Health, Seniors and Active Living

Personal Care Home Standards Review

Tool #2

Regional Health Authority:	Winnipeg RHA
Facility:	Golden Links Lodge
Number of Beds:	88
Review Team:	Kathy Kelly (Manitoba Health, Seniors and Active Living) (MHSAL), Bonnie Lounsbury (MHSAL), and Michael Haip, Winnipeg Regional Health Authority (WRHA)
Review Date (yyyy/mm/dd):	2018/02/14
Report Date (yyyy/mm/dd)::	2018/04/19

Summary of Results

Standard	Regulation	Review Team Rating
02	Resident Council	Met
05	Participation in Care Plans	Met
07	Integrated Care Plan	Met
09	Use of Restraints	Not Met
10	Medical Services	Met
12	Pharmacy Services	Met
13	Health Records	Met
15	Housekeeping Services	Met
19	Safety and Security	Not Met
21	Infection Control Program	Met
24	Staff Education	Not Met
25	Complaints	Met

Summary

Met	**9**
Partially Met	**0**
Not Met	**3**

General Comments:
The Standards Review Team greatly appreciates the work completed by the management and staff of Golden Links Lodge in preparing for the standards review.

Monitoring Tool #2 was randomly selected for this review and the ratings assigned by the Standards Review Team to each standard in this tool are noted in the table above.

For those standards relating to resident health records, a sample of records was selected from the resident list provided by the facility. The health records reviewed by the Standards Review Team included, at minimum, one record for a newly admitted resident, one record for a longer-term resident, and one record for a resident for whom a restraint had been ordered.

Findings:
Nine of the 12 standards reviewed were assigned a rating of Met and three standards was assigned a rating of Not Met.

A priority for action is compliance with any standard that is rated as other than Met and any performance measure in a core standard rated other than Met. Steps must therefore be taken by Golden Links Lodge to comply with the following unmet Standards, Standard 9 - Use of Restraints; Standard 19 - Safety and Security and Standard 24 - Staff Education.

The facility is further encouraged to take steps to meet all performance measures, including those where the standard was found to be met.

Standard 2: Resident Council

Reference: *Personal Care Homes Standards Regulation Sections 5 & 6*

Resident Council

The operator shall ensure that reasonable assistance is given to residents and their designates to help them establish and maintain a resident council.

The purpose of the resident council is to provide a forum where issues, that concern residents, can be discussed including the services provided to residents in the PCH.

The resident council may consist of residents, their designates and any other persons that the council considers appropriate.

Suggestions and concerns raised by the council

The operator shall ensure that a concern raised by the resident council is addressed, including an investigation of the concern if necessary, and that a response, or a preliminary response, is provided to the council at or before its next meeting.

The minutes of the council's meetings must be posted in standard CNIB print (Arial font, size 14 or larger) in a location that is prominent and easily accessible by residents and staff.

Expected Outcome: Residents have a forum to freely discuss their concerns and issues and the management of the home responds to this same forum.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
2.01	**There is evidence that the resident council meets, at a minimum, five times per year.**	Met	Resident council meets monthly. Policy SW-OEP-R-2 reviewed January 8, 2018.	Met	
2.02	Terms of Reference of the resident council meetings provide evidence that residents are encouraged and supported in bringing forward issues and concerns.	Met	Reviewed annually, next review date Feburary 1, 2018. Policy SW-OEP-R-2 revised January 8 2018.	Met	
Minutes of the resident council meetings provide evidence that the residents' issues and concerns are:					
2.03	• Documented;	Met	Each resident concern is documented and forwarded to manager/department to resolve and/or provide response for next meeting. The responses are then shared with the resident council and further action taken if required.	Met	Improvement noted in the 2017 minutes.
2.04	• Investigated;	Met	see above	Met	
2.05	• Responded to at the next resident council meeting; and	Met	see above	Met	
2.06	• Followed-up on in a timely fashion	Met	see above	Met	

Scoring methodology:

- The bolded measure (**2.01**) is a pass/fail performance measure. If it is not met, the standard is not met. If it is met, the other measures are considered before assigning an overall rating to the standard.
- Of the 5 other measures:
  - If ≥ 4 measures are met, standard is met.
  - If 3 measures are met, standard is partially met.
  - If ≤ 2 measures are met, standard is not met.

Result: All performance measures are met.

The standard is: Met

#	Measure	Facility Rating	Comments	Review Team Rating	Comments

Comments:

Standard 5: Right to Participate in Care
Reference: *Personal Care Homes Standards Regulation, Sections 9 & 10*

Resident's right to participate in care
The operator shall ensure that a resident and his or her designate and legal representative are given an opportunity to participate in assessing, planning, providing for, monitoring and evaluating the resident's care.

Resident's wishes
The operator shall ensure that the resident's wishes are considered when a care plan is developed or amended.

Expected Outcome: Residents receive care in accordance with their wishes.

Performance Measures:

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
There is documented evidence on the resident's health record that the resident and their representative have had the opportunity to participate in:					
5.01	• **The development of the initial care plan (completed within 24 hours of admission);**	Met	Upon admission nurse complete's IPN note. Paper Care Plan is completed within 24 hours. This is outlined in GLL policy # N-C-1.	Met	Six resident health records were reviewed.
5.02	• **The development of the integrated care plan (completed within eight weeks of admission), and;**	Met	Integrated Care Plan is completed 8 weeks after admission and discussed at initial Care Conference. This is outlined in GLL policy # N-C-2	Met	
5.03	• **The annual care conferences.**	Met	SW compiles the annual initial Care Conference schedule which is posted on each unit and sent to all relevant departments. SW ensures all summaries from	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			each department are complete for day of conference and facilitates interdiscplinary meetings. Policy SW-OPEC-1, SW-OPE-C-2 and SW-OPOE-F-1. SW		
Scoring methodology: All performance measures (**5.01, 5.02, 5.03**) are pass/fail measures for the standard. If any one of the measures is not met, the standard is not met.					

Result: All performance measures are met.
The standard is: Met
Comments:

Standard 7: Integrated Care Plan
Reference: *Personal Care Homes Standards Regulation, Section 11, 12, 13 & 14*

Initial care plan
Within 24 hours of admission, the operator shall ensure that the following basic care requirements for the resident are documented:

a) medication, treatment and diet orders;
b) the type of assistance required for activities of daily living; and
c) any safety or security risks.

Integrated Care Plan
Within eight weeks after admission, the operator shall ensure that each member of the interdisciplinary team assesses the resident's needs and that a written integrated care plan is developed to address the resident's care needs.

The integrated care plan must include the following information:

a) the type of assistance required with bathing, dressing, mouth and denture care, skin care, hair and nail care, foot care, eating, exercise, mobility, transferring, positioning, being lifted, and bladder and bowel function, including any incontinence care product required;
b) mental and emotional status, including personality and behavioural characteristics;
c) available social network of family and friends, and community supports;
d) hearing and visual abilities and required aids;
e) rest periods and bedtime habits, including sleep patterns;
f) safety and security risks and any measures required to address them;

g) language and speech, including any loss of speech capability and any alternate communication method used;
h) rehabilitation needs;
i) preference for participating in recreational activities;
j) religious and spiritual preference;
k) treatments;
l) food preferences and diet orders;
m) any special housekeeping considerations for the resident's personal belongings;
n) whether the resident has made a health care directive; and
o) any other need identified by a member of the interdisciplinary team.

Where appropriate, the integrated care plan must also state care goals and interventions that may be taken to achieve these care goals.

Review of the integrated care plan
As often as necessary to meet the resident's needs, but at least once every three months, the operator shall ensure that appropriate interdisciplinary team members review the integrated care plan and amend it, if required.

The operator shall ensure that each team member reviews each integrated care plan annually and that any amendments required to meet the resident's needs are made.

Staff to be made aware of current plan
The operator shall ensure that the staff who provide direct care and services to the resident are aware of the resident's current care plan. If the method of communicating the plan includes preparing a summary for staff to refer to, the operator shall ensure that the summary accurately reflects the current plan.

