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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2017	2017_617148_0033	011663-17, 021370-17, 024452-17	Critical Incident System

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

AMANDA NIXON (148), MELANIE SARRAZIN (592)

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): November 10, 14, 15, 16 and 17, 2017

This inspection included three logs, each related to resident responsive behaviours

During the course of the inspection, the inspector(s) spoke with the home's Administrator, VP of Nursing, Assistant VP of Nursing, Registered Nurses, Registered Practical Nurses (RN), Personal Support Workers (PSW), Behavioural Support persons, family and residents.

The Inspectors reviewed resident health care records of identified residents including assessments, plans of care and mental outreach consults. In addition, the Inspectors observed the care and services provided to identified residents and the resident care environment.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed when the care set out in the plan has not been effective.

Resident #005 was admitted to the home with several diagnosis including Alzheimer's disease and unspecified dementia.

The licensee submitted a Critical Incident Report (CIR) to the Director (MOHLTC) on a specified date in early fall 2017, for an incident involving resident #005 and resident #006 related to an alleged physical abuse. The CIR indicated that on the same date as the submitted CIR, resident #005 was found in another home's unit in resident #006's room and an altercation took place including physical aggression with resident #006 and staff members; an injury sustained by resident #006.

The health care records indicated that resident #005 was identified with a past history of having physical responsive behaviours towards co-residents, therefore the resident was followed by the Geriatric Psychiatric Outreach Team. The resident's plan of care indicated that resident #005 was identified with wandering behaviours, being resistive to care and that several interventions were put in place to respond to the resident's needs and manage responsive behaviours. Interventions included the administration of two drugs; an antidepressant as needed (PRN) and if not effective, the administration of an as needed antipsychotic.

The progress notes for resident #005 indicated that during the 24 hour period prior to the CIR submission, resident #005 was observed with increase physical behaviors and wandering episodes which were not easily altered as described below:

On the day prior to the CIR, it was documented that resident #005 was in a co-resident's room hovering over the co-resident and would not leave the room. The notes further indicated that resident #005 was resistive with staff members and was attempting to hit them. The progress notes indicated that about an hour later, resident #005 was wandering and the resident attempted to take a walker away from a resident. The notes further indicated that resident #005 had a physical altercation with a co-resident. The notes described that resident #005 was brought to his/her room after the incident and that the as needed antidepressant was administered with partial effect. The notes after this administration, indicate that resident #005 was still agitated when re-directed from co-residents.

On the same date, the progress notes indicated that resident #005 placed him/herself on the floor and exhibiting mood changes and inappropriate behaviours. The notes further described that the RN was contacted and the as needed antidepressant was administered along with the as needed antipsychotic for the increase agitation due to partial effect from the previous dose of antidepressant. The notes further indicated that resident #005 was observed in the afternoon going in and out of co-resident's room and other inappropriate behaviours. The notes further described that resident #005 was pacing and that the staff had attempted to get the resident to have a rest in the afternoon with no effect.

On the same date of the CIR, the progress notes indicated that resident #005 was observed with increase weepiness and pacing in the morning and going in and out of co-resident's rooms. Resident #005 was observed with increase hallucinations and mood swings. The notes further indicated that morning medications were administered along with an as needed dose of antidepressant.

Later in the day, the notes indicated that resident #005 was observed pacing in the hallways. It is further indicated that the staff attempted several times to encourage resident #005 to take a rest, however the resident refused.

One hour before the described CIR, the notes indicated that resident #005 was observed in and out of co-resident's rooms, hovering over the residents and touching them. The notes further indicated a change in mood and refusing any rest periods. It was documented that an as needed dose of antidepressant was administered with partial effect and that resident #005 was quiet for short periods of time only.

During the review of the progress notes, Inspector #592 noted that on the day of the CIR and the day prior to the CIR, resident #005's was exhibiting behaviours; as needed medication was administered four times by the registered staff and was documented as being partially effective.

