Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 26, 27- 2011	2011_133_2807_26May141201	Critical Incident Log O- 000715

Licensee/Titulaire

Deem Management Limited
990 Edward Street North
P.O Box 1510
Prescott, Ontario
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Long-Term Care Home/Foyer de soins de longue durée

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

Jessica Lapensée, #133

Inspection Summary/Sommaire d'inspection

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The purpose of this inspection was to conduct a critical incident (# 2807-000005-11) inspection related to the enteric outbreak # 2243-2011-008 which spanned from February 4th, 2011 to March 1st, 2011.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care, the Food Services and Housekeeping Services Manager, the Maintenance Services Manager, the Laundry Services Manager, a Registered Nurse, a Registered Practical Nurse, several Personal Support Workers and several Housekeeping Services staff.

During the course of the inspection, the inspector conducted a walk-through of all resident home areas and common areas, observed staff practices related to infection prevention and control and reviewed infection prevention and control related documentation.

The following Inspection Protocols were used during this inspection:

- Infection Prevention and Control
- Critical Incident Response

Findings of Non-Compliance were found during this inspection. The following action was taken:
4 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg 79/10, 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,
(b) is complied with.

Findings:

- Under O. Reg 79/10 s. 229 (8) a and b, the licensee is required to ensure that there is an outbreak management system in place and a written plan for responding to infectious disease outbreaks. The home does have an outbreak management system described in policy (#04-01 – #04-06) including a written plan for responding to infectious disease outbreaks. There is however no evidence that the

policies were referred to or complied with in relation to the enteric outbreak (# 2243-2011-008) which spanned from February 4th 2011 to March 1st, 2011. During this enteric outbreak, 41 of 55 residents were affected.

- The home's "outbreak management team" policy #04-01 requires the home to have a designated outbreak management team (OMT). An OMT was not in place for the enteric outbreak and at the time of the inspection, had not yet been designated. The policy also speaks to and provides a template for OMT meetings, which were not held during the enteric outbreak. The home did continue to hold their daily "multidisciplinary morning report" meetings at which there was usually an update given about the number of people affected by the enteric outbreak.

- The home's "outbreak management team" policy 04-01 also requires that the chairperson of the OMT be responsible for coordinating communication within the home and with the local Public Health Unit. With the home's designated coordinator for the infection prevention and control program away on vacation during the enteric outbreak, there was no one person responsible for communication within the home and with the local Public Health Unit. In a March 16th report from the local Public Health Unit about the enteric outbreak, the public health inspector notes "with *the home's designated coordinator for the infection prevention and control program* away, various personnel were placed in charge of managing the outbreak. This resulted in a lack of effective communication, consistent messaging and monitoring of infection control practices".

- The home's "declaring an outbreak" policy 04-02 was not followed during the enteric outbreak as it relates to the prescribed activities of the OMT and as it relates to the requirement of the Administrator or designate to notify the Ministry of Health and Long Term Care (MOHLTC) of a confirmed outbreak. The enteric outbreak began on February 4th, 2011 and the MOHLTC was notified by the Administrator on March 31st, 2011.

- The home's "outbreak management" policy 04-03 outlines responsibilities for all staff at the home and specific actions related to specific departments and/or managers that are to be taken during an outbreak. This policy was not followed during the enteric outbreak as it relates to the OMT and to the Administrator's responsibilities to directly supervise and monitor all outbreak management activities. As well, there is no evidence that the Housekeeping Supervisor in place during the first two weeks of the enteric outbreak specifically reviewed cleaning procedures required during outbreaks such as correct use of chemicals, extra precautionary measures and frequencies of cleaning. Staff recount that they received reminders about hand hygiene in the form of memo's or at change of shift, however there is no evidence that the interim Director of Care in place during the outbreak took measures to assess the application of outbreak control measures such as staff's adherence to adequate hand hygiene practices. In a March 16th, 2011 report from the local Public Health Unit about the enteric outbreak, it is noted that "the large number of illnesses that occurred in this outbreak is likely a direct result of inadequate hand hygiene practices".

- The home's "outbreak – external communication" policy 04-04 was not followed for the enteric outbreak as it relates to notifying the MOHLTC when an outbreak is confirmed and when an outbreak is declared over by the local Public Health Unit. The enteric outbreak began on February 4th 2011 and ended on March 3rd 2011. The MOHLTC was notified of this on March 31st 2011.

- The home's "outbreak communication – internal" policy 04-05 was not followed for the enteric outbreak as it relates to documentation and the requirement that a copy of all memo's distributed during the outbreak are to be retained. Staff recount receiving memo's during the enteric outbreak, but none were kept.

- The home's "outbreak contingency plan" policy 04-06 requires a contingency plan be developed and a annual "declaring an outbreak" exercise be conducted. This policy has not been followed as there is no contingency plan in place and there has been no "declaring an outbreak" exercise.

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Additional Required Actions:

VPC #1 - 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 with the requirement to ensure that the home's outbreak management system, including the written plan for responding to infectious disease outbreaks, is complied with. The written plan of correction is to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg 79/10, s. 229 (2). The licensee shall ensure,

a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
c) that the local medical officer of health is invited to these meetings;
d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices; and
e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Findings:

- At the time of the enteric outbreak (February 4th 2011 – March 3rd 2011), there was no interdisciplinary team in place to co-ordinate and implement the Infection Prevention and Control program.
- Planning and preparation began for the development of the home's Infection Control Committee (ICC) in March 2011.
- The inaugural meeting of the ICC occurred on April 21st 2011 with a subsequent meeting on May 20th 2011. The next ICC meeting is schedule for June 16th 2011.
- The local medical officer of health is not invited to the meetings.

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Additional Required Actions:

VPC #2 - 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 with the requirement to ensure that the local medical officer of health is invited to the Infection Control Committee meetings at least quarterly.

WN #3: The Licensee has failed to comply with O. Reg 79/10, s. 107 (1). Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined by the *Health Protection and Promotion Act.*

Findings:

- On February 4th 2011, the Leeds, Grenville and Lanark District Health Unit assigned an outbreak number (#2243-2011-008) for an outbreak of enteric illness at Wellington House Nursing Home.
- The Administrator of the home contacted the Ministry of Health and Long Term Care - Ottawa Service Area Office on March 31, 2011 to inform of the enteric outbreak.

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WN #4: The Licensee has failed to comply with O Reg 79/10, s. 107 (4). A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
   - i. names of any residents involved in the incident,
   - ii. names of any staff members or other persons who were present at or discovered the incident, and
   - iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
   - i. what care was given or action taken as a result of the incident, and by whom,
   - ii. whether a physician or registered nurse in the extended class was contacted,
   - iii. what other authorities were contacted about the incident, if any,
   - iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
   - v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
   - i. the immediate actions that have been taken to prevent recurrence, and
   - ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings:

- On February 4th 2011, the Leeds, Grenville and Lanark District Health Unit assigned an outbreak number (#2243-2011-008) for an outbreak of enteric illness at Wellington House Nursing Home.
- The Administrator of the home contacted the Ministry of Health and Long Term Care (MOHLTC) - Ottawa Service Area Office on March 31st, 2011 to inform of the enteric outbreak and to advise that she was experiencing technical difficulties when attempting to submit the written report through the MOHLTC's Critical Incident Reporting System.
- The written report should have been submitted by February 13th 2011 and it was submitted on April 5th, 2011.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Jessica Lapensée
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). June 3, 2011