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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2014	2014_198117_0016	O-000391-14 & O-000435-14	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

LYNE DUCHESNE (117), 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): June 24, 2014

Two (2) critical incident inspections (logs #O-000391-14 and # O-000435-14) were conducted during this inspection with attention paid to resident care and service issues identified in previous inspections in 2014.

During the course of the inspection, the inspector(s) spoke with Vice President of Resident Care, Vice-President Clinical Care, a Registered Practical Nurse (RPN), several Personal Support Workers (PSWs), Restorative Care Lead, a Restorative Care staff member and to two identified residents.

During the course of the inspection, the inspector(s) reviewed the health care records of two identified residents, observed the care and services for the two identified residents, observed part of the breakfast meal service on two resident care units, observed morning beverage pass on two resident care units, reviewed "Guidelines and examination for residents on use of power mobility equipment", and reviewed two critical incident reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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 failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (a) in that the home did not ensure that there is a written plan of care for each resident that sets

out the planned care for the resident.

Resident #1 has a neurodegenerative disease and since a specific day in April 2014, has been using on a trial basis, a loaned power electric wheelchair to self-mobilize. On an identified day in May 2014, Resident #1 was in his/her room. While doing an activity, the resident activated the electric wheelchair controls which propelled the wheelchair forward and up against the resident's bedframe. The resident's foot got caught between the bedframe and the electric wheelchair. The resident sustained an injury.

On a specific day in May 2014, restorative care services reassessed Resident #1's ability to use safely a power electric wheelchair. A decision was made by the resident's Power of Attorney to cancel the purchase of the power electric wheelchair for the resident. A tilt chair with elevated footrest was set up for resident use during the resident's recovery period. The next day, the power electric wheelchair was removed from the home.

On June 24, 2014, Resident #1 was observed to be seated in a tilt wheelchair with elevated footrests. As per the resident, he/she has been using the tilt wheelchair since his/her injury. Staff members PSW S#104 and S#103 stated to Inspector #592 that since the resident's injury, the resident has been using a tilt wheelchair for mobility and that the electric wheelchair has been removed from the home.

On June 24, 2014, staff member PSW #103 was observed to be training a new PSW. As part of the orientation she was showing the new PSW how to read resident's written plan of care and was explaining how the plan gave staff direction on how to provide care to the residents. Resident #1's current written plan of care was revised by LTCH Inspector # 592. The plan is dated as being revised on May 22, 2014. The plan identifies that Resident #1 uses an electric wheelchair as a primary mode of locomotion on the unit. PSW S#103 stated to Inspectors #117 and #592 that new staff would not know of Resident #1's current mobility needs from the written plan of care.

At the time of the inspection, Resident #1's written plan of care did not reflect the resident's current use of a tilt wheelchair. [s. 6. (1) (a)]

2. Resident #2 is identified as being at moderate risk for falls and has a wheelchair with lap belt for mobility. Chart documentation notes that the resident was able to

undo the lap belt by him/herself.

On a specific day in May 2014, while mobilizing in the unit hallway, Resident #2 unclipped the wheelchair lap belt and fell out of the wheelchair. The resident was immediately assessed and noted to have two small skin tears. Four days later in May 2014, the resident's wheelchair was reassessed by the home's restorative care staff. A recommendation was made to change the resident's current wheelchair to one that would be a better fit and that would offer more support to the resident. In consultation and with the consent of the resident's Power of Attorney, Resident #2's wheelchair was changed to a tilt wheelchair with a lap belt, which the resident could undo at will, as a fall prevention intervention on a specific day in May 2014.

On June 24, 2014, Resident #2 was observed by Inspector #117 to be in a tilt wheelchair and to have a lap belt in place. Resident #2 was noted to be able to undo the lap belt by him/herself and staff were observed to regularly monitor and reposition the resident. A review of the resident's current plan of care was done. It documents that the resident uses a walker and occasionally a wheelchair to mobilize on the unit. The plan of care does not identify the use of a tilt wheelchair or of a lap belt. On June 24, 2014, unit RPN S#101 as well as PSWs S#102 and S#103 stated to Inspector #117 that Resident #2 is using on a daily basis the tilt wheelchair and the lap belt. The resident has not been using any walker for ambulation purposes since his/her fall on a specified day in May 2014.

On June 24, 2014, staff member PSW #103 was observed to be training a new PSW. As part of the orientation she was showing the new PSW how to read resident's written plan of care and was explaining how the plan gave staff direction on how to provide care to the residents. PSW S#103 stated to Inspectors #117 and #592 that new staff would not know of Resident #2's current mobility needs and use of a lap belt from the written plan of care.

Resident #2's written plan of care does not set out the resident's planned care as it relates to the daily use of a tilt wheelchair and lap belt. [s. 6. (1) (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 Resident #01 and Resident #02's written plans of care set out the planned care for the residents as it relates the residents current usage of specific mobility aids and safety devices, to be implemented voluntarily.

Issued on this 26th day of June, 2014

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