MINISTRY OF HEALTH AND LONG TERM CARE RESIDENT QUALITY INSPECTION – 2016 Macassa Lodge

RQI Finding	Description	Action
CO#001 2015_210169-0008	2015 Compliance Order relating to bedrails removed.	Work to address Compliance Order began in August 2015 and continues. No concerns found during this RQI so CO has been removed.
WN#1 VPC#1 - Compliance with Policies	Policies are implemented to ensure compliance with LTCH Act / Regulations &/or to promote quality care a. One resident was not assessed three of nine shifts after returning from hospital. (November 2015) b. Head Injury Routine was not completed on one resident after two unwitnessed falls and post fall documentation was not completed on one resident on every shift for a minimum of twenty four hours post fall. (December 2015- March 2016) c. Plan of care did not include an updated Bed-Rail Risk Assessment for two residents. (September 2015 to March 2016)	a. Lodge policy to assess and document resident condition each shift x 3 days exceeds Ministry expectations. Staff will continue with current practice to ensure quality of care and increase our audit activities to ensure we have adherence to internal policies. No resident effect. b. Failure to thoroughly document Head Injury Routine and Post Falls Assessment was reviewed with all registered staff at Mandatory Training in May 2016. Will audit for adherence. Current practice not a Ministry expectation. No resident effect. c. Two residents had change in bedrails with evidence of assessment in the clinical record but non-completion of formal assessment tool. Residents were not at risk; will increase audits to ensure adherence to policy.

	d. Water was not available on nourishment cart as an option for residents in addition to other beverages. (April 2016)	d. Review with Staff the expectation to include water in nourishment pass in addition to juices. Water usually available on cart and always at request.
	e. Three residents were weighed and re-weighed beyond the time limit outlined in our policy, after unplanned weight loss. (March 2016)	e. Will convene a collaborative meeting with Nursing and Dietician to educate, make changes to the current process and determine factors contributing to sporadic non-compliance. Audits will be increased
WN#2 VPC#2 - Safe Transferring and Positioning	Staff shall use safe transferring and positioning devices or techniques when assisting residents. a. A resident's foot slipped off the wheelchair when a Velcro safety strap was not applied correctly and came undone.(January 2016)	a. Resident incident was investigated at time of occurrence. Staff received re-education following incident and all staff reinstructed during Mandatory Training in May 2016. Resident sustained superficial injury.
WN#3 VPC#3 - Skin and Wound Care	Residents exhibiting altered skin integrity shall receive an initial assessment and will be assessed weekly by a member of the registered nursing staff. a. Resident with small scratches to the top of hand did not receive a skin assessment. (April 2016) b. Weekly Wound Assessment Flowsheet was not completed for a resident with an ongoing area of altered skin integrity. (April 2016)	a. Review of Lodge policy reviewed at Mandatory Training. Monitoring is ongoing b. Review of Lodge policy reviewed at Mandatory Training. Monitoring is ongoing. Area was being monitored and treated by staff.

WN#4 VPC#4 -Dining and Snack Service	Service of meals will be course by course. a. Desserts were served prior to completion of main course at lunch on one day. (April 2016) While assisting resident in eating, proper techniques like safe positioning of the resident is essential. b. Three residents in tilt wheelchairs were not seated in a position as per their care plan while eating their meal. (April 2016) Appropriate furnishings at a height appropriate to meet resident's needs will be provided. c. One resident was observed to be seated at a table that was too high to eat comfortably. (April 2016)	a. Review of proper meal service procedures will be done at upcoming staff meeting. Regular audits will continue for meal service which can identify and correct issues. b. Joint communication plan between Nursing and Dietary will be developed and delivered regarding safe positioning. Regular dining room audits will continue and issues will be addressed at the time. c. Staff accommodated 2 residents who requested to sit together for meals. Residents were in appropriate seating, resulting in different heights. Look to find a furniture manufacturer who supplies tables with adjustable heights. Samples will be requested and trialed. Collaborate with Dietary and Nursing Teams

