Manitoba

Health, Seniors and Active Living

Personal Care Home Standards Review

Tool #1

Regional Health Authority:	Interlake-Eastern RHA
Facility:	Tudor House Personal Care Home
Number of Beds:	76
Review Team:	Kathy Kelly, Manitoba Health, Seniors and Active Living (MHSAL); Bonnie Lounsbury, (MHSAL); Tara-Lee Procter, Interlake Eastern Regional Health Authority (IERHA)
Review Date (yyyy/mm/dd):	2016/09/20
Report Date (yyyy/mm/dd)::	2016/10/07

Summary of Results

Standard	Regulation	Review Team Rating
01	Bill of Rights	Met
03	Eligibility for Admission	Met
07	Integrated Care Plan	Partially Met
08	Freedom from Abuse/Neglect	Met
09	Use of Restraints	Not Met
11	Nursing Services	Met
12	Pharmacy Services	Met
17	Therapeutic Recreation	Not Met
19	Safety and Security	Not Met
20	Disaster Management	Met
24	Staff Education	Met
26	Critical Incidents and Critical Occurrences	Met

Summary

Met	**8**
Partially Met	**1**
Not Met	**3**

General Comments:
The Standards Review Team greatly appreciates the work done by the management and staff of Tudor House Personal Care Home to prepare for the standards review.

Monitoring Tool 1 was randomly selected for this facility review. The Standards Review Team evaluated and rated the standards as noted in the table above.

For the purpose of those standards that are related to resident health records and in the interest of time, a sample of health records were selected from the list provided for this review. The Standards Review Team did, at a minimum, review the health record of a newly admitted resident, a resident who has resided in the facility for a longer period of time, and a resident for whom a restraint had been ordered.

Findings:
Eight of the twelve standards reviewed were assigned a rating of Met. One standard was assigned a rating of Partially Met and three standards were assigned a rating of Not Met.

A priority for action is compliance with any standard that is rated as other than met and any measure in a core standard that is not rated as met.

Steps must be taken by Tudor House Personal Care Home to comply with all unmet measures in Standard 7 - Integrated Care Plan, Standard 9 - Use of Restraints, Standard 17 - Therapeutic Recreation and Standard 19 - Safety and Security.

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

Standard 1: Bill of Rights

Reference: *Personal Care Homes Standards Regulation Sections 2, 3, & 4*

Bill of Rights

The operator of a personal care home shall ensure that a residents' Bill of Rights is developed for the home in consultation with the residents and their designates. The Bill of Rights must be reviewed and approved annually by the residents and their designates (at minimum, the members of the Resident Council).

What the Bill of Bights must contain

The bill of rights must be consistent with the Act and this regulation and must, at a minimum, clearly reflect the following principles:

1. Residents are to be treated with courtesy and respect, and in a way that promotes their dignity and individuality.
2. Residents are to be sheltered, fed, dressed, groomed and cared for in a manner consistent with their needs.
3. Residents or their legal representatives have the right to give or refuse consent to treatment, including medication, in accordance with the law.
4. Subject to safety requirements and the privacy rights of other residents, residents are to be encouraged to exercise their freedom of choice whenever possible, including the freedom to do the following:
   a) Exercise their choice of religion, culture and language;
   b) Communicate with, and have contact with and visits to and from friends, family and others in private if desired;
   c) Choose recreational activities;
   d) Choose the personal items to be kept in their rooms, when space permits; and

e) Select the clothing to be worn each day.

5. Residents are to be afforded reasonable privacy while being treated and cared for.
6. Residents are to be provided with a safe and clean environment.
7. Residents may communicate and meet with their legal representative as often as necessary and in private if desired.

Bill of Rights to be respected and promoted

The operator shall ensure that the Bill of Rights is respected and promoted in the personal care home (PCH).
The Bill of Rights must be posted in standard CNIB print (Arial 14 font or larger) in locations that are prominent and easily accessible to residents, family, designates and staff.

Expected Outcome: The resident's right to privacy, dignity and confidentiality is recognized, respected and promoted.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
1.01	**The personal care home has a resident Bill of Rights.**	Met	Elder Bill of Rights has been changed to be consistent with other care facilities in the IERHA. See Policy AM-03-10 in binder	Met	
1.02	**The Bill of Rights is reviewed and approved by residents and/ or their designates annually**	Met	Bill of Rights is reviewed and approved every year by the Resident Council. See Resident Council Minutes. It is also reviewed on admission, and is in welcome book .	Met	
The Bill of Rights is posted:					
1.03	• **In minimum standard CNIB print (Arial font 14 or larger), and;**	Met	Font is Arial 14 or larger on 3 posters located in front vestibule and on each neighbourhood	Met	
1.04	• **In locations that are prominent and easily accessible by residents, families and staff.**	Met	Prominent locations include front hallway(administration area) ,& by nursing stations. Placed at wheelchair height.	Met	
The Bill of Rights is consistent with the requirements of the Personal Care Homes Standards Regulation and reflects that:					
1.05	• Residents are treated	Met	# 1 Elder bill of rights	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	with courtesy and in a way that promotes their dignity and individuality;				
1.06	• Residents are sheltered, fed, dressed, groomed and cared for in a manner consistent with their needs, and;	Met	# 3,4,5 Elder bill of rights See Care Plan and ADL sheet	Met	
1.07	• Residents or their legal representative have the right to give or refuse consent to treatment, including medication, in accordance with the law.	Met	# 3,4,5 Elder bill of rights see signed consents	Met	
Subject to safety requirements and the privacy rights of other residents, the facility's Bill of Rights outlines that each resident has the right to:					
1.08	• Exercise their freedom of choice of religion, culture and language;	Met	# 14 Elder bill of rights	Met	
1.09	• Communicate with, have contact with and have visits to and from friends, family and others, in private if desired;	Met	# 9 Elder bill of right s	Met	
1.10	• Choose their recreational activities;	Met	# 4 Elder bill of rights	Met	
1.11	• Choose the personal items to be kept in their rooms, when space permits;	Met	# 6 Elder bill of right s	Met	
1.12	• Select the clothing to be worn each day;	Met	# 4 Elder bill of right s	Met	
1.13	• Be provided reasonable privacy while being treated and cared for;	Met	# 5 Elder bill of right s	Met	
1.14	• Be provided with a safe and clean environment, and;	Met	# 3 Elder bill of right s	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
1.15	• Communicate and meet with their legal representative as often as necessary and in private, if desired.	Met	#101 Elder bill of right s	Met	
There is evidence that the PCH respects and promotes the bill of rights, as follows:					
1.16	• Facility policies are compatible with the Bill of Rights, and;	Met	AM-08-35 Abuse Policy AM-10-30 - Restraints in personal care homes AM- 3-70 Elder Room Enhancement AM-3-110 Visiting Hours regulations AM-3-55 Conmmunity Concerns- Complaints	Met	
1.17	• Audits of how staff incorporates the bill of rights into their daily interactions with residents are completed at least annually.	Met	See Audit form NB -40 2014 Interlake Eastman RHA Personal Care Home Survey 2015-16 Tudor House Long term care survey	Met	
The audit results:					
1.18	• Are reported;	Met	See Audit form and followup	Met	
1.19	• Are reviewed and analyzed;	Met	Evidence in binder	Partially Met	Summarized but not analysed.
1.20	• Recommendations are made, as required, from the audit analysis, and;	Met	evidence in binder	Not Met	
1.21	• Recommendations are implemented and followed up.	Met	evidence in binder	Not Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments

Scoring methodology:

- The bolded measures (**1.01, 1.02, 1.03 & 1.04**) 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 an overall rating to the standard.
- Of the 17 other measures:
  - If ≥14 measures are met, the standard is met.
  - If ≥10 and <14 measures are met, the standard is partially met.
  - If <10 measures are met, standard is not met.

