DOES THE LEFT HAND KNOW WHAT THE RIGHT HAND IS DOING?

THE CASE OF HAWTHORNE PLACE

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SENIORS FOR SOCIAL ACTION ONTARIO

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An inspection report dated July 2, 2020 shows that inspectors were present on-site at Hawthorne Place on May 13, 14, 15, 19, 20, 21, and 25, 2020 for a complaint related inspection. It was initiated because the Ministry of Long Term Care had received a complaint related to a resident who had been sent to hospital with a temperature and who later died. Under Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 facilities were required to immediately implement active screening of all residents at least twice a day at the beginning and end of the day to identify if any residents who had a fever, cough or other symptoms. In spite of this directive the inspection report shows that especially on evening shifts on 5 identified dates, this was not done with the resident in question (Pg 4). Staffing levels were found to be less than usual and there was a shortage of registered staff in the facility (Pg. 5).

https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25497&FacilityID=20595

Two months after the pandemic began, during this complaints inspection the facility was cited with 1 Written Notice and 1 Compliance Order. Here is what inspectors found:

- "The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices." (Pg 4);
- "The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required." (Pg. 6)

Inspectors were also in this facility during this same period on another Complaints Inspection. This one concerning falls prevention measures not in place and that a resident had fallen resulting in a fracture that was not assessed, that they suffered continued pain, and that it was the family doctor of the person who

ordered the test that showed the injury after the person had been discharged home.

During that inspection, inspectors found that:

- "The licensee has failed to ensure that after resident #001 had a fall, a post fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. (Pg. 4) "The licensee has failed to ensure that the person designated by the resident #002, immediately received the information concerning hospitalization of the resident. s 3. (1)" (Pg 6).

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The details of this situation are pertinent:

"Review of the plan of care indicated resident #002 is potential for specified changes related to their specified diagnosis. In the plan of care, the following interventions were listed:

- Using the holistic perspective of continued monitoring of resident for management of changes to health status.

- Monitor specified test results as per MD order

- Administer medication as per MD order. Monitor effectiveness and for side effects. Review of the test results during an identified six week period revealed fluctuations in a specified range.

Review of Progress notes indicated on an identified date and time, RPN #104 recorded that they received a report that resident #002's test result was high, at the beginning of their shift, and although the last shift left a message for the physician, there was no call back from them.

RPN #104 recorded that a subsequent test check for resident #002 was even higher. They were able to contact the physician on call and received orders. RPN

#104 tested resident #002 again and found the test result continued to increase. RPN #104 tried to reach the physician on call, and as there was no response, contacted the administrator who instructed them to send the resident to hospital. Resident #002 was then transferred to the hospital. During the following shift, RN #124, documented that the SDM was informed about resident #002's transfer to the hospital. Interview with RPN #104 stated, they received the information from the last shift that resident #002 was not doing well and their test result was very high. The transfer decision was initiated as resident #002's test result was very high and they did not respond to the interventions. RPN #104 confirmed that they printed the transfer form to be sent to hospital with the resident, but they did not add any information regarding the SDM contact number as they thought it is included in the transfer form when it will be printed. RPN #104 confirmed that they did not inform the SDM of the resident's transfer and reported it to the next shift. Inspector #764 did a trial run and printed a copy of resident #002's transfer form during the inspection and found the SDM contact number was not specified." (Pg 6/7)

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Findings of the Military During This Same Period

The attached chart details what the military documented during this same period.

- From May 10 through May 16, 2020 the situation in this facility was not stable and throughout this period this facility was unable to self-manage existing cases of COVID-19. New cases were not decreasing. The military charting shows "No Conditions Met" in this regard.
- With respect to appropriate PPE being available and a management plan being established for the facility as well as proper cleaning procedures, waste management, and donning and doffing procedures being in effect, the military charting shows "No Conditions Met" for May 12 through 18, 2020.

- With respect to staffing being sufficient for the number of residents and the availability of civilian medical staff for day and night shifts as well as staff sick leave frequency and percentage not having an impact on effectiveness, the military charting shows “No Conditions Met” for May 10th through 13th”.

Analysis

So essentially infections not properly documented, infection control procedures not in place, staffing not appropriate for the number of residents, and COVID cases not manageable, but inspectors who were on-site during this period did not:

- Issue a Director’s Referral requesting a Cease Admissions order;
- Cite the facility for non-compliances with the Act and Regulations for issues documented by the military re: infection control, staffing, cleaning procedures etc.

Clearly, there was risk of harm and death to residents, and their needs were not being met, yet it appears inspectors did not consider the situation sufficiently high risk to issue Director’s Referrals, and only the Director had the authority to Cease Admissions, order that the facility be placed under management, or that the license be revoked.