Expected Outcome: Beginning at admission, residents consistently receive care that meets their needs, recognizing that residents' care needs may change over time.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
7.01	**Integrated care plans are maintained as part of the permanent resident health record**.	Met	GLL policy # N-C-2	Met	Six Integrated Care Plans (ICPs) were reviewed.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
Within 24 hours of admission, basic care requirements for the resident are documented, including:					
7.02	• Medications and treatments;	Met		Met	
7.03	• Diet orders;	Met		Met	Five of six ICPs noted diet orders for the first 24 hours. The one ICP not met was missing food allergy as documented in the health record.
7.04	• Assistance required with activities of daily living;	Met		Met	
7.05	• Safety and security risks, and;	Met		Met	
7.06	• Allergies.	Met		Met	
7.07	**There is evidence that within the first eight weeks of admission, the resident's needs have been assessed by the interdisciplinary team and a written integrated care plan has been developed.**	Met	The first quarterly review is completed within in the first eight weeks of admission where the careplan is completed and fully developed by the Interdisciplinary Team.	Met	
The active integrated care plan contains detailed and current information on all aspects of each resident's care needs, to ensure all appropriate and proper care is provided, including information on and requirements for:					
7.08	• Bathing;	Met	All items outlined below are intergrated into each resident careplan and reveiwed quarterly and PRN.	Met	
7.09	• Dressing;	Met		Met	
7.10	• Oral care;	Met		Met	
7.11	• Skin care;	Met		Met	
7.12	• Hair care;	Met		Met	
7.13	• Fingernail care;	Met		Met	
7.14	• Foot care;	Met		Met	
7.15	• Exercise;	Met		Met	It was noted that one ICP has contradictory statements about exercise.
7.16	• Mobility;	Met		Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
7.17	• Transferring;	Met		Met	
7.18	• Positioning;	Met		Met	
7.19	• Bladder function;	Met		Met	
7.20	• Bowel function;	Met		Met	
7.21	• Any required incontinence care product;	Met		Met	
7.22	• Cognitive and mental health status;	Met		Met	
7.23	• Emotional status, and personality and behavioural characteristics;	Met		Met	
7.24	• Available family, social network, friends and/or community supports;	Met		Met	
7.25.	• Hearing ability and required aides;	Met		Partially Met	Four of six had both the requirement for aids and abilities.
7.26	• Visual ability and required aides;	Met		Met	
7.27	• Rest periods, bedtime habits, and sleep patterns;	Met		Partially Met	Four of six ICPs noted a nap time. For 2 ICPs it was blank.
7.28	• Safety and security risks and any measures required to address them;	Met		Met	
7.29	• Language and speech, including any loss of speech capability and any alternate communication method used;	Met		Met	
7.30	• Rehabilitation needs;	Met		Met	
7.31	• Therapeutic recreation requirements;	Met		Met	
7.32	• Preferences for participating in recreational activities;	Met		Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
7.33	• Religious and spiritual preferences;	Met		Met	
7.34	• Food allergies;	Met		Met	
7.35	• Diet orders;	Met		Met	
7.36	• Type of assistance required with eating;	Met		Met	
7.37	• Whether or not the resident has made a health care directive;	Met		Met	
7.38	• Special housekeeping considerations, and;	Met		Met	
7.39	• Other needs identified by the interdisciplinary team.	Met		Met	
7.40	The integrated care plan outlines care goals and interventions that will be taken to achieve those care goals.	Met		Met	
There is evidence that the integrated care plan is reviewed:					
7.41	• **At least once every three months by the interdisciplinary team, and;**	Met	Quarterly interdisciplinary team reviews take place on Tuesday and and Wednesdays between the Interdisciplinary Team. Care plans and ADL forms are reviewed and updated. SW & CRN create the quarterly review schedule and post on the MDS bulltens at each nursing station.	Met	Recommend a a reminder that all staff must sign full signature and designation.
7.42	• **At least annually by all staff who provide direct care and services to the resident, as well as the resident and his/her representative(s), if possible.**	Met	Each resident has an annual care conference where care needs are discussed and changes are made as required.	Met	
As part of the facility's continuous quality improvement/ risk management activities, there is evidence that care plans audits:					
7.43	• Occur at least annually;	Met	Care plan audits are done regularly and results are	Met	For 2017, a consistant process has been implemented.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			reviewed and followed up with on an individual basis, and discussed at nursing/HCA meetings.		
7.44	• Are reviewed & analyzed;	Met		Met	
7.45	• Result in recommendations for improvement being made as required, based on the audit analysis, and;	Met		Met	
7.46	• Result in recommendations being implemented and followed up.	Met		Met	

Scoring methodology:

- Bolded measures (**7.01, 7.07, 7.41 & 7.42**) are pass/fail performance measures. If any one is not met, the standard is not met. If all are met, the other measures are considered before assigning a rating to the standard.
- Of the 42 other measures:
  - If ≥34 measures are met, standard is met.
  - If ≥25 and <34 measures are met, standard is partially met.
  - If <25 measures are met, standard is not met.

Result: Bolded performance measures are met and forty of 42 other performance are met.
The standard is: Met
Comments:

Standard 9: Use of Restraints

Reference: *Personal Care Homes Standards, Section 16, 17 & 18 and* Manitoba Provincial Ministerial Guidelines for the Safe Use of Restraints in Personal Care Homes

Written restraint policy

The operator shall establish a written least restraint policy in accordance with guidelines approved by the Minister. A statement describing the PCH Policy on restraints shall be included in the resident handbook given to the resident and/or their substitute decision-maker on or before admission to the facility.

The Minister maintains that all persons receiving care in PCHs in Manitoba can expect to live in an environment with minimal use of restraint. Where care factors require limitation(s) to a resident's liberty, this guideline mandates the inter-disciplinary process of:

- assessment;
- informed consent;
- decision making;
- care planning;
- proper application;
- regular monitoring and removal;
- reassessments completed minimally every 3 months, and;
- discontinuance of the restraint as soon as possible.

Restraint may be used only if risk of serious harm
Except in accordance with this section and section 18, no operator shall permit a restraint to be used to restrain a resident without the consent of the resident or his or her legal representative.

If a resident's behaviour may result in serious bodily harm to himself or herself, or to another person, the operator shall

a) Do an interdisciplinary assessment to determine the underlying cause of the behaviour; and
b) Explore positive methods of preventing the harm.

If positive methods of preventing harm have been explored and determined to be ineffective by an interdisciplinary team assessment, then a physician, physician assistant, a nurse practitioner (RN-EP or RN-NP), a registered nurse (RN), a registered psychiatric nurse (RPN) or a licensed practical nurse (LPN) may order a restraint to be used, except in the case of medication (chemical restraint) which must be ordered by a physician, nurse practitioner or physician assistant.

Requirements for use of physical restraints
Every physical restraint must meet the following requirements:

a) Be the minimum physical restraint necessary to prevent serious bodily harm;
b) Be designed and used so as to
    i. Not cause physical injury
    ii. Cause the least possible discomfort
    iii. Permit staff to release the resident quickly; and
c) Be examined as often as required by the restraint policy referred to in section 16.

Requirements for use of chemical restraints
When a psychotropic medication is being used in the absence of a diagnosis of a mental illness, it is to be considered a chemical restraint. Also any medication given for the specific and sole purpose of inhibiting a behaviour or movement (e.g. pacing, wandering, restlessness, agitation, aggression or uncooperative behaviour) and is not required to treat the resident's medical or psychiatric symptom is considered a chemical restraint. If the medications are used specifically to restrain a resident, the minimal dose should be used and the resident assessed and closely monitored to ensure his/her safety.

Documentation in Resident Health Record

If any restraint is used, the operator shall ensure that the following information is recorded in the resident's health record:

a) A description of the interdisciplinary assessment done to determine the potential for serious bodily harm to the resident or another person;
b) A description of the alternatives to restraint that were tried and that were determined to be ineffective by the interdisciplinary team, signed by the person who directed the restraint to be used;
c) The specific type of restraint to be used and the frequency of checks on the resident while the restraint is in place;
d) Each time the resident and the restraint is checked while it is in place;
e) The time and date when use of the restraint is discontinued and the reason why.