Result: Bolded performance measures are met and fourteen of the 17 other performance measures are met.
The standard is: Met
Comments:

Standard 3: Eligibility for Admission
Reference: *Personal Care Homes Standards Regulation Section 7*

Who is eligible for admission
If a bed is available in a personal care home, any person who meets the eligibility requirements described in clauses 3(a) and (b) of *The Personal Care Services Insurance and Administration Regulation* is entitled to be admitted, unless it can be demonstrated that safe and adequate care cannot be provided to the person in the home.

When determining whether safe and adequate care can be provided, the needs of the person must be considered, as well as the staffing and physical facilities of the personal care home.

The person's needs are those described in the completed Application and Assessment Form and as determined by any contact between the staff of the personal care home and
a) the person and his or her designate or legal representative; and
b) any other person or entity that has provided health care to the person.

A bed designated for short-term respite care is not available under subsection (1).

Expected Outcome: Residents are assessed and placed in the most appropriate setting according to their needs.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
3.01	**There is evidence in the resident's health record that eligibility for admission has been determined by an assessment panel independent of the personal care home;**	Met	Regional policy exists that guides the admission policy to insure consistency within the region. View health records chosen to view A/A is in the chart by a panel. See copy of policy in binder	Met	
3.02	**The admission process is guided by specific documented criteria developed by the facility/Regional Health Authority to determine its ability to meet the needs of the prospective resident.**	Met	PCH Bed Management policy currently being updated and in draft form. See- IERHA Panel guidelines and admission process in binder	Met	
3.03	**There is documented evidence on the resident's health record of pre-admission contact between staff of the facility and the prospective resident, the resident's representative and/or any other person or entity that has provided health care to the prospective resident.**	Met	- see admission checklist with pre-admission visit signed off -preadmission IPN note -completed preadmission assessment -meeting and tour signed off on form 0-33 -tour check list has been developed in order to ensure consistent information is provided Documented evidence exists on IPN that demonstrates pre-admission contact. -Letter to elder /family re application with date of sending out highlighted in chart. sample in binder .	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments

Scoring methodology:

- Each of the measures is bolded (**3.01, 3.02, 3.03**) and are therefore pass/fail performance measures. 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**	Met	Revew Health Records Care plan policy PNM 1-130 and PNM 1-G-40	Met	SIx Integrated Care Plans (ICPs) were reviewed.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	permanent resident health record.		Original ICP are stored in residents file. -Active Care plan is located in daily care book -see evidence binder for integrated care plan. new and old		
Within 24 hours of admission, basic care requirements for the resident are documented, including:					
7.02	• Medications and treatments;	Met	see physician orders / med reconciliation forms	Met	
7.03	• Diet orders;	Met	Diet order sheet and also on Med reconciliation sheet	Met	
7.04	• Assistance required with activities of daily living;	Met	all risks & transfer mobility assessments and adl sheet completed in first 24 hours	Met	
7.05	• Safety and security risks, and;	Met	fall risks & transfer mobility assessments done in first 24 hours	Not Met	Two of five applicable records contained the required information.
7.06	• Allergies.	Met	Page 1 resident admission assessment and history care plan	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	Residents have Multidiscipline review within 8 weeks of admission - see files Letters are sent to families . see copy of letter in evidence binder and on selected files.	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:					

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
7.08	• Bathing;	Met	Page 3	Met	
7.09	• Dressing;	Met	Page 4	Partially Met	Four of six ICPs contained the required information.
7.10	• Oral care;	Met	Page 6	Met	Information sparse given what is available via assessemts and process with the oral care kits
7.11	• Skin care;	Met	Page 3	Met	
7.12	• Hair care;	Met	Page 4	Met	
7.13	• Fingernail care;	Met	Page 4	Met	
7.14	• Foot care;	Met	Page 4	Met	
7.15	• Exercise;	Met	Page 5 & in recreation care plan	Partially Met	Four of six ICPs contained the required information.
7.16	• Mobility;	Met	Page 7	Met	
7.17	• Transferring;	Met	Page 8	Met	
7.18	• Positioning;	Met	Page 8	Not Met	Three of six ICPs contained the required information.
7.19	• Bladder function;	Met	Page 5	Partially Met	Four of six ICPs contained the required information.
7.20	• Bowel function;	Met	Page 5	Partially Met	Four of six ICPs contained the required information.
7.21	• Any required incontinence care product;	Met	page 5 Integrated care plan	Not Met	Three of six ICPs contained the required information.
7.22	• Cognitive and mental health status;	Met	page 10 & 11 Integrated care plan	Met	
7.23	• Emotional status, and personality and behavioural characteristics;	Met	page 11 Integrated care plan	Met	
7.24	• Available family, social network, friends and/or community supports;	Met	-social and communitity support listed on page 2 and on additional recreation plan, (back page) -contact information and any additional information regarding accessing supports, timing & frequency	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
7.25.	• Hearing ability and required aides;	Met	Resident demographic sheet NA-2	Not Met	Three six ICPs contained the required information. 3/6
7.26	• Visual ability and required aides;	Met	Resident demographic sheet NA-2	Partially Met	Four of six ICPs contained the required information.
7.27	• Rest periods, bedtime habits, and sleep patterns;	Met	page 5 Integrated care plan	Met	
7.28	• Safety and security risks and any measures required to address them;	Met	age 5 Integrated care plan	Met	
7.29	• Language and speech, including any loss of speech capability and any alternate communication method used;	Met	age 5 Integrated care plan	Partially Met	Four of six ICPs contained the required information.
7.30	• Rehabilitation needs;	Met	Page 5 Integrated care plan	Not Met	Three of six ICPs contained the required information.
7.31	• Therapeutic recreation requirements;	Met	see recreation sheet following new care plan. all others integrated in care plan .	Met	
7.32	• Preferences for participating in recreational activities;	Met	Page last page of Integrated care plan	Not Met	The ICP did not clearly identify that the choices listed, which appeared to be based on the calendar options available, were the preference of the resident to attend. It is understood that on any given day a resident may or may choose to attend their preferences, if offered.
7.33	• Religious and spiritual preferences;	Met	Resident Demographic sheet	Met	
7.34	• Food allergies;	Met	Resident Demographic sheet	Met	
7.35	• Diet orders;	Met	Page 6 Integrated care plan	Met	
7.36	• Type of assistance required with eating;	Met	Page 6 Integrated care plan	Met	
7.37	• Whether or not the resident has	Met	Resident Demographic Sheet	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	made a health care directive;				
7.38	• Special housekeeping considerations, and;	Met	Special housekeeping considerations -isolation precautions, specific time that they will allow housekeeping to attend to their room, resident would like to be present during the housekeeping, - additional care needs on pg. 13	Partially Met	2 ICP were missing the special housekeeping care plan
7.39	• Other needs identified by the interdisciplinary team.	Met	page 12	Partially Met	
7.40	The integrated care plan outlines care goals and interventions that will be taken to achieve those care goals.	Met	column 3 on care plans	Met	5/6
There is evidence that the integrated care plan is reviewed:					
7.41	• **At least once every three months by the interdisciplinary team, and;**	Met	all residents have MDR's every 3 months with multidisciplinary participation in the review. see attendence on MDR shet .	Met	
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	old and new care plans have signature sheets for all staff who provide direct care as well as resident and representative (when possible.)	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	newer process for Tudor House - auditing 10% quarterly	Met	ICP audits are well done
7.44	• Are reviewed & analyzed;	Met	- using chart audit summary and chart audit trending analysis	Not Met	More work is needed in this area to record the utilization of the

