The Sun Parlor Home (Final) Operational Review

Submitted to:

The Corporation of the County of Essex and The Sun Parlor Home

Submitted by:

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EXECUTIVE SUMMARY

Extendicare (Canada) Inc. was pleased to be chosen by the Corporation of the County of Essex and the Sun Parlor Home to complete the Request For Proposal #PS-1803. The primary focus of this report is to provide:

- A formal opinion of the Sun Parlor Home's operational, financial and regulatory health
- Comprehensive recommendations for improvements and changes, associated implementation plans and financial implications
- Other findings and observations

The report provides the following:

A) Detailed review of the Nursing Department and Policies and Procedures

B) Review of Dietary, Health and Safety, Life Enrichment, Infection Prevention and Control, and Environmental Services

C) Financial Review of the Administration Departments

First, we would like to acknowledge the warm reception and the hospitality the Home's staff provided to our team of consultants over our four (4) weeks onsite. In addition to a review of the Ministry of Health and Long-Term Care (MOHLTC) reports, our team of experts have worked closely with management, County of Essex employees, front line staff, residents to better understand internal programs, processes and systems. This assisted in the identification and verification of trends and issues which have formed the base to support the formulation of recommendations inherent within this report. Our review also considers some of the unique aspects of the Home that include but may not be limited to its geographic location, resident population and mix, staff expertise, skills and availability as well as the unique large footprint of the Home. A number of our recommendations were implemented prior to the end of our review.

Key Findings and Recommendations:

This report reflects the following 12 key areas that have been identified as those areas requiring action and follow-up:

1. Departmental Structures
2. Nursing
3. Policies and Procedures (compliance to all applicable standards, regulations and legislations – Long-Term Care Homes Act (LTCHA), Occupational Health and Safety Act (OHSA))
4. Quality
5. Education and Training
6. Health and Safety
7. Food and Nutrition
8. Environmental
9. Life Enrichment
10. Infection Prevention and Control
11. Financial Review
12. Accreditation

We wish to stress that our findings / recommendations are not to be construed as being the only solutions or approaches that may assist in addressing issues identified; rather they are provided to facilitate further dialogue and discussion as the Home moves forward in its effort to improve. We do invite your feedback on any of the information presented in this report.

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APPROACH TO REVIEW

To organize and implement this review, Extendicare utilized consultants who have expertise in the care, life enrichment, administration and service areas reviewed. The Extendicare team approach was to collect, consider and analyze information and tasks associated with this approach included but were not limited to the following:

- Conducting pre-scheduled on-site meetings with the Sun Parlor Management team. These meetings focused on the intent of the review and the expectation of both parties that would support the success of the review process.
- Conducting pre-scheduled on-site interviews with staff from each department. (Minimal interruption of care was a first priority). Interviews included discussing challenges and successes and opportunities for improvement.
- Reviewing practices and procedures specific with each department.
- Reviewing tools, systems and processes in place (visual review of tools and discussion on processes).
- Reviewing education and training goals for the year, ensuring audit compliance.
- Reviewing staffing patterns and benchmarking with similar size homes – in this regard, benchmarking against Extendicare (both managed and owned Homes including municipal and Not for Profit entities) standard staffing ratios was used.
- Reviewing outcomes with all teams (highlighting need to improve / enhance processes or procedures that could result in improved services to the residents).
- Holding group discussions on possible areas for improvement and potential action plans that would support achievement of improved outcomes.
- Documenting and formulation of recommendations.

Our team found management and staff to be very cooperative, accommodating and helpful throughout the entire review process. This facilitated our staff to conduct a comprehensive review of the Home's operations. Our findings are summarized in this report. Any recommendations we have brought forward were subject to final review with the Sun Parlor Home to ensure accuracy and appropriateness.

ANALYSIS OF DATA/INFORMATION AND RECOMMENDATIONS

Over the past few years and particularly since July 2010, the long-term care home sector has experienced significant change. Accountabilities have been enhanced and expectations with respect to the delivery of quality care, programs and services have increased from both a regulatory perspective and a public expectation perspective.

As the government focuses on new strategies including the expansion of home care services across the province, the resident population profile has changed as well. Residents present with many more co-morbidities and care challenges. Care needs have increased and demand for long term care services – whether community based or institutional based will continue to climb with the increasing number of boomer's entering senior years. Furthermore, the closing of mental health care facilities and the subsequent increase in persons affected by various dementia's will put more pressure on the on long-term care and home care to provide service to those with higher, more complex levels of care and services that is outside The Sun Parlor environment.