Restraint Review and Discontinuance

The operator shall ensure that the use of each and every restraint is regularly reviewed. At a minimum, reviews must occur every three months, whenever there is a significant change in the resident's condition, and whenever the resident's care plan is reviewed.

The operator shall ensure that the use of any restraint is discontinued as soon as the reason for its use no longer exists.

Expected Outcome: Residents are restrained only to prevent harm to self or others. When a restraint is necessary it is correctly applied and the resident in restraint is checked on a regular basis.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.01	**The personal care home's policy on the use of restraints is consistent with *guidelines* approved by the Minister.**	Met	GLL has adapted the WRHA Policy 110.130.050	Met	
9.02	There is documented evidence that the resident, if capable, has given written consent to the use of the restraint. Where the resident is not capable, the consent of the resident's legal representative is documented.	Met	Every resident who has a restraint has a completed Regional Consent for restraint use documentation tool on record	Met	Four health records with restraints reviewed.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.03	If written consent is not available, verbal consent must be obtained from the resident or their legal representative. Verbal consent must be documented, dated and signed by two staff members, one of which must be a nurse.	Met	same as above	Not Applicable	
9.04	**There is documented evidence that a comprehensive assessment of the resident is completed by an interdisciplinary team, prior to application (or reapplication) of any restraint.**	Met	Every resident who has a restraint has a completed Regional basic restraint assessment and Documentation tool, this tool is completed and reviewed by a interdisipilinary team.	Not Met	Three of four assessments had a interdisciplinary team signature.
The assessment includes documentation of each of the following:					
9.05	• Description of the resident's behaviour and the environment in which it occurs (including time of day);	Met	as indicated on the basic restraint assessment and documentation tool for every resident who has a restraint	Met	
9.06	• The resident's physical status;	Met	as above	Met	
9.07	• The resident's emotional status;	Met	as above	Met	
9.08	• The resident's mental status;	Met	as above	Met	
9.09	• The resident's nutritional status;	Met	as above	Met	
9.10	• All alternatives tried and exhausted;	Met	as above	Met	
9.11	• Review of current medications;	Met	as above	Met	
9.12	• Actual and potential benefits to the resident if the restraint is applied;	Met	Every resident who has a restarint has a Regional Benefits and Burdens of restraints assessment and documentation tool completed	Met	
9.13	• Actual and potential burdens to the resident if the restraint is applied, and;	Met	as above	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.14	• Any other additional ethical considerations.	Met	as above	Met	
There is a written order for the restraint in the resident's health record that indicates:					
9.15	• The kind of restraint to be used;	Met	Each resident who has a restraint the written order information is documented on the basic restraint assessment and documentation tool and for all chemical restraints it is also ordered on the physcians ordering form	Met	
9.16	• The frequency of checks on the resident while the restraint is in use;	Met	as above	Met	
9.17	• The signature of the person giving the order (where a chemical restraint is used it must be ordered by a doctor, nurse practitioner or physician assistant);	Met	as above	Met	
9.18	• The professional designation of the person giving the order, and;	Met	as above	Met	
9.19	• For a chemical restraint, the time limit for its use (the discontinuation date).	Partially Met	as above on occasion the stop date is not indicated by the physcian but is reviewed minium quarterly during medication reviews	Met	
There is evidence of a care plan for every restraint in use, that outlines the resident's unique and specific needs, including:					
9.20	• The type of restraint and method of application;	Met	Every resident who has a restraint it is documented on the careplan under the Safety Focus	Partially Met	Three of four integrated care plans (ICPs) identified the type of restraint.
9.21	• The length of time the restraint is to be used for each application;	Met	as above	Not Met	One of four ICPs listed the length of time for the restraint.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.22	• The frequency of the checks on the resident while the restraint is in use, and;	Met	as above	Not Met	One of four ICPs listed the frequency of checks.
9.23	• When regular removal of restraints is to occur.	Met	as above	Not Met	One of four ICPs listed the regular removal.
9.24	There is documented evidence that the continued use of any restraint is reviewed at least once every three months.	Met	Every resident who has a restraint is reviewed using the regional Restraint reassessment tool during the Interdisiplinary quarterly reviews	Not Met	Of the two applicable restraints, one of the two had evidence of completed quarterly reviews.
9.25	There is documented evidence within the health record of efforts to resolve the issue for which the restraint was initiated.	Met	As indicated on the restraint reassement tool	Met	
Where a restraint is used in an emergency situation there is documented evidence of:					
9.26	• The events leading up to the use of the restraint;	Met	GLL did not have any emergency restraints required in the last 2 years- policies and documentation tools are in place for such an occurance.	Met	No emergency restraints were assessed. Measures 9.26 - 9.33 are met on the basis of policy
9.27	• The name of the person ordering the restraint;	Met	as above	Met	
9.28	• The designation of the person ordering the restraint;	Met	as above	Met	
9.29	• The time the restraint was applied;	Met	as above	Met	
9.30	• The frequency of checks;	Met	as above	Met	
9.31	• Notification of the resident's legal representative or next of kin;	Met	as above	Met	
9.32	• Care provided to and response of the resident in restraint, and;	Met	as above	Met	
9.33	• When the resident's reassessment is to occur.	Met	as above	Met	
As part of the facility's continuous quality improvement/ risk management activities, there is evidence that audits of the use of restraints:					

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.34	• Occur at least annually;	Met	GLL completes restraint audits on a quarterly basis with 10% of the population being audited each quarter. Random audits occuring with results shared at each RCAT, Leadership and Nursing meetinjgs. Each deficiency is reviewed with the invidual Nursing teams and follow-up occurs by CRN/DOC to ensure completed	Met	
9.35	• Are reviewed/analyzed;	Met	as above	Met	
9.36	• Result in recommendations for improvement being made, as required, based on the audit analysis, and;	Met	as above	Met	
9.37	• Result in recommendations being implemented and followed up.	Met	as above	Met	

Scoring methodology:

- Bolded measures (**9.01 & 9.04**) are pass/fail performance measures. If any one of these measures is not met, the standard is not met. If they are all met, the other measures are considered before assigning a rating to the standard.
- Of the 35 other measures:
  - If ≥28 measures are met, standard is met.
  - If ≥21 and <28 measures are met, standard is partially met.
  - If <21 measures are met, standard is not met.

Result: One of two bolded prformance measures are met and thirty of 35 other measures are met.
The standard is:
Comments:

Standard 10: Medical Services

Reference: *Personal Care Homes Standards Regulation, Sections 19 & 20*

Designated physician

The operator shall designate a physician, to be responsible for the overall coordination and evaluation of medical services for the personal care home.

Medical care of residents
The operator shall ensure that:

a) A physician supervises each resident's medical care;
b) A physician, Nurse Practitioner or Physician Assistant examines each resident as the resident's condition requires;
c) The professional staff and residents have access to a physician, Nurse Practitioner or Physician Assistant 24 hours per day, seven days per week to provide emergency care and consultation as necessary.

Expected Outcome: Residents receive medical care in accordance with their needs and in a manner that enhances their quality of life.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
10.01	**There is a designated physician (Medical Director) responsible for the overall coordination and evaluation of medical services in the facility.**	Met	Current contracts in place with Medical Director.	Met	
10.02	**Each resident has an assigned physician, nurse practitioner or physician assistant (that work in collaboration with a physician)**	Met	Upon admission to GLL each resident is assigned to a physician in relation to room assignment.	Met	
10.03	There is a physician, nurse practitioner or physician assistant on call for services at all times.	Met	Current call schedule is updated and available in both main floor and 2nd floor nursing stations as well as business office.	Met	
10.04	Staff are made aware of and have access to physician, nurse practitioner or physician assistant contact information during business and after hours.	Met	Business Office and After Hours contact list available in both main floor and 2nd floor nursing stations as well as business office.	Met	
10.05	The personal care home has established rules and regulations	Met	Up to date policy ADM-GA-M-4, up to date GLL Medical Staff by	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	and/or policies governing medical services, which are reviewed at least every three years.		Laws reviewed & approved January 2018 by board of GLL, Medical Director, CEO & DOC.		