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			forms from region		information from the audits
7.45	• Result in recommendations for improvement being made as required, based on the audit analysis, and;	Met	see identified recommendations	Not Met	
7.46	• Result in recommendations being implemented and followed up.	Met	Reporting and Follow up at nursing /HCA meetings and managerment , meetings -	Not 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: All bolded measures are met; twenty five of the 42 other performance measure are met

The standard is: Partially Met

Comments:
The Special Housekeeping Care Plan is excellent.
It is suggested that staff responsible for ICPs be reminded that detail is imperative. The lens to be used is who, what, where, how, why and when, if applicable and "as a new/casual/agency staff what do I need to know to provide the care to resident consistent with their needs"
The culled files require some organization. The current status of the information is disorganized and it is difficult to locate any required information for any enquiry.

Standard 8: Freedom from Abuse/ Neglect

Reference: *Personal Care Homes Standards Regulation, Section 15*

Freedom from Abuse/Neglect

The operator shall establish safeguards to prevent residents from being abused.

The operator shall establish a written policy that sets out:

a) The safeguards established to prevent residents from being abused/neglected; and
b) The appropriate action to be taken when abuse/neglect is alleged.

In this section, "abuse" means mistreatment – whether physical, sexual, mental, emotional, financial or a combination of any of them – that is reasonably likely to cause physical or psychological harm or death to a resident, or loss of property belonging to the resident.

In this section 'neglect' means an act or omission that

(a) is mistreatment that deprives a patient of adequate care, adequate medical attention or other necessaries of life, or a combination of any of them, and

(b) causes or is reasonably likely to cause

(i) death of a patient, or

(ii) serious physical or psychological harm to a patient;

Expected Outcome: Residents will be safeguarded and free from abuse or neglect.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
The personal care home has a policy in place regarding freedom from abuse and neglect that includes:					
8.01	• A definition of abuse and neglect;	Met	Policy located in binder AM- 08-15; AM-03-65	Met	
8.02	• The appropriate action to be taken when abuse or neglect is alleged;	Met	see policy	Met	
8.03	• Circumstances for notification of the resident's designate or legal representative;	Met	see policy (also included on occurrence report)	Met	
8.04	• A description of available local resources to assist an abused resident, and;	Met	Updated Elder abuse resource guide and pamphlets obtained and located in front of building as well as Tudor House library and in nursing areas for easy	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			accessibilty.		
8.05	• Mandatory reporting to the Protection for Persons in Care Office (PPCO).	Met	See Policy which states mandatory reporting	Met	
8.06	**Protection for Persons in Care Act information is posted in locations that are prominent and easily accessible by residents, families and staff.**	Met	Located in resident care areas and on family communication board. Pamphlets available in pamphlet holder in front vestibule and at nursing stations.	Met	
There is documented evidence of:					
8.07	• All facility reports made to PPCO, and	Met	See record of reports made to PPCO	Met	
8.08	• Facility follow up on all allegations of abuse and/or neglect.	Met	follow up is on occurrence reports. we have no reports that have met the threshold	Met	

Scoring methodology:

- The bolded measure (**8.06**) is pass/fail performance measures. If it is not met, the standard is not met. If it is met, the other measures are considered before assigning a rating to the standard.
- Of the 7 other measures:
  - If ≥6 measures are met, standard is met.
  - If 4 or 5 measures are met, standard is partially met.
  - If <4 measures are met, standard is not met.

Result: All performance measures 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	Least restraint in Personal Care home Policy III - R- 10. Tudor house has implemented the IERHA restraint and the documentation in 2015. Education was delivered to staff to implement new forms	Met	Five residents with restraints were reviewed.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
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	See documentation found in health record. & evidence binder	Partially Met	Three of four applicable consent contained the required documentation.
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	See documentation in the health record & evidence binder	Met	One consent was verbal.
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	see documentation in health record. new documentation of PIECES formatted assessment has been completed in any new restraints initiated after summer of 2015.	Partially Met	Three of five restraint assessment documentation forms met the requirement. One restraint was not identify as such and and one restraint assessment form had one signature on the document.
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	see documentation	Met	
9.06	• The resident's physical status;	Met	see documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.
9.07	• The resident's emotional status;	Met	see documentation	Met	
9.08	• The resident's mental status;	Met	see documentation	Met	
9.09	• The resident's nutritional status;	Met	see documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.10	• All alternatives tried and exhausted;	Met	see documentation	Not Met	Two of five restraint assessment documentation forms met the requirement.
9.11	• Review of current medications;	Met	see documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.
9.12	• Actual and potential benefits to the resident if the restraint is applied;	Met	see documentation	Met	
9.13	• Actual and potential burdens to the resident if the restraint is applied, and;	Met	see documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.
9.14	• Any other additional ethical considerations.	Met	see documentation	Not Met	not present on form or narriative
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	see documentation	Met	
9.16	• The frequency of checks on the resident while the restraint is in use;	Met	see documentation	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	see documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.
9.18	• The professional designation of the person giving the order, and;	Met	see documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.
9.19	• For a chemical restraint, the time limit for its use (the discontinuation date).	Met	see documentation	Not Met	The one chemical restraint did not have the required documentation.
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	see health records and care plan documentation	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
9.21	• The length of time the restraint is to be used for each application;	Met	see health records and care plan documentation	Met	
9.22	• The frequency of the checks on the resident while the restraint is in use, and;	Met	see health records and care plan documentation	Partially Met	Three of five restraint assessment documentation forms met the requirement.
9.23	• When regular removal of restraints is to occur.	Met	see health records and care plan documentation	Met	
9.24	There is documented evidence that the continued use of any restraint is reviewed at least once every three months.	Met	see health records	Met	
9.25	There is documented evidence within the health record of efforts to resolve the issue for which the restraint was initiated.	Met	see health records	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	health records for emergency restraints	Met	No emegency restraints were assessed. Measures 9.26 - 9.33 met on the basis of policy.
9.27	• The name of the person ordering the restraint;	Met	health records for emergency restraints	Met	
9.28	• The designation of the person ordering the restraint;	Met	health records for emergency restraints	Met	
9.29	• The time the restraint was applied;	Met	health records for emergency restraints	Met	
9.30	• The frequency of checks;	Met	health records for emergency restraints	Met	
9.31	• Notification of the resident's legal representative or next of kin;	Met	health records for emergency restraints	Met	
9.32	• Care provided to and response of	Met	health records for emergency	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	the resident in restraint, and;		restraints		
9.33	• When the resident's reassessment is to occur.	Met	health records for emergency restraints	Met	
As part of the facility's continuous quality improvement/ risk management activities, there is evidence that audits of the use of restraints:					
9.34	• Occur at least annually;	Met	see restraint audits & chart audits compiled by nurse managers	Not Met	No audits in evidence
9.35	• Are reviewed/analyzed;	Met	reviews of audits completed by nurse managers.	Not Met	
9.36	• Result in recommendations for improvement being made, as required, based on the audit analysis, and;	Met	recommendations for improvement by nurse managers discussed in Health care meetings and Nurses monthly meetings when required.	Not Met	
9.37	• Result in recommendations being implemented and followed up.	Met	Follow up completed by nurse managers in future audits	Not 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 bolded measure is met and one bolded measure is not met. Twenty of 35 other performance measures are met.
The standard is: Not Met

