Alberta Government

Alberta Continuing Care Health Service Standards

Mackenzie Towne Continuing Care LTC Compliance Report

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December 6, 2013

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Outstanding Standard	Facility Action Plan	Implementation Date
1.6 Promoting Wellness – Are continuing care services planned for in a manner that supports the client: this includes mental health, safety and prevention of diseases. • Safety of clients cannot be assured when chemicals are left unlocked. • There are gaps in client documentation • And there is missing legal authority for residents lacking capacity. **1.7 Continuing care health services shall be provided in accordance with all communicable disease and infection and prevention and**	**Facility to provide written update to Alberta Health by February 6, 2014**	**Facility to provide written update to Alberta Health by February 6, 2014**

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control standards issues by Alberta Health. • Medical items were found on the floor and in cardboard boxes. Not in line with Infection Control best practice. • Most soiled utility rooms did not have the required Personal Protective Equipment for staff. • There was unsafe storage of chemicals and oxygen (the room was found unlocked).		
1.13 Continuing Care Health Service Providers – continuing care health services are delivered by educated and qualified health care providers working within their scope of practice. • A 10% chart review was completed and it was noted that there was definite gaps in documentation. Regulated healthcare staff must at all times view documentation as "an integral part of the nurse's practice, and an important tool that ensures high-quality care." Regulated members must adhere to documentation standards to facilitate continuity of care. Examples of gaps noted below in observations and discussed in the debrief.		
1.**21 Operational policies and processes shall include – but are not limited to: Management of client health information, restraints, including decision-making and review of physical, chemical and environmental restraint.** • During chart review it was		

noted that family members had signed consents to provide medical treatment and care to clients; no evidence of legal authority was found on the charts. • There was a restraint policy, but it did not evidence that inclusion of all restraints as stated in the Standard. A separate policy addressed a "Locked Environment, but did not consider the environment as a restraint. Locked/secure units are considered environmental restraints, therefore the policy should state that this is a form of restraint.		

Observations:

Standard 1.10 – Care Plans – Care plans were individualized to specific resident needs and had been updated and current according to MDS/RaI legislation. Interventions required to assess resident health needs were reflected on the resident care plan. The HCA's had a "working copy" of the care plan in the resident room.

1.16 Medication Management – Medication administration was observed for best practice. The regulated staff locked the medication cart, completed hand hygiene between residents, did not pre-sign medication, used two resident identifiers and were able to discuss all relevant indications with the auditor.
Pharmacy annual medication reviews were complete and addressed significant resident changes.

Evidence for gaps in documentation:

Chart #1 - review showed that the resident repeatedly refused care, but there was a lack of charting for interventions provided to mitigate these behaviors. The charting also did not address the types of behavior present on refusal of care.

Chart #2 – a referral was made to the dietician for assessment of swallowing issues; the dietitian remarked that there was no documentation to reflect any issues. The dietician completed an assessment and made recommendations. One recommendation was to

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document difficulties in swallowing. The auditor could not find documentation to reflect the dietician's recommendations.

Chart #3 – The client had foul odor and concentrated urine which the daughter observed and reported, and yet there was no evidence that the staff identified this change in resident status.

Chart #4 – After a conversation with a family member it was noted that the resident was to have compression stockings for his legs, but also confirmed the resident often refused to wear them. The auditor observed severe edema in the resident's lower extremities', and then reviewed the chart to find a minimal amount of documentation regarding this issue.

Charts were also reviewed for wound care. Some of the residents were found to have multiple co-morbidities and chronic wound issues which could have a direct effect on wound healing. On 2 specific charts it was noted that there were referrals to the ET nurse for assessment and evaluation of the complex wounds. A couple of charts evidenced wound improvement and resolution. One resident with multiple wounds, had special equipment ordered in an effort to offset pressure to these areas.

Follow-up Action Plan:

As discussed in the debrief meeting Alberta Health has attached a suggested action plan that may assist McKenzie Towne LTC to achieve full compliance. We would appreciate the Centre advising Alberta Health directly in writing with attached evidence 60 days in receipt of this Action Plan. We will then advise the Centre of their compliance status.

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