Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 3, 2023	
Inspection Number: 2023-1510-0007	
Inspection Type: Critical Incident	
Licensee: St. Patrick's Home of Ottawa Inc.	
Long Term Care Home and City: St. Patrick's Home, Ottawa	
Lead Inspector Pamela Finnikin (720492)	**Inspector Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.11.14 10:09:52 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20-22, 2023

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00094442 (CIR 3015-000061-23) - related to improper/incompetent treatment of a resident that results in harm or risk to a resident
- Intake: #00095899 (CIR 3015-000069-23) - related to fall of a resident resulting in injury and change in condition

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

#1

In August 2023, a Critical Incident Report (CIR) was submitted for a resident for an unwitnessed fall resulting in an injury. The CIR stated that resident was found on the floor at 0620 hours and bed alarm did not sound at time of the fall. The same night, at 0445 hours, RPN was alerted to resident's movements by bed sensor alarm sounding and the resident was redirected to bed.

A review of the resident's care plan confirmed that a bed alarm should be in place while resident is in bed.

An interview with the Restorative Service Worker confirmed that a bed alarm intervention was in place for the resident's risk of falls at time of fall on in August 2023.

An interview with an RPN and DOC confirmed that the bed alarm did not sound at time of residents fall in August 2023.

Failure to ensure that the resident's bed alarm was on and working while the resident was in bed put the resident at increased risk of injury. As a result of bed alarm not working, resident was found on the floor and sent to hospital as a result of an injury.

#2

Inspector #720492 observed that staff had not followed the instructions to decrease a resident’s risk of falls at the time of observation.

A PSW stated that instructions to decrease the resident’s risk of falls were not followed that day.

Review of the resident's care plan and progress notes, and interviews with the Restorative Service Worker and an RPN confirmed that the staff had directions to follow on each shift as a post fall intervention for safety of the resident in September 2023.

Failure to follow resident's post fall interventions puts the resident at increased risk of injury as resident is considered a high fall risk.

Sources: Review of resident's health care records, including progress notes and care plan, Critical Incident Report, interviews with DOC, Restorative Service Worker, RPNs and others.

[720492]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff use safe transferring and positioning devices and techniques when assisting a resident.

Rationale and Summary

In August 2023, two PSW's transferred a resident side by side with the resident's mobility device, from their chair in the dining room to their room.

A Critical Incident Report (CIR) was submitted in August 2023 and stated that the resident's family member was present and notified the staff at that time that the transfer device was required for transferring the resident.

Review of the resident's care plan document and progress notes in Point Click Care (PCC) confirmed that resident's transfer status changed on August 2, 2023 to "two staff side by side using transfer device, assist with mobility device".

Interview with the Restorative Service Worker and an RPN confirmed that staff were aware of the resident's transfer status requiring a transfer device, that staff have been trained on transfer device usage, and that the resident's care plan reflected this transfer status.

Interview with DOC confirmed that staff incorrectly transferred resident in August 2023.

Failure to follow the resident's care plan for safe transfers put the resident at risk of injury.

Sources: Review of resident's health care records including progress notes and plan of care in PCC; CIR, and interviews with the DOC, RPN, Restorative Service Worker and others.

[720492]

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559