Pioneer Manor 2021 2nd Quarter Report

Presented To:	Community Services Committee
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Report Summary

This report provides information regarding a quarterly update with respect to operational issues and good news stories for Pioneer Manor.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This information report supports Council's Strategic Plan in the areas of Asset Management and Service Excellence and more specifically in the area of Creating a Healthier Community through alignment of the Population Health Priorities of Families, Holistic Health and the Age Friendly Strategy.

Financial Implications

There are no financial implications associated with this report.

Background

Executive Summary

This report is for the second quarter of 2021. Pioneer Manor is committed to providing a safe, healthy, and supportive environment by treating residents, families, visitors and employees, with respect and fairness. The Home strives towards finding a balance between ensuring resident safety and that the quality of life is not being adversely affected by the safety measures put into place.

Good News Stories

To mark St-Jean Baptiste Day on June 24th, several events took place at Pioneer Manor for the residents to participate/engage in. Raising of the Franco-Ontarian flag at the front of the Home, Nutritional Services served a traditional French Canadian lunch and all residents received a St-Jean Baptiste place mat.

In addition, the life enrichment programs in the afternoon focused on the Francophone culture and the importance of St-Jean-Baptiste day.

Ministry of Long-Term Care (MOLTC)

Inspections conduct by MOLTC (see reference 1 below for definitions)

During the second quarter of 2021, the MOLTC contacted Pioneer Manor to follow up on sixteen (16) critical incidents and two (2) complaints that had been submitted. No areas of noncompliance were found.

No onsite inspections were conducted during the second quarter of 2021.

Critical Incident Reports

All critical incidents (CI) involving residents must be reported to the Director [under the Act] as designated under the *Long-Term Care Homes Act 2007*. The incidents are documented within the on-line Mandatory Critical Incident System (CIS) and received by the the MOLTC (see reference 2 below for definitions).

2021 Relating to "Alleged/Actual Abuse/Assault"	**Q1**	**Q2**
Number of CIs Submitted	8	8
Number of CIs Resident to Resident	3	0
Number of CIs Staff to Resident	5	8
Number of Staff to Resident allegations **substantiated**	2	3
Number of CIs Visitor to Resident	0	0
2021 Other types of CIs Submitted	**Q1**	**Q2**
Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status	2	4
Outbreak	1	0

Complaints/Concerns

As per section 56 (2) of the Long-Term Care Homes (LTCH) Act 2007, the Home has a duty to respond in writing within ten (10) days of receiving a concern, request, or recommendation from either the Resident or Family Councils. In response to the Councils' concerns the below response/action(s) were put into place:

Family Council brought forward concern of staff name tags not being visible and families having difficult time knowing the name of the staff and department they work in. Council was informed that the Home is in the process of updating the staff nametags and expect to roll out this summer. The new nametags will have larger name font for easier identification.

Family Council requested the breakdown of staff to resident ration on each Home area. A copy of the Resident Care Section Staffing providing a breakdown for RNs, RPNs and PSWs per Home Area noting that

staffing resources will fluctuate due to operational challenges.

The following response was given to Family Council's question in regards to Pioneer Manor's policy with respect to contacting POA in regards to what is being done to the resident. The Home operates under the legislative requirements of the *Long-Term Care Homes Act (2007).* Changes to treatments should be communicated to the Substitute Decision Maker (SDM), unless the Resident is capable and asks that this information not be shared. For consent, it is the Resident himself who provides consent to treatment, unless he is incapable and, in that case, the SDM provides the consent. Usually communication occurs within 24 hours. In most cases, the nurse communicates information on behalf of the physician. For other treatments, the individual initiating the changes would do so e.g. dietitian for diet changes.

Resident Council requested that when all items from the Sacristy have been moved over to the chapel that the Chapel not be used as a dining or program area. when the Chapel is completely set up, members would then like to communicate to residents and families that this area is welcoming and available to meet their spiritual needs. In response to this request the Resident Council was informed that as part of our COVID-19 measures, we have not used the Chapel as a dining space in our plan to enable social distancing and our seating plan for Tulip clearly states that the Chapel cannot be used for dining.

Resident Council brought forward concern regarding the speed at which an electric wheel chair is being driven. As a follow up to this concern the Manager of Therapeutic Services spoke with the specific resident regarding his speed. Communicated to the resident what was considered to be an appropriate speed to be used indoors and the options available to him to consider if he was going to continue to use the power device in the Home. The resident has agreed to adjust his speeds appropriately when driving with the Home.