#	Measure	Facility Rating	Comments	Review Team Rating	Comments

Comments: One chemical restraint was identified by the reviewers and had not been documented as same by staff. The CQI process with restraints must occur annually. Audits will demonstrate areas in need of improvement.

Standard 11: Nursing Services

Reference: *Personal Care Homes Standards, Section 21, 22 & 23; Nursing Services Guideline, Manitoba Health Policy HCS 205.3, Nursing Services Guideline Plan/Template*

Nursing services for residents

The operator shall ensure that nursing services are organized and available to meet residents' nursing care needs, in accordance with guidelines approved by the minister and consistent with professional standards of practice.

Nurse in charge of care

The operator shall designate a registered nurse or a registered psychiatric nurse to be in charge of administering nursing services in the personal care home.

If a personal care home has 60 beds or more, the operator may require the nurse designated under subsection (1) to also be in charge of administering other services at the personal care home. But the operator shall not require that nurse to supervise nursing care in the home or, except in an emergency, provide clinical services to residents.
If a personal care home has fewer than 60 beds, the operator may assign additional responsibilities to the nurse designated under subsection (1).

General nursing requirements

The operator shall establish written nursing policies and procedures relating to the care needs of the residents.

The operator shall ensure that space, equipment and supplies are available to facilitate the professional, educational and administrative activities of the home's nursing services.

Expected Outcome: Residents receive nursing care that meets their needs and in a manner that enhances their quality of life.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
11.01	There is an organization chart for	Met	see Organizational chart in	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	the nursing department that clearly delineates the lines of responsibility, authority and communication.		binder		
Policies and procedures for the nursing department are:					
11.02	• Reviewed minimally every three years, and;	Partially Met	Many policies and manuals have been reviewed and updated as we are working towards having our policies consistent with IERHA policies as they continue to work through their amalgamation.	Partially Met	
11.03	• Readily available to nursing staff.	Met	Manuals are located in Board Room and are on the shared server to provide access for staff. -Infection Control manuals, P & T Manual, Wound Care, Fall Risk Manuals available resources for staff and in neighbourhood or in boardroom	Met	
11.04	There is space, equipment and supplies available to the nursing department for professional development, education and administrative activities.	Met	TV, VCR and Videos are available. Boardroom and recreation space are used for inservices as well as Woodland Court boardroom .	Met	
11.05	**A Registered Nurse or Registered Psychiatric Nurse is in charge of nursing services for the facility.**	Met	Ashley Martyniw RN, RPN is our CEO and in in charge of nursing facilities for the facility.	Met	
11.06	If the home has 60 or more beds, the nurse in charge of the facility does not provide direct care.	Met	The CEO/ Administrator has overall responsiblility for Corporate and Nursing Care Services and does not provide clinical services.	Met	
11.07	A registered nurse or registered psychiatric nurse is on-site at the	Not Met	See records in personal office, for the past 2 years. Copies of	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	home to supervise the nursing care 24 hours per day, seven days per week.		sick shifts and replacements available on request from personal . See also call in list in Ward Clerk office. There are times when an LPN is utilized with an RPN/RN on call.		
If a registered nurse or registered psychiatric nurse cannot be secured to supervise nursing care, as an interim measure only:					
11.08	• A licensed practical nurse is on site at the PCH, and;	Met	See duty schedules. When LPN's are supervising the facility as per policy PNM-II-Q-90, a nurse manager is always on call -There is documneted note on LPN's File demonstrating completion of orientation to managing facility in case of emergency.	Met	
11.09	• A registered nurse or registered psychiatric nurse is accessible (on call).	Met	A Nurse Manager is always on call 24/7 In-charge person's name is posted in front administration office.	Met	
11.10	**There is documented evidence that records are kept of any/all period(s) of time when the facility is unable to secure a registered psychiatric nurse or registered nurse to supervise nursing care on site.**	Met	Human Resources keeps documented evidence of any periods of time when the facility is unable to secure a RPN/RN. see binder for evidence 2014-2016	Met	
There is an advance plan to ensure safe and effective care of residents during any periods where the facility is unable to secure a registered nurse or registered psychiatric nurse to supervise nursing care. The plan includes:					
11.11	• Evidence of ongoing efforts to recruit registered psychiatric nurse(s) / registered nurse(s) to fill such vacant positions as may exist;	Met	copies of posted positions available in CEO office. Job Postings and letters on Q drive on computer (2014-2016)	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
11.12	• Description of the role of the accessible registered nurse or registered psychiatric nurse on call;	Met	Charge Nurse Binder being developed in May 2016 modeled after IERHA Charge Nurse Binder	Met	
11.13	• Description of the role of the licensed practical nurse on-site;	Met	Charge Nurse Binder being developed in May 2016 modeled after IERHA Charge Nurse Binder	Met	
11.14	• Evidence of on-site preparation of the licensed practical nurse(s) to undertake this role, and;	Met	Each LPN has documented note on LPN's file demonstrating completion of orientation to manageing facility in case of emergency	Met	
11.15	• Criteria to support the licensed practical nurse in decision-making for resident care.	Met	Charge Nurse Binder being developed in May 2016 modeled after IERHA Charge Nurse Binder	Met	
11.16	There is documented evidence that records are kept of compliance with the minimum required hours of care per resident per day(HPRD), according to the PCH Staffing Guidelines).	Met	Listed on bottom of page on Schedule book housed in Personnel office.	Met	

Scoring methodology:
The bolded measures (**11.05 & 11.10)** are pass/fail performance measures. If either of these measures are not met, the standard is not met. If they are met, the other measures are considered before assigning a rating to the standard

<u>If the facility has over 60 beds:</u>

Of the remaining 14 measures.

