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
Jul 28, 2016	2016_288549_0020	018908-16	Complaint

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

RENA BOWEN (549)

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): July 13, 14, 15, 18, 19, 20, 25, 26, 2016

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurse (RN), Rehabilitation Service Worker, Behaviour Support Ontario (BSO) Personal Support Worker (BSO PSW), Nutritional Services Supervisor, Assistant Nutritional Supervisor, Recreation Aides (RA), the Resident and Family Services Coordinator, Vice President Nursing Programs (VPNP), Vice President Clinical Care (VPCC), the Chief Executive Officer(CEO) and a Community Care Access Worker.

The inspector reviewed the resident's health care records, fluid and intake flow sheets, nutritional assessments, multidisciplinary care conference documentation, Royal Ottawa Hospital Geriatric Psychiatric consult, electronic communication documentation and the home's Hydration and Nutrition Monitoring policy. The inspector also observed resident care being provided.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure or system instituted or otherwise put in place is complied with.

In accordance with O. Reg. 79/10 r.68(2)(a) every licensee of a long-term care home shall ensure that the Nutrition Care and Hydration programs include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Resident #001 was admitted to the home on a specified date in 2016 with multiple diagnoses. The Minimum Data Set dated a specified date in April 2016 indicated that resident #001 had a Cognitive Performance Scale assessment of five. Resident #001's written plan of care dated a specified date in April 2016 indicated that the resident requires constant cuing to eat and drink.

The Nutrition Assessment completed by the Registered Dietitian on a specified date in April 2016 indicated that resident #001 was a moderate nutritional risk due to dementia affecting intake, moderately underweight, less than 1500 ml fluid intake in 24 hours, and identified medical conditions.

On a specified date in May 2016 the resident was assessed to be a high nutritional risk and to maintain estimated fluids requirements of 1500-1950 ml (25-30ml/kg) 24 hours through to next review date.

The Nutritional Assessment document indicated that the nutritional care interventions would be to provide a Regular Diet, Regular Texture with Pureed Soup, food cut up bite size, soup in mug, only one appropriate utensil at meal, provide first course at table, prior to bringing the resident to the dining room and provide 1500-1950 ml fluid/24 hours.

Resident # 001's written plan of care dated a specified date in April 2016 indicates to maintain estimated fluid requirements of 1500-1950 ml/24 hours through to next review date.

The home's policy titled Hydration and Nutrition Monitoring, number IX NSG E-16.00b, original issue: October 2014 states in the section titled Procedure:
Bullet 1. The Registered Staff member will: Document resident care needs regarding

food and fluids in the individualized resident record and cross reference these to the PSW flow sheets for monthly tracking.
Bullet 2: When a resident is on fluid restrictions, report any fluids consumed with medications (water or supplement) to the resident's primary caregiver for recording.
Bullet 3. Provide close monitoring of residents with uncharacteristic changes in food or fluid intake and refer to Dietitian if there are any unexpected changes.
Bullet 4. Provide close monitoring of residents on fluid restrictions and those most at risk of dehydration i.e. those who are total assistance with intake and refer to Dietitian if there are any unexpected changes.
Bullet 5. Review daily for undesirable intake trends and gaps over a 72 hour period and refer to the Dietitian if exhibiting signs and symptoms of dehydration.
Bullet 6. The PSW staff will: Total all fluids once in a 24 hour period and for any intake below the intake amounts specified on the resident's care plan red circle the amount on the resident's flow sheet and report immediately when three red circles in a row are noted on the flow sheets.

During an interview on July 18, 2016 the Vice President Nursing Programs (VPNP) indicated to Inspector #549 that each resident home area Registered Practical Nurse (RPN) is responsible for the daily review of each resident's fluid intake and to monitor the undesirable intake trends and gaps over a 72 hour period and refer to the Dietitian even if the resident is not exhibiting signs and symptoms of dehydration as a preventative measure.

The VPNP also indicated that the PSWs do not red circle the fluid intakes that are below the intake amounts specified on the resident's plan of care as all of the documentation is completed in PCC. During the same interview the VPNP indicated to Inspector #549 that all residents are to be monitored for fluid intakes of less than 1500 ml in a 24 hour period by the RPN on each resident home area and be referred to the Registered Dietitian.

Inspector #549 reviewed resident #001's fluid intake records for a specified period in 2016. In the specified time period there are 26 days that fluid intake records indicate that resident #001 had a fluid intake of less than 1500 ml in a 24 hour period. During a different specified time period in 2016 there are 16 days that the fluid intake record indicates that resident #001 had a fluid intake of less than 1500 ml in a 24 hour period.