WN#5 VPC#5 - Housekeeping	Procedures for cleaning and disinfecting resident care equipment are in accordance with manufacturer's specifications and in accordance with evidence-based practices. a. An area of dry debris noted near drain of one bath tub and on the underside of two bath chairs. (March 2016)	a. Cleaning of equipment is completed by nursing staff after each use; will continue with this expectation and remind that full cleaning is required. Discuss potential to have Housekeeping assist on a weekly or monthly for deep cleaning.
WN#6 VPC#6 - Physical Restraining Devices	Physical Restraining devices must be applied according to manufacturer's instructions. a. Seatbelt was observed to have a five finger width between the belt and resident's torso – should have been a two finger width. (March 2016)	a. Seatbelt was readjusted at time of incident. Review of restraint application with all Lodge staff at Mandatory Training in May 2016 completed
WN#7 VPC#7 - Medication Administration	Drugs may only be administered when prescribed for the resident. a. A medication order was transcribed into an incorrect residents chart subsequently a medication was given to the incorrect resident. (October 2015)	a. There was no injury to resident. Error was reported by a Registered Staff member at time of occurrence (Oct 2105) in accordance with our Medication Incident Reporting policy. Re-education was provided to the staff member. Medication Administration & Safety reviewed with all Registered Staff yearly at Mandatory Training.

WN#8 - Plan of Care	Multidisciplinary collaboration in the assessment of residents. Assessments shall be consistent and integrate with each other. a. Review of care plans showed 8 examples of inconsistent assessments were noted. (Instances occurred between May 2014 and January 2016) Assessments and care plans shall be reviewed and revised every six months. b. The written plan of care was not updated for one resident when the care needs changed related to transfers. (March 2016)	a. Resident safety was not compromised due to inconsistencies. Ongoing audits continue but should anticipate given volume and complexity of documentation that this issue will continue to be identified. This Written Notification is one of the most often cited across the province. b. As above. Appropriate lift for resident need was used by staff. Care Plan was updated.
WN#9 - Doors in the Home	All doors leading to non-residential areas are to be kept closed and locked when not supervised by staff. a. One soiled utility room and one staff washroom were found unlocked and unattended. (March 2016)	a. Doors were closed and locked immediately. Ongoing monitoring and audits. Review of expectations with all staff across departments.
WN#10 - Bed Rails	When bedrails are used the resident was assessed and his/her bed system is evaluated in accordance to evidence based practices.	

	a. A resident's bed rail assessment was not updated as required. (April 2016)	a. Resident assessment was updated with correct information. Issue relates to Bed Entrapment audits being completed annually and with any change in bed equipment. Process to complete these entrapment assessments being developed at time of Compliance visit and will be implemented by June of 2016.
WN#11 - Plan of Care	A resident's care plan did not reflect that the resident preferred to stay in bed longer in the morning. (November 2015)	a. One instance noted. Resident's choice was maintained. Preference changed from time to time in which staff would adjust. Reviewed with registered staff and will monitor ongoing.
WN#12 - Personal Assistive Safety Device	A resident's tilt wheelchair was found not to be in the position preferred by the substitute decision maker. (April 2016)	a. Issue to be explored more fully. Substitute Decision Maker may require more information and assistance in making decisions that support resident's comfort and care.
WN#13 - Menu Planning	Planned menu item shall be offered and available at nourishment. a. Fresh fruit was the planned menu item for morning nourishment. Whole fruit was observed but there was no option of pureed fruit. (April 2016)	a. Morning Nourishment requires that only beverages be provided as per MOHLTC Standard. Fresh fruit is requested by some residents and therefore is placed on the cart as an option. PM/HS (afternoon and nighttime) Nourishments include food items which are available as required. A review of the nourishment menu has been completed and based on the evaluation, adjustments have been implemented.

WN#14 - Food Production	Food production shall provide for preparation of all planned menu items. a. Pre-cut prepared melons were served when the recipe called for fresh melons. (April 2016) Foods shall be prepared using methods to preserve taste nutritive value appearance and food quality. b. Vegetables were observed to be too soft and mushy. (August 2015- April 2016)	a. A review of the menu and items purchased has been completed. Adjustments in purchasing practises have been implemented. b. Current methods of production will be reviewed and the end product results. Production processes will be corrected and reanalysed as needed to achieve consistent quality for service. Continue to work through Food Council to address meal and food quality.
WN#15 - Notification re: incidents	The resident and substitute decision maker shall be notified of the results of an investigation of abuse or neglect when complete. (January 2016) a. The results of an internal investigation into an unsubstantiated allegation of abuse were shared with the complainant and not with the Substitute Decision Maker.	a. Substitute Decision Maker was aware of allegation and initiation of investigation. Complainant was advised of the outcome. Review of process steps and follow-up expectations was completed with Nurse Leader.

WN#16 - Dealing with Complaints	A documented review of complaints and concerns must be reviewed and analyzed quarterly. a. A quarterly review of the record of complaints was not documented.	a. Quarterly review of complaints has been consistently completed but should include sign-off. Will incorporate this review and documentation into a quarterly schedule at Management Team Meetings.