Villa RQI Update
Required Actions, Planning, Accountability and Sustainability

St. Joseph's Villa Dundas

November 1, 2018

The Villa received their annual inspection from May 2nd to May 25th, 2018. This inspection as well as follow up to last year's inspection, 5 complaints, 18 critical incidents, 9 follow ups, 4 inquiries and 33 triggered inspection protocols. There were a total of 7 inspectors present. The inspection was considered an 'intensive risk focused' inspection. The licensee report for this inspection was received July 23, 2018 and the public copy provided on August 28th, 2018.

We are pleased to advise that our results show a dramatic improvement from the 2017 Report and our written "Orders" and "Written Notifications" are at the lowest level as compared to prior years. Please see below:

St. Joseph's Villa Compliance History		
Annual Resident Quality Inspection (RQI)		
Year	**Compliance Order's**	**Written Notifications**
2014	17	24
2015	9	19
2016	3	17
2017	6	29
2018	2	16

The two orders we received are related to two key areas. One area is related to resident to resident behaviours. This order is specific to two residents and must be in compliance by August 7th, 2018. The second order is related to "Skin and Wound" specific to weekly skin and wound assessments. This order is related to all residents with altered skin integrity and must be in compliance by September 5th, 2018.

This improved inspection is a credit to the entire Villa team - our board members, leadership team, all staff, managers, physicians, and volunteers together with support from our residents and family members - so thank you! That being said there are opportunities for further improvement in our service to those in our care and we will continue to focus on our priority areas – especially our strategies for S*ustainability.* We will be working diligently over the coming weeks and months to address the areas of non-compliance and encourage feedback from all stakeholders.

Definitions of Levels of Non-Compliance:

a) **Written Notification**: Communication to the Licensee by an inspector that an area of non-compliance has been identified under the LTCH Act with specific detail on the section of the Act or Regulations this pertains to.

b) **Voluntary Plan of Correction**: The inspector can make a written request for the licensee to prepare a written plan of correction for achieving compliance to be implemented voluntarily. The licensee/Home is not required to submit the plan to the ministry. There is no required compliance date set out in the inspection report.

c) **Compliance order:** An inspector or the Director may order a licensee to do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act; or prepare, submit and implement a plan for achieving compliance with a requirement under the Act.

d) **Work and activity orders:** An inspector or the Director may order a licensee to allow employees of the Ministry, or agents or contractors acting under the authority of the Ministry, to perform any work or activity at the long-term care home that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under the Act.

e) **Written Notification and referral to Director:** The inspector may issue a written notification to the licensee and refer the matter to the Director for further action by the Director.

	Areas of identified improvement requirements from MOH	Status	Strategies in place and/or underway for RQI follow up Green: Complete Yellow: Underway Green/Yellow: considerable work has been completed and more work is underway.	MOH Due Date
CO #1 & WN #1	**Duty to Protect**			
1. Sec. 19	• *Abuse and Neglect (Resident to Resident Behaviour)*		• Interdisciplinary plan of care review of specific residents (2) identified to ensure interventions are in place and effective, with ongoing monitoring. • Prepare and implement the plan, to be developed by the interdisciplinary team for the specific residents, inclusive of care plan, safety plan, and family involvement in plan to ensure that co-residents are protected from abuse. • Plan should be written and evaluated in the residents' health care record. • Evaluate the effectiveness of the plan at weekly risk rounds and document in the resident(s) health care record (ongoing evaluation through weekly Risk Rounds format).	• August 7, 2018. • No submitted plan required by the Ministry of Health and Long Term Care.
CO #2 & WN #2	**Skin and Wound**			
2. Sec. 50	• *Skin and Wound*		• Review and audit of 4 specified residents as well as all other resident with altered skin integrity (completed August 2018) • Complete audit of ALL clinical records remaining, for residents with altered/potential altered skin integrity using developed audit/tracking tool (completed August 2018). • Once all altered skin integrity identified/confirmed; ensure that assessment is completed, current and reflective on plan of care, as well as ongoing for compliance and weekly completion through ongoing documented audits. • Interdisciplinary team review of policy, practice, tools, and user defined assessment, education and programs relative to skin and wound practice. Altered skin integrity reflects rashes, ulcers, skin tears etc. as per Regulations and policy. • Ongoing weekly audits to ensure completion and sustainability of the required assessments	• September 5th, 2018 • No submitted plan required by the Ministry of Health and Long Term Care.

