Committee Report

To:	Chair Burley and Members of the Committee of Management
Committee Date:	February 12, 2019
Subject / Report No:	LTCR-CM-14-19
Title:	Grey Gables 2018 Resident Quality Inspection
Prepared by:	Jennifer Cornell, Administrator
Reviewed by:	Lynne Johnson, Director of Long Term Care
Lower Tier(s) Affected:	All Grey County
Status:	

Recommendation

1. **That Report LTCR-CM-14-19 regarding the Grey Gables 2018 Resident Quality Inspection be received for information.**

Executive Summary

A Resident Quality Inspection (RQI), conducted by Compliance Officers with the Ministry of Health and Long-Term Care, was completed on October 18, 19, 22, 24, 26, 29, 30, 31, November 1 and 2, 2018. During the course of the RQI the inspector reviewed Critical Incidents and Complaints. Two compliance orders from a previous visit were also reviewed and returned to a compliant status.

The inspectors toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, policies and procedures, internal investigation notes, training records and minutes of meetings.

Background and Discussion

The following Inspection Protocols were used during the inspection: Continence Care and Bowel Management, Critical Incident Response, Dignity, Choice and Privacy, Dining Observation, Falls Prevention, Family Council, Hospitalization and Change in Condition, Infection, Prevention and Control, Medication, Nutrition and Hydration, Pain, Personal Support Services, Prevention of Abuse, Neglect and Retaliation, Reporting

and Complaints, Residents' Council, Responsive Behaviours, Safe and Secure Home, Skin and Wound Care, Sufficient Staffing.

The outcome of the inspection included 12 Written Notifications (WN), 5 Voluntary Plans of Correction (VPC) and 2 Compliance Orders. The various finding types are outlined on the following table with the order of severity listed from the lowest to highest.

Finding	Description
Written Notice (WN)	Evidence that not all information was found readily available as per the regulation
Voluntary Plan of Correction (VPC)	It is recommended that a plan of action be put in place to ensure sustained follow up
Compliance Order (CO)	The inspection found the regulation had not been followed
Directors Referral (DR)	Sustained non-compliance is found and the Director of the Performance, Compliance and Inspection Branch (MOHLTC) will review the home's record
Work and Activity Order (WAO)	Ministry staff will be on site regularly to ensure safe operations of the home

In total, there were 7 (seven) areas of non-compliance which are summarized as follows:

1. **Medication Management: Medication policies need to be followed and medication incidents reported.**

a) Corrective Actions

i. Re-education provided on the process of medication incident management, including reporting to MOHLTC and to police

ii. Medication incidents reviewed monthly at Resident Quality and Safety Meetings and quarterly at Professional Advisory Committee

iii. Incidents tracked and trended

2. Annual Program Evaluations: There must be a written description of each program that must include goals and objectives, relevant policies and procedures and each program must be evaluated and updated annually.

a) Corrective Actions

i. Review and update process for ensuring the completion of Annual Program Evaluations including quarterly review the Leadership and Quality Committee Meeting

ii. Re-education regarding the completion of Annual Program Evaluations with the appropriate team leads

iii. Monitor the completion of goals/objectives according to target dates, review quarterly and ensure documentation is completed

3. Plan of Care and Documentation: The plan of care must be collaborative, integrated and consistent and the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified. The plan of care is to be reviewed and revised at least every six months and at any time a goal is met or when the resident's care needs change.

a) Corrective Actions

i. Re-education of staff on ensuring that care and services are implemented/provided as specified in the care plan, with a specific focus on nutrition and hydration and physiotherapy

ii. Meeting with Physiotherapy provider to ensure PTA staff were attending the home as scheduled

iii. Weekly documentation audit implemented specific to Physiotherapy

4. Communication and Response System: Ensure the all residents' call bells are easily seen, accessed and used by residents, staff and visitors at all times.

a) Corrective Actions

i. Re-education of all staff to reinforce the need for accessibility of call bells

ii. Audit implemented for testing compliance to this standard

6. 24/7 RN Coverage: A Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present at all times.

a) Corrective Actions

i. Recruitment of Registered Nurses

ii. Recruitment of an Associate Director of Care

iii. Review and update staffing contingency plan to include backup plan

iv. Contract with a nursing agency to provide RN coverage when regular staff are not available

7. Prevention of Abuse and Neglect; Every licensee of a long-term care home shall protect residents from abuse by anyone. Reporting of abuse and neglect, suspected or actual needs to occur immediately and investigated.

Note: An investigation was initiated and completed, at the time of incident, and resulted in the termination of two staff.

a) Corrective Actions

i. Re-education of all staff on the policy entitled Prevention of Abuse and Neglect of a resident

ii. Re-education for registered staff regarding the Ministry of Health and Long-Term Care algorithms and reporting timelines

iii. Evaluate staff knowledge and understanding of mandatory reporting

Legal and Legislated Requirements

Long-Term Care Homes Act, 2007- Part IX Compliance and Enforcement Inspections

Ontario Regulation 79/10- Part IX Compliance and Enforcement

Long Term Care homes are inspected on a regular basis by Ministry of Health and Long-Term Care Inspectors. The results of the inspections are public and available on the ministry website and posted publicly in the home.

The public inspection report was received December 6, 2018 and action plans have been developed and implemented.

Financial and Resource Implications

Considerable oversight is required to support compliance requirements. Staff are working to implement structures and processes to guide activities that align with regulatory requirements.

Relevant Consultation

X Internal Grey Gables Leadership Team

X External Sienna Clinical Partners

Appendices and Attachments

Public Copy MOHLTC Inspection Report December 6 2018