Resident Council brought forward their frustration regarding the length of time it takes for staff on some Home Areas to answer call bells. The Resident Care Coordinators discussed this concern with all Home Area staff at their next team meeting.

As per O. Reg. 79/10, s. 101, every written or verbal complaint made to the Home or a staff member concerning the care of a resident or operation of the Home is investigated and resolved where possible, and a response indicating what the licensee has done to resolve the complaint, or that the Home believes the complaint to be unfounded and the reasons for the belief within ten (10) business days of the receipt of the complaint.

Fourteen (14) written concerns were submitted by residents' family members in relation to care issues. All concerns were investigated and family members received a written response to their concerns.

Key Performance Indicators

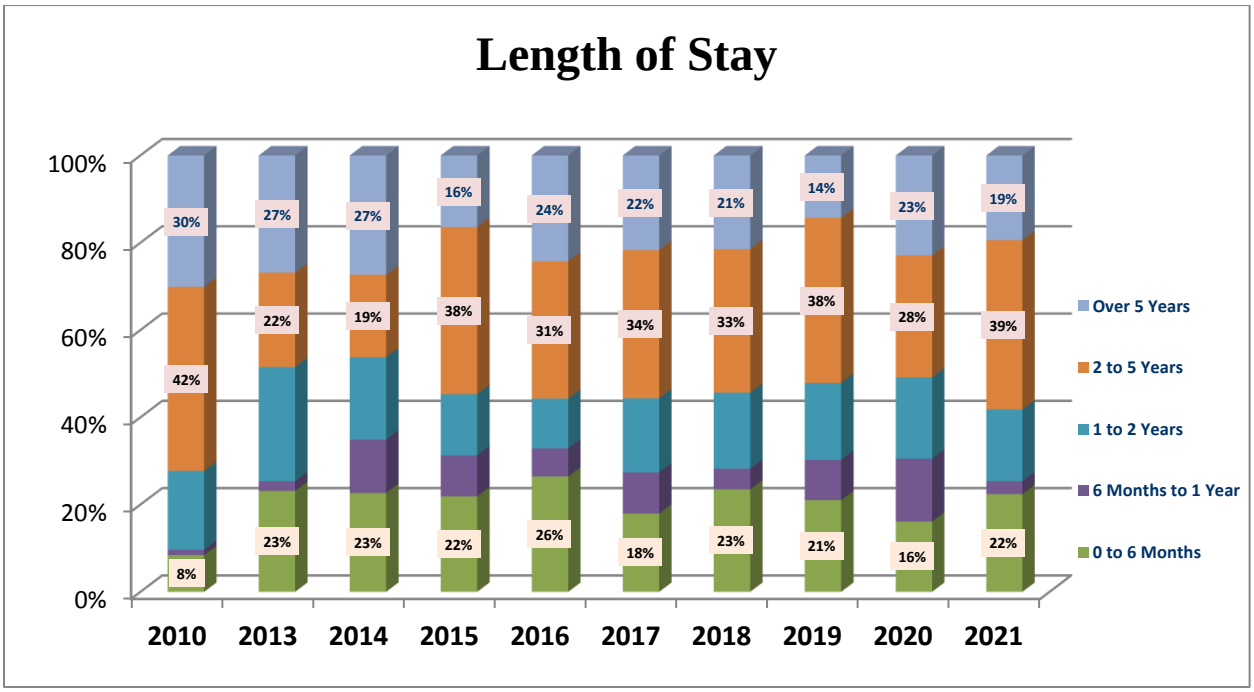
Long-Term Care Home Availability (as of May 2021)					
Facility Name	**Beds**	**# on waitlist for Basic Bed**	**# on waitlist Private Beds**	**Average beds available/month**	**Total # waiting**
Pioneer Manor	433	453	186	10	586
North East LHIN	1639			49	1156

Resident Care Stats (433 Residents)		**2019**	**2020**	**2021**
Admissions	Total	134	109	76
Discharges	Total	11	6	1
Deaths	Total	119	118	67
Internal Transfers	Total	100	111	88