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			through champion wound care model. New supportive clinical skin and wound position started August 13th, 2018. Ongoing audits and follow up successful for completion of weekly assessments as required.	
WN #3 VPC	**Plan of Care (Item noted in CIS as in plan, and in place when on site, but not in written plan of care)**			No due date or submitted plan required by the Ministry of Health. Team goal is to have all individual issues addressed by late September 2018, and all Education and Training completed by late December 2018.
	• Review of policy and risk assessment relative to plan of care, and review with registered staff and nurse management team importance of all interactions being within the plan of care. • Review of expectations that plan of care changes should be reviewed during shift report/transfer of accountability. • Ensure that developed interventions are not only physically in place, but written in the plan of care.			
WN #4 VPC	**Reporting to the Director (Incident occurred, not reported within time frame required)**			
	• MOHLTC memo "Clarification of Mandatory and Critical Incident Reporting Requirements" sent to all registered staff and managers via email and in staff communication books on home areas (August 31, 2018) as a reminder, as well as reviewed through staff meetings. Memo remains on unit with guidelines for reporting as well (audit completed August 2018). • Reminder to staff that the on-call manager is always available, if concerns or questions arise regarding reporting. • Copy of memo from MOHLTC re "clarification of incident reporting requirements/critical incident reporting requirements" placed in on call binder added to orientation for new staff. • Updated memo from MOHLTC regarding reporting received (received August 31, 2018) and sent to teams September 2018.			
WN#5 VPC	**Plan of Care (Plan of care missing falls focus, Palliative care measures not noted in plan of care, Plan of care not updated based on hydrations status)**			
	• Review with relative teams, that upon return from hospital – importance of updating diagnosis in PCC, and updated interventions to reflect this including but not limited to diagnosis, falls, palliative measures, hydration, intake, and skin and wound interventions. • Review expectation that plan of care is reviewed / updated at a minimum at admission, with significant change and quarterly. • Nurse Management team supporting plan of care requirements, utilizing information obtained during daily huddles and resident home area rounds.			

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WN#6 VPC	**Falls Prevention and Management (Post Fall Assessment not completed)**			
	• Reviewed with team, to ensure that post fall assessments completed as per policy for residents, regardless if they have left the home to hospital. • Resident Care Managers oversee completion of post fall assessments, and lead falls' huddles weekly through tower team meetings.			
WN#7 VPC	**Behaviours and Altercations (VAT bracelet not in place as per plan of care, 1:1 staffing, Staff were unaware of safety plan)**			
	• Complete audit of all residents identified at high risk per policy who should be wearing VAT bracelet indicator, ensure wearing unless refused and ensure reflective in plan of care accordingly. Completed September 2018. • Have plan in place for residents with 1:1 to provide service or mitigation strategies and plan if 1:1 not in place/available. • Review expectations of report and transfer of accountability, review of resident list and ensure staff is aware of resident(s) with high VAT score / have care plan and /or safety plan for relative behaviours and ensure this is reflective in plan of care and readily available to staff.			
WN#8 VPC	**Training (Education not at 100% for all direct care staff (Infection Control, Abuse/Neglect, Hand Hygiene) & (Lap Belts not on as per manufacturer's instructions – and no information in available resource binder)**			
	• New plan for completion of annual education, where designated staff will begin reminder through phone calls and emails in October. Then re-check and complete further follow up in November. Staff will then be assigned to come into home to complete the education, so completion rates can be at 100% as required. • Manufacturer's Instructions book to be updated to reflect more information on seat belts (Completed August 28, 2018), as well as complete blitz education/marketing on this and place communication in staff binders, email, Friday Flyer etc. Accountability for maintaining this manual has been assigned. • Orientation reviewed to ensure coverage of required education.			
WN#9 VPC	**Infection Prevention and Control (Signage not on doors, PPE not readily available, Staff unaware resident was unwell)**			
	• IPAC lead now has support through additional role, to ensure that during outbreaks, all appropriate measures are in place. Line listing to be updated to reflect check box for initiation of PPE (done Sept 2018 season outbreak), and re-instruction and reminders to be provided regarding review of the line listing during shift report so that all staff are aware of who is ill. • Review with registered staff and nurse management team that those with infection control considerations need to have plan of care updated accordingly. • New designated area for all infection control PPE holders, so equipment is readily available.			