Resident #001 was referred to the Registered Dietitian once on a specified date in April 2016 by the resident home area RPN related to the Substitute Decision Maker (SDM) requesting resident #001 be assessed for a supplement if not eating. The Registered

Dietitian reviewed the referral on a specified date in April 2016 and requested consent from the SDM for the home to start foods with extra calories and protein due to the resident expending energy.

The VPNP indicated during an interview on July 20, 2016 that Resident #001 was not referred to the Registered Dietitian related to having a fluid intake of less than 1500ml in a 24 hour period.

In summary the licensee failed to ensure that the home's policy titled Hydration and Nutrition Monitoring number IX NSG E-16.00b was complied with. [s. 8. (1) (a),s. 8. (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 to ensure that home's Hydration and Nutrition Monitoring policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented.

In accordance with O. Reg. 79/10, s. 68. (2) (d) the home is required to have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to

nutrition and hydration.

Resident #001 was admitted to the home on a specified date in April 2016 with multiple diagnoses. The Minimum Data Set (MDS) assessment dated a specified date in April 2016 indicated that resident #001 had short term and long term memory problems , cognitive skills for daily decision-making was severely impaired- never/rarely made decisions. The MDS also indicated that the resident's Cognitive Performance Scale assessment (CPS) was five and that the resident required extensive assistance with food and fluid intake.

During an interview with the Behavioural Support Outreach (BSO) PSW #105 on July 13, 2016 it was indicated to Inspector #549 that the resident would not sit for any length of time in the dining room to complete his/her meal. BSO PSW #105 indicated that co-residents at the dining table would get upset with resident #001. The issue was that the resident was leaving the table and staff were calling the resident back to the table numerous times during the meal service. BSO PSW #105 indicated that the resident was moved to a different table in the dining room so the resident would have his/her back to the wall hoping this would assist with keeping the resident at the table for longer periods. Care staff would sit with the resident at the table during meal service and provide extensive assistance to encourage the resident to eat.

The Registered Dietitian (RD) completed a nutritional assessment on a specified date in April 2016 indicating resident #001 was assessed as being at a moderate nutritional risk.

The six week multidisciplinary care conference for Resident #001 was completed on a specified date in May 2016 and indicated a weight loss of 5% in a month and the resident had a fluid intake of less than 1500ml in a 24 hour period. The interdisciplinary staff and RD suspected the resident had more fluid intake than 1500ml in a 24 hour period however; there is no documentation to support that. The care conference documentation also indicated staff is to code all flood/fluid consumed.

During an interview on July 14, 2016 the Assistant Nutritional Supervisor indicated to Inspector #549 the home's food and fluid intake monitoring and evaluating system includes daily documentation of food and fluid intake for each resident in Point Click Care. The Assistant Nutritional Supervisor provided an explanation of the coding of the food and fluid intake to Inspector #549.

The Assistant Nutritional Supervisor indicated during the same interview with Inspector

#549 that it is the responsibility of the Personal Support Worker (PSW) to complete the Food and Fluid Intake in Point Click Care (PCC) for their assigned residents after each meal.

On July 14, 2016 during an interview the Vice President Nursing Program (VPNP) indicated to Inspector #549 that the PSWs are responsible for completing the food and fluid intake in PCC for their assigned residents.

Inspector #549 reviewed resident #001's food and fluid intake records for a specified time period in 2016.

There were no entries on a specified date in April 2016 of any food intake for afternoon snack, dinner meal service or evening snack, on a different date in April 2016 there were no entries for any food intake for the dinner meal service or evening snack, on two more different dates in April there was no food intake entry for evening snack, and on four dates in May 2016 there was no food intake entries for afternoon snack or dinner meal service.

There were no entries in PCC for the resident's fluid intake for lunch, afternoon snack, dinner meal or evening snack on three specified dates in April 2016.

The VPNP indicated during an interview on July 14, 2016, if a resident does not have a food or fluid intake the expectation is that the PSW would enter a zero in the appropriate section on PCC. If the resident refused the meal the PSW is expected to enter RR and if the resident is not in the home the PSW is expected to enter RU (resident unavailable) in PCC. The VPNP indicated that there should be no blank sections on the food and fluid intake records for any resident who has identified risks related to nutrition and hydration.

The VPNP indicated to Inspector #549 on July 14, 2016, that the home's expectation is that all residents will have their daily food and fluid intake amount documented in Point Click Care each day including refusal and resident is unavailable.

In summary the licensee has failed to ensure that the food and fluid intake for resident #001 was documented for each meal service and snack provided to the resident as part of the home's system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. [s. 30. (2)]

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 as part of the home's system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, resident's food and fluid intake will be documented daily, to be implemented voluntarily.

Issued on this 28th day of July, 2016

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

Original report signed by the inspector.