- If ≥11 measures are met, the standard is met.
- If ≥8 and <11 measures are met, the standard is partially met.
- If <8 measures are met, the standard is not met.

<u>If the facility has under 60 beds:</u>

Of the remaining 13 measures:

- If ≥10 measures are met, standard is met.
- If ≥8 and <10 measures are met, standard is partially met.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	○ If <8 measures are met, standard is not met.				

Result: Bolded performance measures are met and thirteen of 14 other 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	Current contract kept inCEO office and available on request (with Rexall-Geri-Aid)	Met	
12.02	The contract defines the scope of service.	Met	See Contract	Met	
12.03	The contract includes provision for emergency and after hour services.	Met	Provision is in contract	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	Nurse documents in IPN, and Med review copy which is placed in file.	Met	
12.05	Policies and procedures for pharmacy services are available, complete and reviewed minimally every three years.	Met	Policies and procedure manual are in each nursing unit (2) and in board room for references and easy access by nurses. Last reviewed October 2015	Met	
There are designated medication storage areas that are:					
12.06	• Clean;	Met	observe on tour /	Met	
12.07	• Well organized;	Met	observe on tour / contents of cupboards are organized and labeled; internal/ external products are separated;	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
12.08	• Well equipped;	Met	observe on tour	Met	
12.09	• Well maintained, and;	Met	observe on tour - see maintenance records	Met	
12.10	• Secure.	Met	observe on tour - door locks automatically & only nurses have keys	Met	
12.11	All controlled substances are securely stored under a double lock.	Met	observe on tour / locked box in locked drawer on med cart	Met	
12.12	All controlled substances are counted and signed by two nurses at least once every seven days.	Met	Tudor House counts controlled substances every shift - see records - see narcotic count kept in medication room	Met	
Nursing staff have access to:					
12.13	• A supply of medications for emergency use (emergency drug box), and;	Met	Emergency drugs are securely stored in a box located in Poplar oak Medication room and are checked monthly. There is a list of all the medications in the emergency drug box in both med rooms . Monthly check sheets are completed by night nurse and stored in binder in Photocopy room office.	Met	
12.14	• Medications that should be administered without undue delay (in-house drug box for antibiotics, analgesics, etc).	Met	these medications are checked by night staff and are also checked by Pharmacist Med Room Audit.	Met	
Withdrawals from the emergency drug box, in-house drug box and controlled substance storage are documented, including:					
12.15	• Date;	Met	See blank withdrawal sheet . See Current tracking sheets are in medication room and completed ones are stored in Ward Clerk Office.	Met	It is recommended that a withdrawal sheet be implemented for stock/emergency injectables.
12.16	• The name and strength of the drug being withdrawn;	Met	see withdrawal sheet	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
12.17	• Quantity taken;	Met	see withdrawal sheet	Met	
12.18	• The name of the resident being given the drug, and;	Met	see withdrawal sheet	Met	
12.19	• The name of the nurse making the withdrawal.	Met	see withdrawal sheet	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 physician/Nurse Practitioner, the pharmacist and the nursing staff at the receiving facility (i.e. medication reconciliation)	Met	Medication reconciliation is completed on all residents on admission and transfers between health care facilities (see resident files)	Met	5/5
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	Pharmacist audits every 3 months. Completed audits are kept in Administration Office	Met	It is encouraged that the audits be summarized and reviewed to see if there are potential themes that need to be addressed.
12.22	• The audit results are shared with nursing staff.	Met	Audit results are posted in medication room for all nurses to review	Met	
12.23	**A monitored dose or unit dose system is used for medication distribution in the facility.**	Met	Pac- Med system is used. See on tour	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	Medications are signed off on checklist	Met	
12.25	• Periodic audits of a medication pass for each nurse.	Met	See binder with medication pass audits	Met	Med pass audits are being completed. However, it is

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
					suggested that these audits be summarized to see if there are potential themes that all staff require education/training for.
12.26	The resident's identity is confirmed prior to administration of medications by use of minimally two identifiers.	Met	Pictures on all MARS and TARS (updated yearly). residents have wrist bands.	Met	
12.27	The medication administration record identifies allergies and diagnoses.	Met	Allergies and Diagnosis is on all MARS sheets (written in Red on CP	Met	
12.28	**A pharmacist is available to provide drug information as required.**	Met	See contact list at each nursing station (24 hour x 7days)	Met	
A committee has been established:					
12.29	• **That includes representation from pharmacy, medicine, nursing and administration;**	Met	See P drive for minutes of meetings. (sample in binder) Pharmacy Physician, Nurse manager attend committee.	Met	
12.30	• **That meets at least once every 3 months.**	Met	see P drive for with dates of meetings.	Met	
12.31	• To review and make recommendations on drug utilization and costs;	Met	see past two years of minutes (or more) on p drive ; agenda and follow up with each meeting	Met	
12.32	• To review and follow up on medication incidents and adverse reactions, and;	Met	see past two years of minutes (or more) on p drive ; agenda and follow up with each meeting	Met	
12.33	• To review and make recommendations on all policies for the procurement and administration of medication within the home;	Met	see past two years of minutes (or more) on p drive ; agenda and follow up with each meeting	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

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	met. If all are met, the other measures are considered before assigning an overall rating to the standard. • Of the 27 other measures: o If ≥22 measures are met, the standard is met. o If ≥16 and <22 measures are met, standard is partially met. o If <16 measures are met, standard is not met.				

Result: All performance measures are met.

The standard is: Met

To ensure there is no breach of PHIA, MAR sheets should be covered either by a solid color (laminated is bes) or the MAR book closed. It is important that when the cart is out of the line of sight of the nurse it is locked not latched as occurs by turning the black knob on the cart.

Comments:

Cautionary Note: Injectable Lorazepam meets the federal requirement as a controlled substance and it is counted in the controlled substance count. It is suggested that a small lock box with a key is purchased and kept in the fridge for this medication when it is in use. The keys would be kept with the nurse along with the other keys they carry for the med cart and medication room.

Standard 17: Therapeutic Recreation

Reference: *Personal Care Home Standards Regulation, Section 31*

The operator shall ensure that:

a) Recreational programming, for both individuals and groups, are available to meet residents' physical, emotional, cultural and social needs;
b) Recreational programming is available to residents who are unable to leave their rooms;
c) Recreational programming is available during some evenings and weekends;
d) Recreational areas with suitable equipment and materials to enhance residents' quality of life are available to residents, and;
e) Information about the current recreational programs available is posted in large print in a prominent and easily accessible location in the personal care home.

Subject to safety requirements and the privacy rights of other residents, the operator shall ensure that residents are assisted to participate in the recreational programs referred to in subsection (1).

