff.

A progress note entry on a specified day in March, 2016 indicated that the resident exhibited a stageable pressure ulcer to the specified area with redness and rash to the

upper torso.

On a specified day in March, 2016 a progress note entry described the stage ulcer recording its dimensions.

On a specified day in April, 2016 a progress note entry indicated that treatment was applied to the ulcer and reddend areas.

On a specified day in April, 2016 a progress note entry indicated that it was observed that there was light bleeding to the ulcer area and the resident refused any treatment.

On a specified day in April, 2016 a progress note entry described the ulcer area and its measurements.

On a specified day in April, 2016 the stageable wounds measurements and wound base are described.

On a specified day in April, 2016 the resident is admitted to hospital and returned to the home several days later.

On a specified day in May, 2016 the wound base and measurements are recorded.

On a specified day in May, 2016 during an interview both the ADOC and Charge RN confirmed that skin assessments are conducted when there is an alteration in skin integrity, for new admissions and post hospitalizations. The Charge RN indicated there is a clinically specific tool used for skin assessments with the home’s policy.

The home policy titled: Skin and Wound Program, policy #E18, Revision date: November 2015 specifies that residents are to be assessed upon return from hospital. In addition, accompanying the policy is an assessment tool titled: Skin Care Assessment. There is a descriptor on the tool that specifies that an assessment is to be conducted quarterly or when there is a change in health status affecting skin integrity. In addition, the policy specifies that upon discovery of a pressure ulcer registered nursing staff are to initiate a baseline assessment using the Pressure Ulcer/Wound Assessment Record and the resident is assessed weekly as indicated. The Pressure Ulcer/Wound Assessment is to be completed post dressing change and to document the size, circumference and depth of the wound, discharge from the wound, appearance, progression, pain, nutrition and equipment being used.

On a specified day in May, 2016 during an interview the ADOC indicated the tool is specific to skin assessments and the observations of the assessment are to be recorded in the progress notes. The skin assessment tool specifies the documentation of: Distribution/Location, Appearance, Colour, Texture, Skin Temperature, Character, Shape and Treatment. On an specified day in May, 2016 RPN #116 indicated progress notes titled Skin is completed with new wounds and for new admissions and post hospitalization.

On a specified day in May, 2016 during an interview RPN #116 indicated that weekly wound assessments should be completed for the resident due to the resident's diagnosis, area of the wound and the resident always wanting to sit.

On a specified day in May, 2016 the ADOC indicated the wound assessments should be completed and have record of the assessment to include document the size, circumference and depth of the wound, discharge from the wound, appearance, progression, pain, nutrition and any equipment that is being used. [s. 50. (2) (b) (iv)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The Licensee failed to ensure when a resident is taking any drug or combination of

drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Related to Log #: log 001755-16

Resident #017 requires assistance for activities of daily living due to several comorbidities.

The health care record and home policies were reviewed.

A physician ordered the administration of a special pain intervention that was started on a specified day in March, 2016 for pain relief.

Inspector #548 reviewed progress note entries from a specified period of time between March, 2016 to May, 2016. There is an entry dated on a specified day in March, 2016 indicating the POA agreed to the special pain intervention.

The Minimum Data Set assessment reference date on specified day in March, 2016 indicated the resident was being administered analgesia.

The resident's care plan dated on a specified day in April, 2016 does not specify any interventions related to pain management. Review of the resident's care plan from admission resulted in no interventions related to pain management.

On a specified day in May, 2016 during an interview RPN #116 indicated the home has a pain management program and when a new medication is administered a pain assessment should be completed. RPN #116 further indicated that the resident is difficult to assess. RPN #116 indicated that the home has a pain assessment tool that has a scale that can be used to see if the resident is exhibiting pain behaviour and the resident's pain is associated with the resident's co-morbidities. RPN #116 indicated that there is no pain assessment tool in the health care record.

On a specified day in May, 2016 during an interview the ADOC indicated the home's process is to ensure those residents administered pain medication are to have an assessment completed for pain level and effectiveness of the prescribed pain management. ADOC further indicated that pain levels are to be recorded.

Inspector #548 reviewed the electronic Medication Administration Record (e-MARs) dated for a specific period of time in March, 2016. Registered nursing staff are prompted by a code to record the effectiveness of medications. It is noted the special pain intervention was administered on a specified day in March, 2016 in the morning, removed on a specified day in March, 2016 at a specified time and reapplied shortly after, then on a specified day in March, 2016 the special pain intervention was removed and reapplied as required. There is no record of the effectiveness of the special pain intervention for pain management.

A progress note entry dated for a specified day in March, 2016 indicated that the physician increased the dose of the special pain intervention. On a specified day in May, 2016 RPN #116 indicated the dose was elevated due to the resident's increased pain. Review of the health record resulted in no documentation indicating the need to elevate the dosage.

Inspector #548 reviewed the resident's progress notes for specified days in March, 2016. A progress note entry dated for a specified day in March, 2106 indicated the resident denied pain or any discomfort. The special pain intervention was initiated on a specified day in March, 2016 and the dosage increased on a specified day in March, 2016. There is no record of the monitoring and resident's response nor, of the effectiveness of the drug.

The home's policy titled: Pain Management Program, policy # E 34, Effective date: March 2013 specifies that the effectiveness of interventions (pharmacological and non-pharmacological) are to be documented. In addition, the policy reads: registered nursing staff are to: "monitor according to care plan, continually monitor resident verbalizations and behaviours indicative of discomfort and pain and evaluate to determine if pain strategies are effective- are changes to the care plan required?"

The Licensee failed to ensure the monitoring of the resident's #017 response to and the effectiveness of pain management interventions. [s. 134. (a)]

Issued on this 16th day of June, 2016

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

Original report signed by the inspector.