Scoring methodology:

- The bolded measures (**10.1** & **10.02**) are pass/fail performance measures. If they are not met, the standard is not met. If they are met, the other measures are considered before assigning a rating to the standard.
- Of the remaining 3 measures:
  - If 3 measures are met, standard is met.
  - If 2 measures are met, standard is partially met.
  - If 1 measure is met, standard is not met.

Result: All performance measures are met.
The standard is: Met
Comments:

Standard 12: Pharmacy Services

Reference: *Personal Care Homes Standards Regulation, Sections 24, 25 & 26*

Pharmacy services and medications

In clause (2)(a), pharmacist includes a corporation or other legal entity that:

a) Contracts with an operator to direct and be accountable for pharmacy services in a personal care home; and
b) Designates one or more individual pharmacists to provide pharmacy services for the personal care home.

The operator shall:

a) appoint or contract with a pharmacist to direct and be accountable for pharmacy services for the personal care home;
b) ensure that the pharmacist maintains a medication profile of each resident;
c) ensure that the pharmacist and other relevant members of the interdisciplinary team review the medications and treatments ordered by a physician for each resident at least every three months;
d) ensure that the pharmacy services for the personal care home are consistent with residents' needs and the scope and complexity of the care offered at the home;
e) ensure that emergency and after-hours pharmacy services are available for residents;
f) ensure that accurate and comprehensive drug information is available to medical, nursing and other staff of the personal care home as required;
g) establish written policies and procedures for pharmacy services for the personal care home that provide for the following:

i) transmitting medication orders to the pharmacy,
ii) handling medication from the point it is procured until it is administered, including delivery, automatic stop orders, recommended times of administration and self-administration by residents,
iii) reporting, documenting, and follow-up of medication incidents, adverse reactions and refusal of medication,
iv) providing medications for residents who are on planned social leave and for persons who are receiving respite care in the personal care home,
v) security of all medications, including appropriate security measures for narcotic and controlled drugs and medications kept at a resident's bedside;

h) by using a current photograph, ensure that each resident's identity is confirmed before staff administers medication;
i) ensure that the overall medication use in the personal care home is monitored; and
j) ensure that the need for education programs about medications, including education for nursing staff and residents, is assessed and that appropriate programs are developed.

Administering medications

The operator shall ensure that when staff administers medications to a resident, such medications are administered:

a) only on a physician's, physician assistant's or nurse practitioner's order, or the order of a pharmacist, made in accordance with the *Pharmaceutical Act* and its regulations, or registered nurse made in accordance with *The Registered Nurses Act* and its regulations;
b) only by a physician, physician assistant, nurse practitioner, registered nurse, registered psychiatric nurse or licensed practical nurse, in accordance with their respective standards of practice; and
c) only after the resident's identity has been confirmed using minimally two identifiers.

When a physician, physician assistant, nurse practitioner or registered nurse who is not on-site at the personal care home gives a medication order by telephone, the operator shall take reasonable steps to ensure that it is confirmed in writing on the next visit to the home by the physician, physician assistant, nurse practitioner or registered nurse.

The operator shall:

a) take reasonable steps to ensure that all medication orders are legible and up-to-date; and
b) ensure that the person who administers any medication records it immediately after in the resident's medication administration record.

Limited medication supplies

The operator shall ensure that:

a) a monitored dosage or unit dosage system for drug distribution is adopted and implemented in the personal care home;
b) the personal care home has a supply of medications for emergency use;
c) there is at least one designated, locked, properly equipped medication storage and preparation area that it is clean, well-organized and maintained;

d) medications are stored in a locked medication storage and preparation area in a manner that protects them from heat, light and other environmental conditions that may adversely affect the efficacy and safety;
e) medications requiring refrigeration are kept in a refrigeration unit used only for medication storage;
f) the responsible pharmacist ensures regular audits are conducted of medication kept at the personal care home and that any expired, unused and discontinued medications are removed and properly disposes of; and
g) the responsible pharmacist ensures regular audits of medication storage areas are conducted and takes any action necessary to ensure that medications are properly stored in accordance with this section.

Expected Outcome: Residents receive prescribed treatments and medications in accordance, with their needs and their treatments/medications are correctly administered and documented.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
12.01	**There is a current contract with a licensed pharmacist.**	Met	Geri-Aid is the current pharmacy provider for GLL	Met	
12.02	The contract defines the scope of service.	Met		Met	
12.03	The contract includes provision for emergency and after hour services.	Met		Met	
12.04	**The pharmacist conducts medication and treatment reviews on a quarterly basis (once every 3 months) with the interdisciplinary team (pharmacist, nurse, physician/ nurse practitioner/physician assistant and other members as needed) and this is documented in the health record.**	Met	Medication reviews are completed quartely and include the physician, pharmacist, and unit nurses. Quarterly med reviews are maintained in the resident chart in the phsycians order section. These quareterly med reviews are signed by the physician, nurse and pharmacist once completed.	Met	
12.05	Policies and procedures for pharmacy services are available, complete and reviewed minimally every three years.	Met	Geri-aid provides an updated policy manual for pharmacy policies.GLL pharmacy policies will need to be reviewed and revised over the next 6 months.	Met	
There are designated medication storage areas that are:					

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
12.06	• Clean;	Met		Met	
12.07	• Well organized;	Met		Met	
12.08	• Well equipped;	Met		Met	
12.09	• Well maintained, and;	Met		Met	
12.10	• Secure.	Met		Met	
12.11	All controlled substances are securely stored under a double lock.	Met		Met	
12.12	All controlled substances are counted and signed by two nurses at least once every seven days.	Met		Met	
Nursing staff have access to:					
12.13	• A supply of medications for emergency use (emergency drug box), and;	Met		Met	
12.14	• Medications that should be administered without undue delay (in-house drug box for antibiotics, analgesics, etc).	Met		Met	
Withdrawals from the emergency drug box, in-house drug box and controlled substance storage are documented, including:					
12.15	• Date;	Met		Met	
12.16	• The name and strength of the drug being withdrawn;	Met		Met	
12.17	• Quantity taken;	Met		Met	
12.18	• The name of the resident being given the drug, and;	Met		Met	
12.19	• The name of the nurse making the withdrawal.	Met		Met	
12.20	There is a process in place whereby the medications ordered for a resident on admission, and for any transfer between health care facilities, is confirmed by the	Met	Golden Links Lodge policy N-M-13 and PH-ADM-26-1 (based on the WRHA policy # 110.170.040 Medication Order Writing Standards).	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	physician/Nurse Practitioner, the pharmacist and the nursing staff at the receiving facility (i.e. medication reconciliation)				
The pharmacist ensures that:					
12.21	• Audits of the medication storage room, emergency drug box, in-house drug box, and controlled substance storage are conducted and documented at three month intervals;	Met	Geri-Aid completes quaterly reviews of the medication rooms and audits are posted and reviewed with the nurses. Results are to discussed at the nurses meetings.	Met	
12.22	• The audit results are shared with nursing staff.	Met	as above	Met	
12.23	**A monitored dose or unit dose system is used for medication distribution in the facility.**	Met	provided by Geri-Aid	Met	
There are processes in place to ensure staff administering medications are trained and follow the appropriate procedures for the monitored dose system, including:					
12.24	• An orientation for new staff, and;	Met		Met	
12.25	• Periodic audits of a medication pass for each nurse.	Partially Met	The regional recommendation (October 2017) is that Med pass audits are completed at minimum of annually. At this time 60% of the nursing staff have had a med pass audit completed in 2017. GLL will beging the implementation of the regional med pass audit form which was introduced in October 2017. This has been reviewed at the GLL RCAT and nurses meetings.	Met	
12.26	The resident's identity is confirmed prior to administration of	Met	Residents are identified using 2 methods of identification as	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	medications by use of minimally two identifiers.		outlined in the Geri-Aid pharmacy policy and GLL policy # N-M-12		
12.27	The medication administration record identifies allergies and diagnoses.	Met		Met	
12.28	**A pharmacist is available to provide drug information as required.**	Met		Met	
A committee has been established:					
12.29	• **That includes representation from pharmacy, medicine, nursing and administration;**	Met	The Resident Care Advisory Team (RCAT) meets quarterly. This team is made up of the facility physicians, CEO, DOC, CRN, unit nurses, Geri-Aid pharmacy, and dietitian and SW on an ad hoc basis.	Met	
12.30	• **That meets at least once every 3 months.**	Met	as above	Met	Four meetings held in 2017. Improvement since the unannounced review.
12.31	• To review and make recommendations on drug utilization and costs;	Met		Met	
12.32	• To review and follow up on medication incidents and adverse reactions, and;	Met		Met	
12.33	• To review and make recommendations on all policies for the procurement and administration of medication within the home;	Met		Met	
Scoring methodology: • The bolded measures (**12.01, 12.04, 12.23, 12.28, 12.29, 12.30,**) are pass/fail performance measures. If any are not met, the standard is not met. If all are met, the other measures are considered before assigning an overall rating to the standard.					