Expected Outcome: Residents participate in therapeutic recreational programming that enhances their quality of life.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
There is evidence in the resident's permanent health record of:					
17.01	• A recreation assessment that identifies the resident's individual therapeutic recreation needs;	Met	review Leisure assessment in health care record	Not Met	The current use of the LCM provides the number of recommended interventions per month. The assessments lack specificity to the resident. The assessment should determine not only identify how past and current interests fit the what is offered currently by the PCH but also may expand the breadth of what is offered by the PCH or facilitated by the PCH (one to one or assistance to residence for choice in their room or quiet room) or is self-directed.
17.02	• Recreation staff participation in each resident's quarterly interdisciplinary care plan review;	Met	review recreation staff participation in residents quarterly MDR in care record	Not Met	The section of the form was either blank and the recreation staff sent regrets or if attended provided a verbal report; and did not complete the recreation section on the form.
17.03	• Recreation staff participation in the annual interdisciplinary care conference, and;	Met	Tudor House has quarterly interdisciplinary care confereces and recreation staff have input .	Not Met	
17.04	• The resident's participation in recreation programs.	Met	See health record and Recreation participation records	Met	
There is an individual recreation plan, that is part of the resident's integrated care plan:					
17.05	• That is based on the resident's assessed recreation needs;	Met	Needs and interests are assessed and care plan is developed from same. TH is currently changing our care plans to reflect enhanced resident centered programs that meet their needs. See	Not Met	The individual recreation plan was not consistent with the LCM based on number of requirements or on what the resident is attending as in reported in the quarterly care plan meeting summaries.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			Resident health records		
17.06	• That identifies the resident's specific recreation goals, and;	Met	See resident health records	Met	
17.07	• That identifies the resident's specific recreation interventions.	Met	See Resident health records	Met	
Each month's recreation programming includes:					
17.08	• A variety of planned programs to meet all residents' physical, emotional, cultural and social needs (including large and small group activities);	Met	See last two years of recreation calendars. (separate calendars for poplar-oak area and maple area) see recreation binder that outlines descriptions for activities see attendance records.	Met	Suggest that activites that are "regular" i.e. Mon/Wed/Fri - be listed on the calendar each day it is scheduled.
17.09	• Some evening and weekend activities, and;	Met	noted on calendar	Met	
17.10	• Options for residents who cannot/do not prefer to participate in group programs.	Met	1-1 individualized visit are identified on calendar	Met	
Information about recreation programs:					
17.11	• Is posted in prominent, resident-accessible locations throughout the home, and;	Met	recreation programs are posted on resdient/family board and in every resident room	Met	
17.12	• Is clear and easy for residents to read.	Met	Large type - at least 14 arial font	Met	The actual titles of events were not clear. It is recommended that the title reflect the activity.
A variety of recreation audits, including program/services audits and audits related to meeting individual resident's recreation goals (as they were determined by the resident and from their recreation assessment):					
17.13	• Are conducted at least every three months;	Partially Met	Program audits have recently been changed to implement resident centered audits in July 2016 .	Not Met	Calendar audits have been implemented for 2016 which are very good. However there are other types of audits that can also be implemented e.g. program audits, attendance audits and surveys.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
17.14	• Are reviewed, analyzed and reported;	Met	audits are reviewed, analyzed and reported in management meeting	Not Met	
17.15	• Recommendations are made from the audit analysis, as required, and;	Met	recommendations are suggested at management meetings	Not Met	
17.16	• Recommendations are implemented and followed up.	Met	see notes on audits for recommended follow - up	Not Met	

Scoring methodology:

- There are no pass/fail performance measures.
- Of the 16 measures:
  - If ≥ 13 measures are met, standard is met.
  - If ≥ 10 and < 13 measures are met, standard is partially met.
  - If < 10 measures are met, standard is not met.

Result: Eight of 16 performance measures rated as met.

The standard is: Not Met

Comments: The LCM will generate a number of required interventions based on an assessment. It is suggested that research into a tool that assess both leisure preferences and requirements for possible use or an additional assessment with the LCM to determine the type of leisure pursuits the resident prefers or might choose to participate in.

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	see temperature monitoring for past 2 years.	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.**	Met	see water temperatures records . and testing on review day	Not Met	10 of 14 water temperatures taken at resident accessible location were under 43C. Those temperatures that were within the range were at the low end of the scale and the water ran for a long time to reach that temperature.
19.03	There is documented evidence of frequent monitoring (minimally once per week) of domestic hot water temperatures at locations accessible to residents.	Met	see water temperature records for past two years monitored twice weekly in 3 locations	Met	
19.04	There is an easily accessible call system in all resident rooms.	Met	view on tour - call system close to bed. it is audible at nursing station and near vicintity . call system is being reviewed with possible consideration to upgrades to building in future renovations	Met	
19.05	There is an easily accessible call system in all resident washrooms.	Met	view on tour - call system in washroom accessible to resident. it is audible at nursing station and near vicintity . call system is being reviewed with possible consideration to upgrades to building in future renovations	Met	
19.06	There is a call system in all bathing facilities that is easily accessible from all areas around the tub.	Met	view /assessed on tour - call system within reach and accessible around the tub. it is	Met	One call bell string on Oak requires lengthening.

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			audible at nursing station and near vicintity . call system is being reviewed with possible consideration to upgrades to building in future renovations		
19.07	All open stairwells are safeguarded in a manner which prevents resident access.	Met	view/assessed on tour. see signage	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	view/ on tour.- stairwell doors are not accessible to residents Outsider doors have key pad / magnetic locks approved by fire code.- see fire inspection verification	Met	
19.09	All windows are equipped with a mechanism or are appropriately designed so they cannot be used as exits.	Met	view/ assessed on tour - all windows have limiters installed. See audts completed by Workplace Health and Safety	Met	
19.10	Handrails are properly installed and maintained in all corridors.	Met	assessed on tour - audts completed by Workplace Health and Safety -	Met	
19.11	Grab bars are properly installed and maintained in all bathrooms and bathing facilities.	Met	assessed on tour -audts completed by Workplace Health and Safety	Met	
19.12	All potentially dangerous substances are labeled and stored in a location not accessible to residents.	Met	assessed on tour. Locked cabinet in tub rooms. Denture cleaners, hair spray, are kept in closed drawers in resident rooms and are not accessible to wanderers. Hair dressing supplies are locked in hairdressing room and door is locked unless hairdresser is present.	Met	Two combustibles were found and removed.
19.13	Combustible materials are stored	Met	assessed on tour - Metal	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	separately and safely in a container that does not support combustion.		combustible storage cabinet is in maintenance area in basement .		
Upon inspection/observation, all equipment is;					
19.14	• Safe for use;	Met	assessed during visit	Met	
19.15	• Safely stored, and;	Met	assessed during visit	Met	
19.16	• Used in a manner that protects residents.	Met	assessed during visit	Met	
There is documented evidence for all equipment, including building systems, that demonstrates the completion of:					
19.17	• As needed repairs, and;	Met	see work order binder in boardroom and copy of maintenance repair request sheet	Met	
19.18	• Preventive maintenance.	Met	see preventative maintenance binder in boardroom (divided into departments)	Met	
19.19	The facility has a current policy governing the use of personal electric appliances kept by the resident.	Met	See new admissions handbook and Policy I-A-65 Elders Personal Equipment & supplies	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	see also policy AM-4-40 Tobacco use/ smoke free environment	Met	
All exits are:					
19.21	• Clearly marked, and;	Met	assessed on tour	Met	
19.22	• Unobstructed.	Met	assessed on tour	Met	
19.23	The exterior of the building is maintained in a manner which protects the residents.	Met	assessed on tour, see also maintenance check forms	Met	
19.24	The grounds and exterior furniture are maintained in a manner which	Met	assessed on tour	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	protects the residents.				
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	Tudor House has a Roam Alert system in place which has identifying bracelets for residents as well as key pad at all exit doors . Residents who are at risk for elopment are identified by name and picture placed in discreet staff observered places (admin office, nursing station)	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: Bolded measure is not met and twenty three of 23 other performance measures are met.