On November 17, 2017, in an interview with RN #104 and the DOC, they both indicated to Inspector #592 that when partial effectiveness is documented as the outcome after the administration of a medication, that it indicates that the effect from the medication was not 100 percent effective. They both added that the physician must be made aware in order to reassess and readjust the resident's medications when the medications are not being effective and that in the meantime, new interventions should be put in place. An

antidepressant, as needed medication, was administered as part of the plan of care for resident #005, however, the antispychotic, as needed medication, was not provided to resident #005 when the antidepressant was not effective.
(Log #021370-17) [s. 6. (10) (c)]

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 the resident is reassessed and the plan of care reviewed when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behavioural patterns, any identified responsive behaviours and potential behavioural triggers and variations in resident functioning at different times of day.

The health care record and staff interviews demonstrate that resident #003 had responsive behaviours including verbal aggression, resistance to care and wandering. A critical incident report related to aggression was submitted to the Director (MOHLTC) on a specified date in the fall of 2017, whereby the resident allegedly wandered into a co resident's room and was exhibiting inappropriate behaviours and aggression.

The most recent assessment by mental health outreach, which was conducted prior to the critical incident above, describes the resident has having dementia with vocalizations and wandering. Behavioural mapping conducted after the incident, indicates most instances of pacing and restlessness were noted after 1500 hours. In review of the progress notes incidents of aggression, specifically verbal aggressions and wandering, tend to occur during the evening shift (1500-2100 hours).

Inspector #148 spoke with a regular day shift RPN #106 and PSW #107, both described that the resident's behaviours of resisting care are prevalent during the day shift but noted improvement with recent changes in medication. The resident is known to also wander the unit and/or become verbally aggressive. However, both staff indicated that the resident's behaviours are more common during the evening shift. Inspector #148 spoke with regular evening shift staff including RPN #108 and three PSWs. It was reported to the Inspector that the resident is generally quiet until the supper meal. At the supper hour and for the hours proceeding supper the resident is more active, noting it common that the resident will wander the unit and can become loud; exampled by the resident yelling out. The staff indicated that the concern is that the resident is attempting to be social and will approach other residents, will want to reach out and touch other residents and that this can provoke the behaviours of other residents on the unit.

The current plan of care for resident #003 includes responsive behaviour such as resisting care, exit seeking, agitation and potential for aggression (unspecified). The plan of care does not include wandering or verbal aggression (yelling out/getting loud) or the variations of the resident's behaviours as it relates to the time of day.
(Log 024452-17) [s. 26. (3) 5.]

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 the plan of care includes any mood and behavioural patterns, any identified responsive behaviours and potential behavioural triggers and variations in resident functioning at different times of day, to be implemented voluntarily.

WN #3: 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 has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's responses and the effectiveness of the drugs appropriate to the risk level of the drug.

Resident #001 is prescribed three, as needed (PRN) medications as part of managing the resident's pain and responsive behaviours.

Inspector #148 reviewed the medication administration records for two months in 2017, whereby there were five administrations of the noted as needed (PRN) medications for pain and/or behaviours. For two of the administrations, documentation related to the administration of the PRNs does not include the residents responses or effectiveness of the medication.
(Log 011663-17) [s. 134. (a)]

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's responses and the effectiveness of the drugs as appropriate to the risk level of the drug, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours.

The health care record and staff interviews demonstrate that resident #003 has responsive behaviours including verbal aggression, resistance to care and wandering. A critical incident report related to aggression was submitted to the Director (MOHLTC) on a specified date in the fall of 2017, whereby the resident allegedly wandered into a co resident's room and was exhibiting inappropriate behaviours and aggression.

As it relates to the incident described above, the physician ordered behavioural mapping to be completed for one week after. Inspector #148 reviewed the Behaviour Mapping document completed by nursing staff. The document directs staff to use corresponding number codes to record the resident's condition/status in one hour intervals. On four dates within the seven day period, there are one hour intervals that were not documented, including up to eight hours of no documented behaviour mapping.