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
• Of the 27 other measures: ○ If ≥22 measures are met, the standard is met. ○ If ≥16 and <22 measures are met, standard is partially met. ○ If <16 measures are met, standard is not met.					

Result: All performance measurers are met.
The standard is: Met
Comments:

Standard 13: Health Records
Reference*: Personal Care Home Standards Regulation, Section 27*

The operator shall maintain a health record in the personal care home for each resident that includes the following information:

a) admission information that includes:
   i) a completed application and assessment form, and
   ii) any other information provided by the resident and his or her designate or legal representative and any person or entity that has provided health care to the resident;
b) current information about the resident's care that includes the following:
i) the initial care plan and the integrated care plan and any amendments made to them,
ii) medications and treatments ordered by a physician, nurse, nurse practitioner or physician assistant,
iii) medications and treatments administered,
iv) information about the use of restraints, as required by subsection 18(2),
v) interdisciplinary progress notes,
vi) the results of ongoing clinical monitoring,
vii) consent forms where necessary,
viii) the resident's health care directive, if any,
ix) a copy of any committeeship order under *The Mental Health Act*, appointment of a substitute decision-maker under *The Vulnerable Persons Living with a Mental Disability Act* or enduring power of attorney, and
x) the date of discharge, transfer or death.

The operator shall ensure that all the documentation in a resident's health record is:

a) accurate, legible, up-to-date, complete and not misleading;
b) written by the person who made the observation or who provided or supervised the care or treatment, or that person's supervisor;

c) written as soon after the event occurred as possible;
d) identified by the date and time of the entry; and
e) identified by the signature and professional designation of the person making the entry or by such other means of identifying the person as may be approved by the Minister.

Expected Outcome: Residents' health records (hardcopy and electronic) provide a full, complete and accurate picture of residents and of their care from the time of admission.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
The resident's health record must minimally include the following information:					
13.01	• A completed application and assessment form, or such alternate form as approved by the Minister;	Met		Met	
13.02	• The initial care plan;	Met		Met	
13.03	• The current integrated care plan;	Met	maintained in the care plan binder on each unitr	Met	
13.04	• Amendments to the integrated care plan;	Met	as above	Met	
13.05	• Medications and treatments ordered;	Met		Met	
13.06	• Medications and treatments administered;	Met		Met	
13.07	• Interdisciplinary progress notes;	Met		Met	
13.08	• The results of ongoing clinical monitoring;	Met		Met	
13.09	• Consent forms;	Met		Met	
13.10	• The resident's Health Care Directive, if applicable;	Met		Met	
13.11	• Record of referrals made to an external agency or specialist on the recommendation of a member of the interdisciplinary team;	Met		Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
13.12	• Results of any examinations or tests conducted as a result of referral;	Met		Met	
13.13	• The date of any discharge or transfer, and;	Met		Met	
13.14	• Copy of any Enduring Power of Attorney or Committeeship (if one is in place).	Met		Met	
13.15	There is documented evidence of appropriate follow-up of resident issues throughout the health record.	Met		Met	
Documentation for all entries in the health record identifies the:					
13.16	• Date;	Met	Resident Chart audits are completed monthly per GLL quality program plan. Results are reviewed and actions taken to correct deficiencies and/or educate staff on charting errors.These are reviewed during staff meetings.	Met	
13.17	• Time;	Met		Met	
13.18	• Writer's Signature, and;	Met		Met	Gaps noted in signatures. Staff should be reminded that name and designation must be clear on progress notes or written on a master sheet.
13.19	• Writer's Professional designation.	Met		Met	
13.20	There is evidence of written direction related to the order in which items are filed within each health record.	Met	There is a GLL policy # ADM-IM-C-1	Met	
13.21	There is evidence within the health records that the specified chart order is consistently applied.	Met	GLL policy # ADM-IM-C-1	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
13.22	There is a current policy to guide thinning/archiving of the resident health records.	Met	GLL policy # N-C-30 and # ADM-C-3	Met	
13.23	There is evidence that the thinned files are maintained in a organized state that allows for easy access to the information within each file.	Met	Thinned resident charts are maintained in a file cabinet in each medication room for ease of access to thinned chart material.	Met	Some thinned files were tidy. Other files had no organization of information pulled from the chart.
13.24	There is a current policy on retention and destruction of health records.	Met	GLL policy # ADM-IM-P-4 and #ADM-IM-P-12	Met	
13.25	There are no impermanent (i.e. pencil) or obliterating (i.e. white-out) entries found in the permanent health record.	Met	Chart audits are to be completed monthly and reviewed for deficiencies.There are no pencils used in the charts or care plans. White out is not permitted and there is no evidence of use in audits completed.	Met	

Scoring methodology:

- There are no pass/fail performance measures.
- Of the 25 measures:
  - If ≥20 measures are met, standard is met.
  - If ≥15 and <20 measures are met, standard is partially met.
  - If <15 measures are met, standard is not met.

Result: All performance measures are met.
The standard is: Met
Comments:

Standard 15: Housekeeping Services

Reference: *Personal Care Homes Standards Regulation, Section 29*

The operator shall ensure that a housekeeping service is in place to provide a clean and well-maintained environment for residents, staff and visitors.

At a minimum, the operator shall ensure that

a) all floors, stairs, walls, ceilings, doors, windows, window coverings, sinks, toilets, furniture and equipment in the personal care home are cleaned as often as may be necessary to keep these clean and to minimize odours;
b) all bathing facilities in the personal care home, including hydrotherapy units (whirlpools), tubs, showers, shower chairs and lift chairs are cleaned and disinfected after each resident use; and
c) there is an organized pest control program in the personal care home.

