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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2017_625133_0020	026722-17	Critical Incident System

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Drive 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

JESSICA LAPENSEE (133)

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 29, 30, December 1, 5, 8, 11, 19, 2017, January 29, 2018

This inspection was related to a Critical Incident Report submitted by the home, in relation to the abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the identified resident and their Substitute Decision Maker, other residents, Personal Support Workers, Registered Practical Nurses, a Registered Nurse, the Vice President of Nursing, the Human Resources Manager, the President and Chief Executive Officer.

During the course of the inspection, the inspector reviewed the identified resident's health care records, in-service training content related to resident abuse and mandatory reporting, a staff member's education history and employee file, the licensee's investigation file as well as the licensee's policies and procedures titled: "Resident Abuse: Prevention, Reporting and Elimination, and "Resident Abuse: Definitions", both with a review date of 2017-09-29.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001 sets out clear directions to staff and others who provide direct care to the resident, with regards to the resident's resistance to care.

Resident #001 was admitted to the home on a specific date. The resident's diagnoses included Alzheimer's disease.

On November 29, 2017, the Inspector reviewed resident #001's plan of care. A focus on "resistive to care behavior", dated 05/11/2017, was noted. The stated goal and interventions related to the resident taking a specific dietary supplement, exclusively.

On November 30, 2017, the Inspector interviewed Personal Support Worker (PSW) #105 about her experience with resident #001 during the day shift. The PSW indicated that resident #001 could be resistive to the provision of personal care. The PSW described situations in which the resident may demonstrate resistance, such as during morning care, at meal times, and when attempting to toilet the resident. The PSW described ways in which the resident may demonstrate resistance during such situations. The PSW described strategies she used to respond to the resident's resistance during such situations, so as not to escalate the resistance. The PSW reviewed resident #001's plan of care with the inspector and indicated that it did not reflect what staff were doing for the resident in response to his/her resistive behaviors.

On November 30, 2017, the Inspector interviewed Registered Practical Nurse (RPN) #106 about her experience with resident #001 during the day shift. The RPN indicated that the resident has significant cognitive impairment. The RPN indicated that the confusion could make resident #001 frustrated, and that overall the resident could be resistive to care, which may be demonstrated verbally or physically. The RPN described situations in which the resident may demonstrate such resistance, such as during morning care. The RPN described ways in which the resident may demonstrate such resistance. The RPN described ways in which staff responded to the resident's resistance, so as not to escalate the resistance. The RPN described a specific approach that worked well with resident #001. The RPN reviewed resident #001's plan of care with the inspector and indicated that the referenced supplement was no longer given. The RPN indicated that the plan of care did not reflect the interventions in place with regards to resident #001's resistance to care. The RPN indicated that resident #001's resistance to care was not new, and it related to both personal care and activities of daily living.

On December 8, 2017, the Inspector interviewed PSW #107 about her experience with resident #001 during the day shift. The PSW indicated that resident #001's resistance to care varied depending on the day. The PSW described ways in which the resident may demonstrate resistance to personal care in the morning. The PSW described approaches that would result in, or escalate, resident #001's resistance to care in the morning. The PSW described ways in which she approached resident #001 in the morning, to ensure that the resident was agreeable to the provision of care.

On December 8, 2017, the Inspector interviewed PSW #108, in the presence of PSW #107, about her experience with resident #001 during the day shift. PSW #108 and PSW #107 described an approach that appeared to cause resident #001 to become fearful and to become resistive to personal care. PSW #108 described the way in which staff could approach resident #001 to ensure he/she felt secure and would therefore be more likely to accept personal care. PSW #108 described ways in which she responded to the resident's resistance to care if it occurred, so as not to cause an escalation. PSW #108 referenced the offer of a specific item and a specific topic of conversation that resident #001 responded well too.

On December 8, 2017, the Inspector interviewed PSW #109, about her experience with resident #001 during the evening shift. The PSW indicated that resident #001 can be resistive to the provision of care, such as when toileting the resident and when the resident is exit seeking. The PSW described the ways in which the resident may demonstrate resistance during these times. The PSW described ways in which she responded to the resident's resistance during these times, so as not to cause an escalation. The PSW described her approach with resident #001, to ensure the resident would accept care. The PSW indicated that there were two specific items she offered to resident #001 in an effort to help him/her remain calm and to be accepting of care.

On December 19, 2017, the Inspector interviewed PSW #110 about her experience with resident #001 during the night shift. The PSW indicated that resident #001 becomes agitated when he/she is woken up and may be resistive to care. The PSW described specific challenges to the provision of care for resident #001 when he/she is in bed. The PSW described her approach to these challenges. The PSW described her approach should the provision of care not be possible as a result of the resident's resistance to care.

On December 19, 2017, the Inspector interviewed PSW #111 about her experience with

resident #001 during the night shift. The PSW indicated that if resident #001 is sleeping, he/she can be resistive to care. PSW #111 indicated that resident #001 does not like to be woken up. The PSW explained what causes the resident discomfort and irritation during the provision of care. The PSW described how the resident may demonstrate resistance to care. The PSW explained how she would respond to the resident's resistance to care, so as not to escalate the resistance.

The licensee has failed to ensure that the written plan of care for resident #001 sets out clear directions to staff and others who provide direct care to the resident, with regards to the management of responsive behaviors when providing personal care. [s. 6. (1) (c)]

Issued on this 13th day of February, 2018

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

Original report signed by the inspector.