The strategy of behavioural mapping in response to a resident demonstrating responsive behaviours was not implemented.
(Log 024452-17) [s. 53. (4) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, shall document the following: the person who applied the device and the time of application; all assessment, reassessments and monitoring including the resident's response; every release of the device and all repositioning; the removal or discontinuation of the device, including time of removal.

Resident #001 was observed by the Inspector for a period of time on November 15 and 16, 2017, to be seated in a wheelchair with seat belt and tilt applied. It was determined through the health care record and staff interviews that the wheelchair and seat belt are primarily used to prevent the risk of fall and injury, but have also been used as an intervention for responsive behaviours and to manage the resident's and co-resident's safety. The wheelchair and seat belt are used for the resident, as needed (PRN). The physician orders include, wheelchair with safety belt as required for safety for fall prevention/agitation.

The home maintains a Point of Care (POC) Response History document in POC related to the required documentation for the application, assessment, monitoring, repositioning and removal of restraints. In the case of resident #001, staff are prompted to record application, assessment, repositioning, removal and safety checks; each response is to represent an hour of time. The time at which a staff member creates an entry is the time stamped on the document. Resident #001's documentation directs staff to document on a PRN seatbelt while in chair, the resident's condition is to be reassessed every hour while seatbelt is in place with tilt wheelchair for effectiveness and relevance. Inspector #148 reviewed the last 14 days of PSW and Registered nursing staff documentation and found that for each day the application, assessment, monitoring, repositioning and removal of resident #001's physical restraints, including seat belt, were not documented as required. Below describe examples of same:

On a specified date, there are three entries at approximately 1340 hours, all of which indicate that the seat belt restraint has been applied; it is noted that there are entries indicating safety checks and repositioning occurring prior to this time of application. There are nine entries, including the three at 1340 and six entries at approximately 2100 hours, indicating the restraint is applied. During the period of nine entries, there is no indication of repositioning during this time and only one safety check at 1441 hours. There is no documentation on this date to support that registered staff assessed the restraint for effectiveness every eight hours.

On a specified date, there is an entry at 1411 hours that the seat belt restraint was applied. There are 16 entries to indicate that safety checks have been completed after 1411 hours. There is no documentation to support reposition during this period of time; there is no documentation to support the removal of the restraint at any time on this date. There is an entry at 2254 hours by registered staff indicating that the eight hour assessment for effectiveness has been completed; this does not support that the restraint applied at 1411 hours was assessed every eight hours.

On a specified date, there are three notations at 1128 hours that the seat belt restraint is applied; during this time period there is no documentation to support safety checks or repositioning. On the same date, there is no documentation to support the removal of the restraint.

On a specified date, there are 15 entries denoting safety checks related to the seat belt restraint, with time stamps of approximately 0305, 0630 and 1342 hours; in addition to three entries prior to 1342 of repositioning. During this time period there is no documentation to support when the restraint was applied. On the same date, there are five entries time stamped at 2100 hours indicating the seat belt restraint is applied. An entry at 2101 hours indicates the restraint is removed. During the period of five entries there is no documentation to support repositioning or safety checks. The POC response history for eight hour effectiveness by registered staff is time stamped at 1345 hours which does not support that the restraint was assessed every eight hours, with consideration of the previous entries related to safety checks and application.

On November 16, 2017, resident #001 was observed by the Inspector ton three occasions between 1050 and 1330 hours to be seated in the wheelchair with seat belt applied. Inspector #148 reviewed the documentation for November 16; there was no documentation for the period of observation described above for either the application, monitoring, repositioning or removal of the physical restraint.
(Log 011663-17) [s. 110. (7) 5.]

Issued on this 22nd day of December, 2017

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

Original report signed by the inspector.