Expected Outcome: The residents' environment is safe, clean and comfortable and is consistent with resident care needs.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
15.01	The facility is clean and odour free.	Met		Met	
15.02	There is a written process for proper cleaning and disinfection of all bathing facilities in the personal care home, (including relevant equipment such as tubs, showers, lifts and chairs) after each resident use.	Met	GLL policy # N-E-C-1 Century Whirlpool Disinfection/Cleaning Procedure	Met	
15.03	There is documented evidence that the tub and bathing equipment cleaning process is completed after each resident use.	Met	HCA's record on the "Tub Disinfection and Temperature Log" after each resident tub/shower.	Met	
15.04	Upon inspection all shared equipment is found to be clean.	Met		Met	
15.05	There is a schedule for all required daily cleaning.	Met	Policies SS-H-R-01 to SS-H-R-10 oultines the process for weekly cleaning on the nursing units, resident rooms, laundry/housekeeping and generally.	Met	
15.06	There are schedules for all required periodic cleaning (i.e. weekly, monthly and annually).	Met	A schedule of all periodic cleaning is maintained by the housekeeping lead hand.	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
15.07	There is a list of approved cleaning products, including their purpose and proper use.	Met	MSDS sheets are updated and available in the clean utility rooms as well as a quick reference sheet for staff on housekeeping carts.	Met	
15.08	All potentially dangerous chemicals used by housekeeping staff are securely stored.	Met	Cleaning carts used in the resident areas are locked.	Met	
15.09	Personal protective equipment is available for housekeeping staff.	Met		Partially Met	Basement housekeeping supply room did not have protective eyewear, gloves or gown. Policy indicates goggles are to be worn when mixing chemicals, although only found safety glasses in housekeeping closets on units.
15.10	There is evidence of an organized pest control program.	Met	Able Pest Control is on contract to the facility. Monthly visits and inspections are made and as required.	Met	
Housekeeping audits:					
15.11	• Are conducted quarterly;	Met	There are housekeeping audits that evaluate the resident room, nursing station and public areas that are conducted quarterly.	Met	
15.12	• Are reported and reviewed;	Met	Information is reveiwed by the support services manager	Met	Audits reviewed and issues resolved at monthly Laundry/Housekeeping meetings
15.13	• Recommendations are made from the audit analysis, and;	Met	recommendations are discussed at senior leadership meetings and department staff meetings and issues addressed.	Met	
15.14	• Recommendations are implemented and followed-up.	Met	as above	Met	Issues requiring follow-up documented as action items in

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
					meeting minutes and carried forward until resolved.

Scoring methodology:

- There are no pass/fail performance measures.
- Of the 14 measures:
  - If ≥11 measures are met, standard is met.
  - If ≥8 and <11 measures are met, standard is partially met.
  - If <8 measures are met, standard is not met.

Result: Thirteen of 14 performance measures met.

The standard is: Met

Comments: Housekeeping closets appear organized. Recommend signage be improved advising staff to wear protective equipment when dispensing/mixing chemicals. Staff personal clothing observed hanging in one of the housekeeping closets. Recommend staff store personal clothing in staff lockers/room.

Standard 19: Safety and Security

Reference: *Personal Care Homes Standards Regulation, Sections 33 & 34*

Temperature

The operator shall take reasonable steps to ensure that the temperature in residential areas of the personal care home is kept at a minimum of 22 degrees Celsius.

Safety and Security

The operator shall ensure that the environment of the personal care home is maintained so as to minimize safety and security risks to residents and to protect them from potentially hazardous substances, conditions and equipment.

Without limiting the generality of the above subsection, the operator shall ensure that:

a) nurse call systems are installed and maintained in proper working order within resident rooms, resident washrooms, and bathing facilities;
b) open stairwells are safeguarded in a manner which prevents resident access;
c) all outside doors and doors to stairwells accessible to residents are equipped with an alarm or a locking device approved by the fire authority under the *Manitoba Fire Code*;
d) windows cannot be used to exit the personal care home;
e) handrails are properly installed and maintained in all corridors, and grab bars are properly installed and maintained in all bathrooms and bathing facilities;

f) all potentially dangerous substances are labelled and stored in a location that is not accessible to residents;
g) all equipment is safe and it is used, stored and maintained in a manner which protects residents;
h) domestic hot water temperature in resident care areas is not less than 43 and not more than 48 degrees Celsius (C)`;
i) the personal care home is kept clean and combustible materials are stored separately and safely;
j) exits are clearly marked and kept unobstructed at all times;
k) facility grounds and exterior furniture are safe for resident use;
l) and a system is in place whereby all residents who may wander are identified and all staff are informed.

To ensure compliance with this section, the operator shall establish an ongoing safety and accident prevention program that includes the following:

a) maintenance programs for resident safety devices, ventilation, heating, electrical equipment and all other equipment used by staff and residents;
b) protocols relating to hazardous areas; and
c) a policy governing electrical appliances to be used or kept by residents in their rooms.

Expected Outcome: Residents are provided a safe, secure, and comfortable environment, consistent with their care needs.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
19.01	The temperature in residential areas is a minimum of 22˚C.	Met	All set points to supply a constant 22 degrees. Daily temperature logs have been kept.	Met	
19.02	**Domestic hot water, at all water sources that are accessible to residents, is not less than 43˚C and not more than 48˚C.**	Partially Met	Currently experiencing issues with regulating the temperature. Testing water temperatures weekly. The mixing valve will be replaced immediately.	Not Met	13 water measurements taken. Five measurements within range, the others were too cold, below 43C with one degree of variance taken into consideration.
19.03	There is documented evidence of frequent monitoring (minimally once per week) of domestic hot water temperatures at locations accessible to residents.	Partially Met	Weekly log for resident areas for 2017 have been maintained with the exception of June, July, August, September. The facility was experiencing Maintenance Staffing issues that were resolved in September 2017.	Met	Facility has recently implemented process to monitor boiler and holding tank temperatures. Facility has a software system that will alert if boiler temps out of range. Facility is in the midst of

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
					replacing boiler pump. Leaking valve noted on one boiler scheduled to be repaired this spring/summer.
19.04	There is an easily accessible call system in all resident rooms.	Met		Met	
19.05	There is an easily accessible call system in all resident washrooms.	Met		Met	
19.06	There is a call system in all bathing facilities that is easily accessible from all areas around the tub.	Met		Met	
19.07	All open stairwells are safeguarded in a manner which prevents resident access.	Met	All stairwells are equipped with mag locks, out of reach covered button required to be depressed and cannot be accessed by resident.	Met	
19.08	All outside doors and stairwell doors accessible to residents are equipped with an alarm or locking device approved by the Fire Authority under the Manitoba Fire Code.	Met		Met	
19.09	All windows are equipped with a mechanism or are appropriately designed so they cannot be used as exits.	Met		Met	
19.10	Handrails are properly installed and maintained in all corridors.	Met		Met	
19.11	Grab bars are properly installed and maintained in all bathrooms and bathing facilities.	Met		Met	
19.12	All potentially dangerous substances are labeled and stored in a location not accessible to residents.	Met	All dangerous substances are kept locked and not accessible to residents.	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
19.13	Combustible materials are stored separately and safely in a container that does not support combustion.	Met	Stored in flammable liquid storage cabinet in basement maintenance area.	Met	One can of WD40 seen on open shelf. Appears it may have been used recently, although no one in the maintenace workshop at the time. Workshop is equipped with a steel cabinet for storage.
Upon inspection/observation, all equipment is;					
19.14	• Safe for use;	Met	All equipment is stored as per GLL policies.	Met	
19.15	• Safely stored, and;	Met		Met	
19.16	• Used in a manner that protects residents.	Met		Met	
There is documented evidence for all equipment, including building systems, that demonstrates the completion of:					
19.17	• As needed repairs, and;	Met		Met	Facility relies on a paper based process to identify/track repairs. Facility is palnning to transition to HIPPO for on demand and preventative maintenance.
19.18	• Preventive maintenance.	Met	GLL is currently reviewing the potential to incorporate the same process as WRHA HIPPO Maintenance Program.	Met	
19.19	The facility has a current policy governing the use of personal electric appliances kept by the resident.	Met		Met	
19.20	In facilities where smoking is permitted, it takes place in designated areas only, and the ventilation system prevents exposure to second hand smoke within the facility.	Not Applicable		Not Applicable	
All exits are:					
19.21	• Clearly marked, and;	Met		Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
19.22	• Unobstructed.	Met		Met	All exits, pathways and sidewalks clear of snow and debris.
19.23	The exterior of the building is maintained in a manner which protects the residents.	Met	Weekly exterior walk arounds are completed.	Met	
19.24	The grounds and exterior furniture are maintained in a manner which protects the residents.	Met		Met	Appear in good order, although snow covered at time of assessment.
19.25	A system is in place to identify, and inform all staff of any resident who may wander and/or is at risk for elopement.	Met	Facility follows Code Yellow.	Met	

Scoring methodology:

- The bolded measure (19.02) is a pass fail measure. If it is not met, the standard is not met. If it is met, the other measures are considered before assigning an overall rating to the standard
- Where smoking is permitted, of the 24 other measures:
  - If ≥19 measures are met, standard is met.
  - If ≥14 and <19 measures are met, standard is partially met.
  - If <14 measures are met, standard is not met.
- Where smoking is not permitted, of the 23 other applicable measures:
  - If ≥18 measures are met, standard is met.
  - If ≥14 and <18 measures are met, standard is partially met.
  - If <14 measures are met, standard is not met.