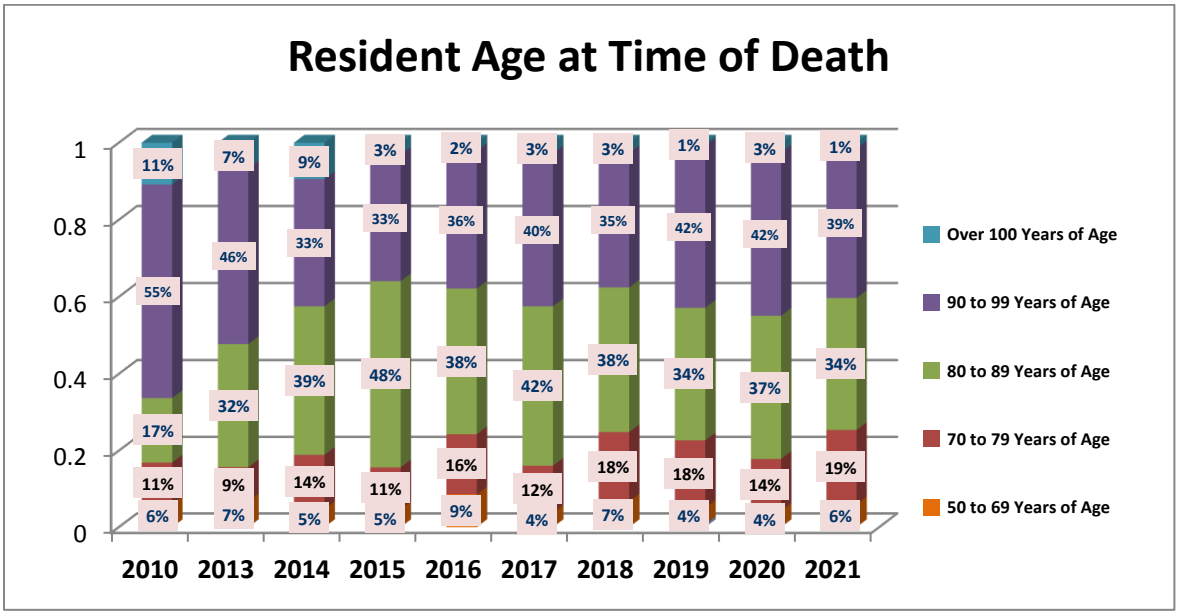
Occupancy Rate	Required to maintain >97%	99%	99%	97.3%**

** Based on 425 beds as 8 beds being utilized for IPAC and admissions purposes during second quarter of 2021.

In 2021 Q1 and Q2, 96% of residents who passed away did so at the Home (versus the hospital) compared to 92% in 2020 and 86% in 2019.



In 2021 Q1 and Q2, 58% of residents who passed away were residents at Pioneer Manor longer than two years compared to 72% in 2010. This is reflective of residents being admitted to the Home with higher acuity.



In 2021 Q1 and Q2, 38% of residents were over 90 years of age at time of death compared to 66% in 2010.

Ministry of Labor Training and Skills Development (MLTSD)

A critical incident in the Home occurred on June 9, 2021. An Employee was removing the garbage bag of soiled briefs from a cart. The garbage bag had not been detached from the role of bags but they did not realize this until they were partway down the hall. When they turned around to see what was happening, they inadvertently stepped on the bags on the floor, slipped and fell resulting in a broken wrist.

The investigation determined that the root causes of the incident were related to the garbage bag was not removed from the roll prior to securing it to the receptacle as per typical practice, the employee was not watching what they were doing before turning their back to the garbage container and the trail of bags from the roll created the slip and fall hazard since they were on the ground.

Corrective actions put into place at the Home included all Employees to be reinstructed of the need to detach the garbage bag from the roll of bags prior to securing it onto any receptacle (garbage can, cart etc.). In addition signage reminding Employees to detach the garbage bag to be added to the lid of the brief disposal carts.

On June 10th, the MLTSD conducted an investigations via phone and on site regarding the above critical injury. One (1) time based requirement was issued. The Home has sent the required information (copy of the internal incident reports pertaining to the incident) to the MLTSD and awaiting response.

Infection Control

Tracking of infection control rates and analysis of the information to identify clusters (note inherited cases are brought into the Home from the community) continued during the second quarter of 2021.

No outbreaks were declared during the second quarter of 2021.

COVID-19 Pandemic

On March 17, 2020, a state of emergency was declared in Ontario under the Emergency Management and Civil Protection Act relating to the COVID-19 Pandemic. Pioneer Manor has been vigilant in its efforts to protect its residents, as well as staff and visitors. “Appendix A” provides specific details relating to Pioneer Manor’s Response to COVID-19.

