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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 9, 2016	2016_393606_0003	011027-15	Critical Incident System

Licensee/Titulaire de permis

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

Long-Term Care Home/Foyer de soins de longue durée

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

JANET GROUX (606)

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): February 16, 17, 18, and 19, 2016.

The following Critical Incident (CI) inspection was inspected during the time of this inspection: #004576-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), and Personal Support Workers (PSW).

During the course of the inspection, the inspector conducted observations of residents and home areas, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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).

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 there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Review of a Critical Incident Report (CI) indicated resident #002 fell in an identified area of the home while being transferred by a staff member without the assistance of another staff member which required the resident to be transferred to the hospital and diagnosed with a medical condition.

Review of resident #002's current plan of care stated resident requires "extensive assist x 1; assist x 2 prn (i.e in the morning)".

Interview with PSW #115 revealed that he/she transferred resident without the assistance of another staff member on the identified date and confirmed resident was not following directions during the transfer causing him/her to spin around and fall to the floor.

Interviews with PSW #115, #116, #117, and RPN #118 revealed resident requires one staff to provide assistance some days and requires two staff assistance for transfers on days when resident is observed to be unsteady, when not feeling well and when not

following directions. They confirmed the written plan of care does not provide clear directions to staff and others who provide direct care to the resident.

2. The licensee has failed to ensure that that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change.

Review of resident #002's progress notes revealed a change in condition related to a fall on an identified date causing increased pain to an identified area of his/her body. Review of the physician's orders indicated resident to receive an identified pain medication orally every hour when needed for pain. Further review of the resident's monthly pain evaluation on an identified date indicated previous interventions to manage resident's pain such as:

-relaxation techniques;
-heating pad;
-encouraging resident to raise legs on bed; and
-turning and repositioning;

A review of the current written plan of care did not include the increased pain.

Interview with RPN #118 revealed the expectation is for the plan of care to be updated when there is a change in the resident's condition and confirmed the written plan of care was not updated to reflect resident #002's change in pain status.

Interview with the DOC confirmed the plan of care must be updated when there is a change in condition. [s. 6. (10) (b)]

3. The licensee failed to 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 the care set out in the plan has not been effective.

Review of a CI indicated resident #002 fell in the bathroom while being transferred by a staff member without the assistance of another staff member which required the resident to be transferred to the hospital and diagnosed with a medical condition.

Review of a home's policy indicated “effective pain assessment and management is multidimensional in scope and requires coordination interdisciplinary intervention.

However, registered staff are the primary team members involved in assessing pain, effectiveness of treatments, and the presence of side effects. Registered staff requires a strong understanding of the key areas of assessment and must be able to gather evidence of uncontrolled pain or symptoms of side effects and communicate this to other team members. They are legally and ethically obligated to advocate for change in the treatment plan where pain relief is inadequate."

Review of resident #002's progress notes revealed resident was exhibiting signs of pain related to a fall he/she had on an identified date.

Review of a pain assessment conducted on an identified date indicated resident stated the pain is specific to two identified areas of his/her body and rates his/her on a scale of one to ten to be ten. The pain assessment concluded resident's pain was most likely to be caused from the fall on an identified date.

Review of resident #002's clinical health records on an identified date revealed a physician order for a pain medication to be administered every hour or as needed. Four days later, another physician order was obtained with changes to the dose and frequency of the identified pain medication.

Review of resident #002's clinical records revealed resident was administered the identified medication 11 times as mentioned during the identified dates and was documented as ineffective six out of the 11 times.

Interview with RPN # 104, #105, and #118 revealed when the current interventions are no longer effective in managing the resident's pain, the physician is notified via email to communicate the need to make changes to the treatment plan.

Interview with the DOC revealed when there is a change in resident's pain level and the current interventions are no longer effective, a pain assessment must be conducted and communicated to the physician to make changes to the treatment plan in managing the pain and confirmed this was not completed.

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;

to ensure that that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change in regards to pain management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of a CI indicated resident #002 fell in an identified area of the home while being transferred by a staff member without the assistance of another staff member which required the resident to be transferred to the hospital and diagnosed with a medical condition.

Review of resident #002's progress notes and current written plan of care revealed resident experiences chronic pain to an identified area of his/her body. Review of the progress notes revealed resident verbalized daily of increased pain after falling on the identified date. A further review of the progress notes revealed resident #002 complained of severe pain multiple times throughout a 24 hour basis for several days in a row. When pain medication was administered it was found to be ineffective to manage the resident's pain. The resident requested to be transferred to the hospital for further assessment. Resident #002 was diagnosed with a medical condition that was contributing to the intensity of the pain being experienced.

Review of a home's policy indicates when a resident appear to have pain, a Pain Assessment or PAINAD (Pain Assessment in Advanced Dementia (UDAs in PCC) [User Defined Assessment in Point Click Care] is to be completed and the results documented.

Review of resident #002's clinical records revealed a pain assessment was completed the day after the resident fell. Review of a pain assessment conducted on the identified date, indicated resident stated the pain is specifically in two identified areas of his/her body rates his/her pain on a scale of one to ten to be ten. There were no pain assessments records other than the one conducted as mentioned above was available for review.

Interview with RPN #118 revealed the home completed a pain assessment only on the identified date, and no other time after that as the resident was transferred to the hospital. RPN #118 confirmed that it is the expectation of the home to complete the pain assessment located in PCC each time a resident's pain has increased and/or not relieved.

Interview with the RN #103 and DOC confirmed that when a resident is exhibiting new pain or an increase in pain, a pain assessment in PCC must be initiated. [s. 52. (2)]

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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 25th day of May, 2016

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

Original report signed by the inspector.