Result: One bolded measure not met and all other performance measures are met.

The standard is: Not Met

Comments: Discussion with staff suggests the facility may not have a formal schedule/agreement to periodically power vac the dryer ventillation system. Laundry worker recalls in the past (prior to flood) they had a "shop vac" to help with cleaning lint traps. Vacuum has not been replaced. Facility encouraged to establish schedule and process to have larger dryer exhaust duct work inspected and cleaned.

Maintenance staff are encouraged to return flammable substances to the steel storage cabinet when not in use.

Standard 21: Infection Control Program

Reference: *Personal Care Homes Standards, Section 36*

In order to prevent or control the spread of infection in the personal care home, the operator shall implement an infection control program that includes

a) surveillance of health care associated infections with review of data at regular intervals;
b) establishing policies and procedures designed to minimize or eliminate transmission of infectious disease;
c) education for staff about infectious diseases, their modes of transmission and methods of prevention; and
d) a contingency plan for outbreaks of infectious diseases with delineated responsibilities for staff, including the reporting requirements under *The Public Health Act.*

Expected Outcome: Residents are protected from the spread of infection by an infection control program.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
There is evidence of an Infection Control Program that includes:					
21.01	• **Designation of an individual responsible for infection control;**	Met	This is currently the GLL Clinical Resource Nurse	Met	
21.02	• Surveillance of health care acquired infections;	Met	Surveillance tool is completed by the Nurse and submitted for review and auditing to the CRN. This information is provided to the WRHA Infection control manager	Met	
21.03	• Data collection, review and follow-up; and	Met	Auditing of surveilance tools and compliance with tools completed each month and calculated quarterly- results shared with RCAT, Senior Leadership and at Nursing meetings	Met	
21.04	• **Reporting of infectious diseases as required under *The Public Health Act*.**	Met	Have not had any reportable diseases- procedures in place and located in each department for such an occurance	Met	
There are Infection Control policies and procedures including:					

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
21.05	• Policies aimed at preventing or controlling the spread of infectious disease;	Met	GLL has adapted the regional Infection Control Policies and guidelines as indicated in the Long term care Infection Control manual- The manulas are found on each Nursing station and department. and updated by the CRN	Met	
21.06	• Protocols for handling clean and soiled laundry, and contaminated laundry;	Met	Policy in place SS-L-W-1 Laundry Collection, Handling and washing of Soiled Laundry	Met	
21.07	• Contingency plans for dealing with a suspected or confirmed outbreak;	Met	The procedures for dealing with a suspected or confirmed outbreak are found in the Influenza/outbreak management binders found in each department	Met	
21.08	• Restriction of visits to the home during an outbreak;	Met	as above	Met	
21.09	• Protocols for cleaning schedules and cleaning products, and;	Met	GLL has cleaning schedules in place for each department- see specific cleaning schedule lists. These are also audited and reviewed at departmental meetings	Met	
21.10	• Protocols related to pet care, including visiting pets.	Met	GLL has adapted the WRHA operational Guideline pets and Pet Therapy in Personal care homes and Long Term Care facilities- Binder located at reception with every pet who enters GLL as outlined in guideline	Met	
There is a staff education program which contains information on:					
21.11	• Infectious diseases, and;	Partially Met	GLL has experienced staffing changes related to the educator	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			this past year- plan is in place for 2018 to provide education on an infectious diseases- see education calendar for 2018		
21.12	• Infection control practices.	Met	GLL provided education on hand hygeine and infection control practices in September and October 2017	Met	
There is a quality improvement process for infection control practices (i.e. hand hygiene) that includes:					
21.13	• Random audits of staff compliance with infection control practices (at least annually);	Partially Met	WRHA recommends Hand Hygiene Audits to be completed quarterly- with the change in staff-educator and DOC Hand Hygiene audits were only completed for 1 quarter in 2017. Surveillance audits completed monthly, equipment cleaning audits, tub disinfection audits, resident care personal items cleaning audits to be completed annually	Met	2017 processes implemented well.
21.14	• Review and summarization of audit results;	Met	All Audits are reviewed and presented at the RCAT/Leadership meetings and plans to be further discussed at the Nursing/HCA and other department meetings	Met	
21.15	• Development of improvement strategies where deficits are found, and;	Met	More training to occur in 2018 for Hand Hygiene Auditors to meet the quarterly auditing targets. Infection Surveillance compliance audits reviewed with the Nursing/HCA and departmental teams and further education to occur in 2018	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
21.16	• Implementation and follow-up of improvement strategies.	Met	Education to occur in 2018 regarding infection control practices- see education calendar for 2018	Met	

Scoring methodology:

- The bolded measures (21.01, 21.04) are pass/fail performance measures. If either one is not met, the standard is not met. If they are met, the other measures are considered before assigning an overall rating to the standard.
- Of the 14 other measures:
  - If ≥ 11 measures are met, standard is met.
  - If ≥ 8 and < 11 measures are met, standard is partially met.
  - If < 8 measures are met, standard is not met.

Result: All performance measures are met.
The standard is: Met
Comments: Well done.

Standard 24: Staff Education

Reference: *Personal Care Homes Standards Regulation, Section 39*

The operator shall provide an organized orientation and in-service education program for all staff of the personal care home.

The operator shall ensure that each new employee signs an acknowledgement of the information received in the orientation.

The operator shall ensure that the orientation and in-service education programs are evaluated at least annually and revised as necessary to ensure that they are current and meet the learning needs of the staff.

The operator shall make available health related resources, including books, journals and audio-visual materials, to staff and volunteers at the personal care home.