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	• Post outbreak review tracking tool developed and implemented to easily identify trends in outbreak management so that mitigation strategies can be implemented as necessary.			
WN#10 VPC	**Following our own policy for medication administration (Staff not ALL provided education on Nursing Standard – Medication Administration, based on part of previous order)**			
	• Completion of education on Nursing Standard – Medication Administration for registered staff, as well as any relative practice changes. • Orientation reviewed, to ensure that Medication Administration standard reviewed at time of hire. • Additional training for 'champion' group of electronic medication administration requirements (Completed August 2018).			
WN#11 VPC	**Physical Devices (Pelvic Support guidelines not followed and lap belt too loose, Staff unable to find manufacturer's instructions)**			
	• Link with WN #8 follow up – Manufacturer's Instructions book to be updated to reflect more information on seat belts/guidelines, as well as complete blitz education on this and place in communication in staff binders, email, Friday Flyer etc. • Policy review to ensure all devices represented. • Therapy team to continue ongoing audits of seatbelt application, and address concerns at time of audit if findings arise.			
WN#12 VPC	**Administration of Drugs (Relative to medication incident and follow up)**			
	• Review of medication incident reporting, and policy. Incidents reviewed and shared with registered staff at meetings. • Medication Incidents as standing agenda item for registered staff meetings, reviewed quarterly at Medication Management committee and bi-annually at the Continuous Quality Improvement Committee. • Continue 'Just Culture' for reporting of incidents, to remove culture of blame and encourage culture of reporting and safety.			
WN#13 VPC	**Infection Prevention and Control (Items not labelled in bathrooms, resident with symptoms not on line listing)**			
	• Complete random audits to ensure that personal items are labelled in shared washroom – Initiated audits in August 2018, with monthly ongoing audits being completed and documented. • Ensure staff is following policy and protocol to add residents to line listing based on symptoms and policy.			

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	• IPAC staff to ensure those with symptoms are on the line listing as required through random audits, and capture through NM huddles.			
WN#14	**Bedrails (Bedrail assessment not completed)**			
	• Ensure that entrapment assessment (inclusive of resident and bed system) completed for every resident. • Complete audit of all bed systems and health records to ensure completion of entrapments assessment – Initiated August 1, 2018 with reviewing which residents have old entrapment assessments (Goldcare or paper) with plan to complete in PCC with goal date of fall 2018. Completed October 2018.			
WN#15	**General Program Requirements (PASD/Flow sheets monitoring form not in resident chart, blank documented in PSW flow sheets)**			
	• Ensure appropriate documentation in place for each resident with a PASD/Restraint for monitoring. • Complete random audits of flow sheets for completion and follow up with staff where completion is lacking completed October 2018. • Review of restraint/PASD policy and practice.			
WN#16	**Report re: Critical Incidents (Reported late *This incident occurred before the 2017 RQI and was identified during this RQI*)**			
	• Link with WN #4 follow up - Ensure that critical incidents are reported as required in Act/Regulations. • Ensure staff has tools/resources to report concerns at time of occurrence, or resource if unsure of reporting requirements.			