The standard is: Not Met

Comments: Tub rooms require both cleaning instructions and sign off for cleaning as well as PPE. Tubs only require 38 - 42 degrees. Most residents would not tolerate up to 43C. Tub and shower room were not locked as per instructions. Tub rooms had evidence of potential multi-resident use items ie sharps/deoderant . These require labeling to denote to whom the item belongs or discarded if unsure to prevent cross resident use.

Standard 20: Disaster Management Program

Reference: *Personal Care Homes Standards Regulation, Section 35* and *Manitoba Fire Code, Section 2.8.3* - Performance Measure #20.18

The operator shall establish a disaster management program that at a minimum consists of

a) Processes and procedures for the facility, its residents, and staff to identify, manage and prepare for risks and vulnerabilities from hazards; and
b) A disaster response plan to ensure staff are able to protect and care for the residents during an emergency.

The disaster response plan must be developed in consultation with appropriate authorities and community agencies, and must

a) Provide direction and outline the procedures to be followed in response to internal and external threats to the personal care home, including but not limited to,
    i) Severe weather, floods and other natural events,
    ii) Failure of the heating, water or electrical supply, and other equipment or technological problems, and
    iii) Bomb threats or other threats of violence or harm arising from the actions of persons;
b) Outline specific operational roles, responsibilities and lines of authority for personal care home staff;
c) Outline procedures to be followed in evacuating and relocating residents to a safe temporary or long-term location;
d) Outline procedures to be followed in searching for a missing resident;
e) Include procedures to alert staff and residents of disasters;
f) Include procedures to locate, acquire, distribute and account for services, personnel, resources, materials and facilities required during a disaster response;
g) Outline procedures for returning evacuated residents to the personal care home or for placing them in safe temporary or long term accommodations; and
h) Identify a program for the restoration of services, programs and infrastructure at the facility following a disaster.

The disaster management program established under subsection (1) must

a) Document the objectives, requirements and schedule to ensure appropriate training is provided to staff;
b) Ensure training for all staff on methods to lift and transfer residents to safety;
c) Ensure instruction on staff roles and responsibilities under the personal care home's disaster response plan;
d) Ensure records are maintained that document the training conducted; and
e) Include a process to exercise, test and evaluate all components of the disaster management program, at specified periodic intervals, and to implement improvements as required.

Expected Outcome: Residents are provided with a safe environment. Threats/risks that threaten the safety of the environment are proactively identified, hazards minimized and steps taken to respond when disasters occur.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
20.01	The home has documented evidence of having identified potential risks and vulnerabilities from hazards.	Met	SEE FMEA completed each year. 2016 HVAC was completed and new process was used to analyze. We partnered with IERHA Disaster MGMT to ensure our process is consistent. see binder for	Met	
The home has taken steps to manage and prepare for the identified risks and vulnerabilities by developing disaster response plan, specific to the PCH, that provides direction and outlines the procedures to be followed in response to:					
20.02	• Severe weather;	Met	see our emergency response manual based on incident command system	Met	
20.03	• Floods;	Met	see emergency response manual	Met	
20.04	• Failure of heating;	Met	see emergency response manual	Met	
20.05	• Failure of water;	Met	see emergency response manual	Met	
20.06	• Failure of electrical supply, including generator, if applicable;	Met	see emergency response manual	Met	
20.07	• Bomb threats;	Met	see emergency response manual	Met	
20.08	• Technological failures, such as data loss and computer failures, and;	Met	see emergency response manual	Met	
20.09	• Other threats of violence or harm;	Met	see emergency response manual- code white has recently been modified to be consistent with IERHA Code white .	Met	
The disaster management plan includes:					
20.10	• Procedures for evacuating and relocating to a temporary or long term location;	Met	see emergency response manual	Met	
20.11	• Operational roles, responsibilities and lines of authority;	Met	see emergeny response manual	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
20.12	• Procedures to be followed in searching for a missing resident;	Met	code yellow / see emergency response manual	Met	
20.13	• Procedures for alerting staff and residents of disasters;	Met	see emergency response manual	Met	
20.14	• Procedures to locate, acquire, distribute, and account for personnel, resources, equipment and supplies and facilities;	Met	see emergency response manual	Met	
20.15	• Procedures for returning evacuated residents to the home, or moving them to short/long term accommodations, and;	Met	see emergency response manual	Met	
20.16	• A program for the restoration of infrastructure, services, and programs following a disaster.	Met	see emergency response manual	Met	
20.17	Training is provided for all staff on methods to lift and transfer residents to safety in an emergency, at least every three years.	Met	training of emergency lift is provided at annual reviews and to all new staff. see staff development records.	Met	
20.18	A record of attendance at all disaster management training is maintained.	Met	see staff development records	Met	
20.19	There is documented evidence of exercising, testing and evaluation of all components of the disaster management program, over a period of three years, based on the level of risk.	Met	See evidence of exercising components of disaster management program in record binder (includes type of code, as well as evaluation of exercise)	Met	
20.20	There is documented evidence of implementing improvements as identified in the review/evaluation of	Met	see staff development records, changes to code green, review of emergency bin.	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	exercises/ tests.				
20.21	There is documented evidence that fire drills are conducted at least once a month.	Met	see records of fire drills	Met	
20.22	Staff participation in fire drills is recorded and reviewed annually to ensure staff competency.	Met	see records of staff participation in fire drills and annual review on fire safety . (Fire & Emergency code records binder)	Met	

Scoring methodology:

- There are no pass/fail performance measures.
- Of the 22 measures:
  - If ≥18 measures are met, standard is met.
  - If ≥13 and <18 measures are met, standard is partially met.
  - If <13 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.**	Met	Located in Employee file is : -evidence of general and department specific orientation -performance appraisals -oaths of confidentiality -all new staff receive new staff orientation booklet	Met	
Orientation includes:					
24.02	• general orientation, and; A	Met	see binder whech has current package for general orientation and agenda.	Met	
24.03	• job specific orientation. A	Met	checklists for all departments are included in binder	Met	
24.04	Each staff signs an acknowledgement of the information received at general and job specific orientation.	Met	see employee files for evidence	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
The orientation program includes, at a minimum, the following components:					
24.05	• Resident Bill of Rights;	Met	copy of powerpoint presentation and check off sheets & booklet	Met	
24.06	• Mission Statement;	Met	copy of powerpoint presentation and check off sheets & booklet	Met	
24.07	• Organization chart;	Met	organizational chart reviewed and given to new employee	Met	
24.08	• Disaster management including the fire plan;	Met	see powerpoint presentation	Met	
24.09	• Workplace Hazardous Materials Information System (WHMIS);	Met	see presentation and check off sheet	Met	
24.10	• Infection control;	Met	see presentation and check off sheet - including 4 moments of handwashing	Met	
24.11	• Proper use of all equipment specific to job function;	Met	Included in specific orientation	Met	
24.12	• Personnel policies;	Met	presented in powerpoing and additional handouts given	Met	
24.13	• Personal Health Information Act;	Met	presented in powerpoint information	Met	
24.14	• ***Protection for Persons in Care Act*;**	Met	presented in powerpoint information - signage pointed out on tour and pamplets shared 1) protecting adults in care 2) support for staff	Met	
24.15	• The facility policy on freedom from abuse;	Met	policy given to all new staff and reviewed .	Met	
24.16	• Signing an Oath of Confidentiality;	Met	see employee files and also review information in booklet	Met	
24.17	• Job description, and;	Met	Job descriptions are available in personnel office and staff are made aware of accessing through human resources or manager	Met	
24.18	• Expected skills and routines.	Met	completed forms of expected	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
			skills are on staff files.		
24.19	There is an organized staff education program for all staff.	Met	see Calendars for September 2014- September 2016 and attendance records	Met	
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;**	Met	Annual reviews are completed every November where by all staff sign off they have completed fire prevention education. see also list of staff present in monthly fire drills or additional training. All new staff have fire prevention education	Met	
24.21	• Review of the Freedom from Abuse policy;	Met	see annual review - abuse policy	Met	
24.22	• Review of the Resident Bill of Rights;	Met	see annual review- resident bill of rights	Met	
24.23	• Review of the Use of Restraints Policy;	Met	see annual review - Use of restraints and additional training	Met	
24.24	• Workplace Hazardous Materials Information Sheets (WHMIS);	Met	see annual review WHMIS	Met	
24.25	• Education about Alzheimer's and related dementias, and other geriatric care information, and;	Met	see sign off sheets for annual review on dementia care in 2014, P.I.E.C.E.S. education in 2014, 2015 & 2016 . We have had 2 Virtual Tour education sessions from the Alzheimers society in the last 3 years	Met	
24.26	• Education opportunities that match the special considerations/ needs of the facility's current	Met	Additional education considerations for the needs of our current resident population	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	resident population.		include Alcohol related dementia, Parkinson Disease (fall 2016) ; Psychotropic Medications, see also calendar for additional educational opportunities		
24.27	Education on the proper use of new, job-specific equipment is provided whenever new equipment is acquired.	Met	See sign off sheets for the new tubs, new medication carts, housekeeping department new equipment, ceiling lifts reintegration.	Met	
The staff education program also includes the following, minimally once every 3 years:					
24.28	• Oral Health care;	Met	Education on oral care in 2014 when program introduced and part of annual review 2015.	Met	
24.29	• Proper resident transferring techniques;	Met	See new employee orientation formam as well as additional information and sign off sheets for reviews throughout year. Disaster management emergency lift education and practice is done with all new employees in all departments and in selected November annual review	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.	Met	See Spiritual care inservice notes presented in August 2016.	Met	
24.31	An attendance record is maintained for every in-service education program provided.	Met	Attendence binders provided in boardroom for your review 2014-2015-2016	Met	
24.32	There is a process to ensure that all staff are made aware of all new or	Met	All new / revised policies are posted on bulletin board in	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	revised policies.		basement. Some are shared with staff with a signed Memo of verification - See Memo Verification -binder in boardroom for your review		
There is evidence of an education services audit process which includes:					
24.33	• Annual evaluation of all education programs;	Met	Staff attending inservices complete evaluation sheets. see Inservice record binder for each year	Not Met	Started in 2015. Process will continue year over year to meet measures 24.33 - 24.36.
24.34	• Review and analysis of the program evaluations;	Met	evaluation sheets are reviewed by Inservice coordinator	Not Met	
24.35	• Recommendations for improvement resulting from the analysis, as required, and;	Met	recommendations when identified are flagged	Not Met	
24.36	• Implementation and follow-up of those recommendations.	Met	implementation and followup onn recommendations are completed when they have been identified.	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: All bolded performance measures are met and 29 of 33 other performance measures are met.
The standard is: Met
Comments:

Standard 26: Reports about Critical Incidents and Critical Occurrences

Reference: *Personal Care Homes Standards Regulation; Regional Health Authorities Act: Section 42;* Part 4.1 Patient Safety 53.2(1); *RHA Amendment Act; Manitoba Evidence Act.*

The operator shall provide to Manitoba Health, Healthy Living and Seniors, via the respective RHA, all reports about incidents and occurrences in or related to the personal care home that have resulted in a consequence that:

a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay, and does not result from the individual's underlying health condition or from a risk inherent in providing the health services, or;
b) loss of or damage to property, or;
c) other harm or risk not described in clause (a) or (b);

in accordance with the policy developed in accordance with guidelines approved by the minister and approved by the authority

Expected Outcome: Critical incidents and critical occurrences are reported in accordance with the requirements set out by the minister. Reported incidents and occurrences are reviewed with the goal of preventing a recurrence wherever possible.

Performance Measures

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
26.01	There is a record of all critical incidents and critical occurrences that have taken place in the personal care home.	Met	record of all incidents in accessible online Manager drive. there has been no critical occurrences or incidents since 2014	Met	
The PCH has a policy that includes the following information about critical incidents and critical occurrences:					
26.02	• Definitions;	Met	See Policy AM-08-35 Critical Occurrences, Reporting and Management see also AM-08-30	Met	
26.03	• Procedures for recording incidents;	Met	See Policy AM-08-35	Met	
26.04	• Procedures for reporting incidents, and;	Met	See Policy AM-08-35	Met	
26.05	• Procedures for follow up.	Met	See Policy AM-08-35	Met	
There is documented evidence of:					
26.06	• Timely reviews following a critical incident or critical occurrence;	Met	See documentation related to CI review committee process in binder (completed documentation on computer	Met	
26.07	• Regular evaluation of the	Met	see outcomes on computer	Met	

#	Measure	Facility Rating	Comments	Review Team Rating	Comments
	outcomes of those reviews;				
26.08	• Development of recommendations from the evaluation of outcomes, as required, and;	Met	see documentation 2014	Met	
26.09	• Implementation and follow-up of those recommendations.	Met	see implementation and follow up online.	Met	

Scoring methodology:
- There are no pass/fail (bolded) performance measures.
- Of the 9 measures:
  - If ≥7 are met, standard is met.
  - If ≥5 or <7 are met, the standard is partially met.
  - If <5 are met, the standard is not met.

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