Expected Outcome: The appropriate knowledge, skills and abilities for each position in the personal care home have been identified, documented and training is available to staff to enable them to perform their roles effectively.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
24.01	**There is documented evidence that all new staff participate in an orientation program.**	Partially Met	All new staff members attend General oreintation and Job specific orientation from respective departments. General orientation includes the below listed requirments.General orinetation checklist will be included on all 2018 HR staff files.	Met	
Orientation includes:					
24.02	• A general orientation, and;	Met	A General orientation occurs for all new staff members and will be conducted on a monthly basis dependent on hiring	Met	
24.03	• A job specific orientation.	Met	Each department has a job specific orientation checklist which is completed and then reviwed by the department manager and kept in the employee HR files	Met	
24.04	Each staff signs an acknowledgement of the information received at general and job specific orientation.	Partially Met	A check list will be implemented in 2018 for the general oreintation which will include all the requirements for orientation as outlined below. This checklist will be signed off by the employee and the educator. Job specific checklists are already in place and will continue to be used and signed off by employee and reviewed by department manager	Partially Met	Of those applicable files, job specific sign off sheets were not present.
The orientation program includes, at a minimum, the following components:					
24.05	• Resident Bill of Rights;	Met	Included in oreintation- see agenda and orientation package	Met	
24.06	• Mission Statement;	Met	as above	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
24.07	• Organization chart;	Met	as above	Met	
24.08	• Disaster management including the fire plan;	Met	as above	Met	
24.09	• Workplace Hazardous Materials Information System (WHMIS);	Met	as above	Met	
24.10	• Infection control;	Met	as above	Met	
24.11	• Proper use of all equipment specific to job function;	Met	completed during job specific orientatoin	Met	
24.12	• Personnel policies;	Met	included in orentation- see agenda and orientation package	Met	
24.13	• Personal Health Information Act;	Met	as above	Met	
24.14	• ***Protection for Persons in Care Act*;**	Met	as above	Met	
24.15	• The facility policy on freedom from abuse;	Met	as above	Met	
24.16	• Signing an Oath of Confidentiality;	Met	as above	Met	All staff should have an Oath of Confidentiality, including long - term staff.
24.17	• Job description, and;	Met	This is given upon hire by HR prior to general orientation	Met	
24.18	• Expected skills and routines.	Met	as above	Met	
24.19	There is an organized staff education program for all staff.	Partially Met	Due to educator turnover a comprehensive education program is being created for the 2018 education year that will be carried forward year to year that meets the WRHA rquirements. See 2018 education calendar and actionplan. There was some education provided by the WHRA at the mandatory education fair which occurred in Feb and may 2017 (freedom from abuse, bill of rights,	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			infection control/routine practices, WHIMIS, safe handeling of hazaderous meds, alzheimers education, restraint, leadership, skin/perrycare, oral care, wound care, documentation and careplaning) but did not meet the education requirements suggested by the LTC education program.		
The staff education program annually includes at least the following:					
24.20	• **Fire drill participation or fire prevention education for every staff member, including permanent, term and casual employees;**	Not Met	At point of submission GLL was unable to confirm all documentation confirming that all GLL staff have received Fire prevention traning and/or activley participated in a fire drill in 2017. Going forward mandatory education will take place at a mandatory education fair in the spring, see education action plan. Fire Drills will be changed from the last day of the month to a rotating schedule to ensure most staff can be captured. In addition to this GLL is committed to ensuring through our education planning that throughout the year there will be several opportunities for training of Fire Education.	Not Met	
24.21	• Review of the Freedom from Abuse policy;	Met	This was completed at the Mandatory education fair that occurred in Feb, 2017 and May 2017 that was presented by the WRHA regional educator	Not Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
24.22	• Review of the Resident Bill of Rights;	Met	as above	Not Met	
24.23	• Review of the Use of Restraints Policy;	Met	GLL follows the WRHA policy 110.130.050- restraints in Personal care homes. This package was reviewed by all Nursing staff in August-September 2017. All New Nursing Hires receive the package for review. In 2018 education will be aimed towards other departments and also will include the annual review for Nursing	Met	
24.24	• Workplace Hazardous Materials Information Sheets (WHMIS);	Met	This was completed during the mandatory education fair that occurred in feb and may 2017. This was presented by the WRHA regional educator team	Not Met	
24.25	• Education about Alzheimer's and related dementias, and other geriatric care information, and;	Met	This was completed during the mandatory education fair that occurred in feb and may 2017. This was presented by the WRHA regional educator team	Met	
24.26	• Education opportunities that match the special considerations/ needs of the facility's current resident population.	Met	GLL had the U of M dental department in on 2 occasions for resident specifc training for dental care due to the complex needs of the particular residents. This occurred in	Met	
24.27	Education on the proper use of new, job-specific equipment is provided whenever new equipment is acquired.	Met	GLL received safe lifts and transfer training which included the use of slider sheets which were purchased new for the facility. This occurred in may - June 2017. All relevent staff	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			attended the training. Documentation related to this is found in the employee HR file		
The staff education program also includes the following, minimally once every 3 years:					
24.28	• Oral Health care;	Met	Oral Health Care was presented during the manadatory education fair in Feb and May 2017, this was presented by the WRHA Regional Educator team	Met	
24.29	• Proper resident transferring techniques;	Met	All relevent staff received safe lifts and transfer training in may and June 2017 this was presented by	Met	
24.30	• Education opportunities to ensure staff have a basic understanding of the value of spiritual and religious care as an integral part of holistic care.	Not Met	Spiritual care education will be provided as discussed with the regional educatior who will come to the facility to provide spiritual care education. date to be determined	Not Met	
24.31	An attendance record is maintained for every in-service education program provided.	Partially Met	inconsistently maintained; staff have not always signed that they have attended. Going forward the plan inplace is for all staff to print and sign there names which will be recorded on a master education tracking form.	Met	
24.32	There is a process to ensure that all staff are made aware of all new or revised policies.	Partially Met	all new policy revisions are indicated on a listing which is provided to each department which includes a staff sign off form that they have read and understand the new policy/revisions which is kept in the policy binder.	Met	
There is evidence of an education services audit process which includes:					

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
24.33	• Annual evaluation of all education programs;	Met	Evaluations are completed after each education session. These evaluations are reviewed and recommendations are carried forward- see 2018 education calendar for the recommended education session as per the evaluation forms	Not Met	
24.34	• Review and analysis of the program evaluations;	Met	as above	Not Met	
24.35	• Recommendations for improvement resulting from the analysis, as required, and;	Met	as above	Met	
24.36	• Implementation and follow-up of those recommendations.	Met	as above	Not Met	

Scoring methodology:

- The bolded measures (24.01, 24.14, 24.20) are pass/fail performance measures. If any one is not met, the standard is not met. If they are met, the other measures are considered before assigning a rating to the standard.
- Of the 33 other measures:
  - If ≥26 measures are met, standard is met.
  - If ≥20 and <26 measures are met, standard is partially met.
  - If < 20 measures are met, standard is not met.

Result: Two of 3 bolded performance measures are met and 25 of 33 other performance measures are met.
The standard is: Not Met
Comments:

Standard 25: Complaints

Reference*: Personal Care Homes Standards Regulation, Section 40*

The operator shall establish a written policy for dealing with complaints made by residents and others about the home's care, services or environment, in accordance with any guidelines established by the regional health authority for the health region in which the personal care home is located.

The operator shall post an outline of how to lodge a complaint in a prominent and easily accessible location in the personal care home.

The operator shall keep such records respecting the receipt and handling of complaints as may be required by the regional health authority for the health region in which the personal care home is located.

An operator, other than a regional health authority, shall provide to the regional health authority for the health region such information respecting complaints received as the authority may require, in the time and in the form the authority requires.

A regional health authority shall provide to the minister, as required by the minister and within the time and the form specified, reports respecting complaints received by the personal care homes in the health region, including reports provided to the authority under subsection (4).

Expected Outcome: A complaint process is available to residents and their representatives to address concerns.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
25.01	**There is a written policy that includes a process for dealing with complaints made about the home's care, services or environment.**	Met	GLL policy number: ADM- GA-C- 10	Met	
Directions related to complaint processes:					
25.02	• Are posted in a prominent location in the home;	Met		Met	
25.03	• Include the position and contact information of the appropriate person (people), and;	Met		Met	
25.04	• Are included in the home's admission information package.	Met		Met	
There is record of every complaint received which includes:					
25.05	• The name of the complainant;	Met		Met	
25.06	• The nature of the complaint;	Met		Met	
25.07	• The date of receipt of the complaint;	Partially Met	New complaints form created to accurately reflect 25.7-25.10	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			complaints form to be implemented		
25.08	• The action taken, and;	Met		Met	
25.09	• The date(s) a response was provided to the complainant.	Partially Met	New complaints form includes date received section.	Met	
25.10	There is evidence that complaints are responded to in a timely manner.	Met		Met	
There is evidence that audits of the complaints process are completed, including:					
25.11	• Overall analysis of the number and type of complaints received;	Met	Complaints are tracked and compiled quarterly and reviewed during RCAT meetings. Each department Manager follows up on concerns/issues directly related to their department.	Met	
25.12	• Review of the analysis;	Met		Met	
25.13	• Recommendations made from the review results, as required, and;	Met		Met	
25.14	• Implementation and follow-up of those recommendations.	Met		Met	

Scoring methodology:

- The bolded measure (25.01) is a pass/fail performance measure. If it is not met, the standard is not met. If it is met, the other measures are considered before assigning an overall rating to the standard.
- Of the 13 other measures:
  - If ≥10 are met, standard is met.
  - If ≥ 8 and <10 are met, the standard is partially met.
  - If < 8 are met, the standard is not met.

Result: All performance measures are met.

The standard is: Met

Comments: A review of complaints since late 2016 suggests significant improvement in process has occurred to manage complaints. Notably the facility has revised the complaint form to include previously missing elements, and is now using a database to record and manage the status of the complaint. Complaints are reviewed quarterly at the Resident Care Advisory Team meeting that includes the attendance of the Medical Director and Director of care. Minutes of these meetings detail discussion and action items decided upon and acted upon to resolve issues brought forward.