Public Health Sudbury & Districts (PHSD) Visits

During the second quarter of 2021, PHSD was in the Home on April 23rd and April 27th to conduct Food Safety inspections. Five (5) Home Area kitchens/serveries were inspected, zero (0) violations were noted.

2021 Falls Prevention

Number of Residents	Q1	Q2
Using chair or chair pad sensors	102	102
Using bed sensors or bed pad sensors	140	147
Using infrared sensors	12	12

Monthly audits of universal precautions were completed by committee members. Among the concerns needing attention were; loose bed rails, light not working, call bell in washroom not working, bedrail photo missing, and mats left on floor. All areas of concerns were reviewed and issues addressed.

Facility Services

Remedial painting continued throughout the Home. A generator test was completed during each month of the second quarter of 2021 including annual inspection/maintenance.

During the second quarter of 2021, maintenance was provided to both domestic hot water tanks for improved performance, improvements with outdoor ground beautification and semi-annual cleaning/maintenance has been completed on all HVAC units including upgrading to MERV 13 filters.

Emergency Preparedness

During the second quarter of 2021, fire drills on all three shifts occurred each month. There were seven (7) Code Whites (situation with an actual or potential violent or out of control person). In addition, there was zero (0) Code Red (fire), zero (0) Code Yellow (missing resident), and zero (0) Code Blue (medical emergency).

Reference 1

The Long-Term Care Home Quality Inspection Program (LQIP) safeguards residents' well-being by continuously inspecting complaints and critical incidents, and by ensuring that all Homes are inspected at least once per year. This is achieved by performing unannounced inspections and enforcement measures as required, and ensuring that actions taken by the government are transparent. The MOLTC conducts complaint, critical incident, and follow up, comprehensive and other types of inspections. An RQI inspection is a comprehensive, systematic two-stage inspection.

For each instance where 'non-compliance' with the legislation has been identified during an inspection a decision must be made by the inspector on the appropriate action to take, including whether to impose a sanction that is an Order. At minimum the inspector will issue a **Written Notification of Non-Compliance (WN**). Whether further action is required is based on an assessment of the following factors; severity and scope of harm (or risk of harm) resulting from the non-compliance and the licensee's past history of compliance for the last 36 months. Actions taken may include; **Voluntary Plan of Correction (VPC),** which is a written request for the Home to prepare a written plan of correction for achieving compliance to be implemented voluntarily. The Home is not required to submit the plan to the ministry. There is no required compliance date set out in the inspection report. **Compliance Order (CO)**, which is an order for the 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 this Act. The Home is required to follow the Order to achieve compliance with the LTCHA within the timelines for compliance set out in the Order. **Work and Activity Orders (WAO)**, which is an order for the Home 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 LTC Home that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under this Act; and to pay the reasonable costs of the work or activity. The Home is required to follow the Order to achieve compliance with the LTCHA within the timelines for compliance set out in the Order. **Written Notification and Referral to the Director (WN & Referral**) is a written notification to the Home that they have referred the matter to the Director for further action by the Director. *(LTCHA, 2007, C.8 s. 152 – 154).*

Reference 2

The LTCH Act defines a CI as an event which poses a potential or actual risk to the safety, security, welfare and/or health of a resident or staff member or to the safety and security of the facility which requires action by staff and/or outside agencies.

- A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the MOLTC Director:
  - Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident,
  - Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,
  - Unlawful conduct that resulted in harm or a risk of harm to a resident
  - Misuse or misappropriation of a resident's money,
  - Misuse or misappropriation of funding provided to a licensee under this Act,
  - An emergency, including fire, unplanned evacuation, or intake of evacuees that affect the provision of care or the safety, security or wellbeing of one or more resident of a LTC Home.

- A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall within one (1) business day report the information upon which it is based to the MOLTC Director:
  - An unexpected or sudden death, including a death resulting from an accident or suicide,
  - A resident who is missing for three hours or more,
  - Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing,
  - An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act,

- Contamination of the drinking water supply,
- An environmental hazard, including a loss of essential services, flooding, breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours,
- A missing or unaccounted for controlled substance,
- A medication incident or adverse drug reaction in respect of which a resident is taken to hospital,
- An injury in respect of which a person is taken to hospital and that resulted in a significant change in the resident's health condition.