There is an enhanced degree of responsibility and accountability being placed on the long-term care home sector to provide these services. As a result, every long-term care home organization has an obligation to ensure that they have a clear understanding of the environment – now and future and the direction the MOHLTC and other community stakeholders are moving towards in order to provide the quality of care expected by residents and families in the community. Residents and families have the ability to access the performance of individual homes in relation to specific quality indicators and that presents new challenges as well as new opportunities for homes to both deliver on improved quality care and service outcomes as well as to reflect upon their own quality improvement journey. Regardless, the so called "unveiling of public reporting" in relation to specific clinical indicators presents a new reality for all long- term care homes in the province.
These ongoing changes along with the issues identified by the Ministry have and continue to put ongoing responsibility and accountability on long-term care to consistently perform at its best.

Key Opportunities for Improvement

As indicated earlier, this report reflects 12 areas that have been identified as those key areas requiring action and follow-up:

1. Departmental Structures
2. Nursing
3. Policies and Procedures (compliance to all applicable standards, regulations and legislations – Long-Term Care Homes Act (LTCHA), Occupational Health and Safety Act (OHSA). The Home is already aware of Policy and Procedure needs.
4. Quality
5. Education and Training
6. Health and Safety
7. Food and Nutrition.
8. Environmental
9. Life Enrichment
10. Infection Prevention and Control

11. Financial Review
12. Accreditation

We wish to once again stress that our findings / recommendations are not to be construed as being the only solutions or approaches that may assist in addressing issues identified; rather they are provided to significantly move the Home forward in achieving compliance based on Extendicare's best practice and proven methodologies.

Opportunities for improvement exist in these areas and the Home is encouraged to prioritize these areas of focus.

1. Departmental Structures

Issue(s)	Recommendation(s)
▪ **Nursing Department** ▪ The Home has a significant amount of RN hours in addition to front line RPN's. ▪ PSW hours have opportunity to examine and adjust to meet resident care needs. ▪ Ward clerk hours have opportunity to examine and adjust to meet departmental needs.	▪ It is understood that there is a current Letter of Understanding with the Home which makes it difficult to alter RN hours and affecting RPN hours. ▪ Please see suggested staffing hours (Appendix B) ▪ Please see suggested staffing hours (Appendix B). Recommend one day ward clerk work 6-2.
▪ **Environmental Department** ▪ The Home has an unusually large number of maintenance positions relative to the Home size. The Home utilizes these roles in other departments such as stocking and property maintenance but there is opportunity for efficiencies in staffing.	▪ Please see suggested staffing hours as an industry comparator. ▪ This may necessitate a change to the Home's fire plan, workload and roles and responsibilities.

2. Nursing

Issue(s)	Recommendation(s)
▪ **Restorative Care**	▪ There is no formal process for referral of residents to restorative care. Residents do not have Restorative Care strategies noted on care plans. Restorative Care interventions on care plan are vague. There are no SMART goals. There is an opportunity to expand this program and achieve additional MOHLTC funding. The Home will be sending 2 RN's for restorative education * if purchasing 3rd party policies

	as recommended, this will include the restorative program.
▪ **Infection Control**	▪ It is recommended that cleaning and disinfection processes for all resident equipment be audited regularly for completion. The Home currently completes quarterly environmental audits. ▪ Routine hand hygiene can be improved. Routine auditing of the 4 moments of hand hygiene for 15 seconds should be completed regularly, with re-instruction of staff at the point of care. Results should be posted and communicated throughout the organization. ▪ It is recommended that strict routines for cleaning and disinfection of personal items and resident equipment be implemented; documentation of cleaning and disinfection of tubs after every bath in all units have large gaps. The Home states they will be implanting an audit schedule for the afternoon RPN shift to address these areas. ▪ For Infection Control purposes, it is recommended to provide two slings per resident. The Home will review due to budget considerations.
▪ **Not all personal items are labelled or re-labelled in a timely manner.** Walkabout audit conducted in the Home identified several items not labelled. There is a policy in place for labelling all resident personal items.	▪ Recommend re-education of families and residents re the Home process for labelling of new resident items.

▪ **Pain and Palliative Care Management** The Home has received training in this care area but the program has not been optimally implemented. Re-education to the front line staff re- the committee functions is recommended to increase knowledge sharing with stakeholders.	▪ It is highly recommended that the Home re-launch their Pain/Palliative/Ethics Committee and ensure this Committee is interdisciplinary and includes Life Enrichment staff. The committee should be ensuring ongoing education is provided (by internal or external resources) to staff and families as well as exploring new practices and technology to assist in moving the Pain and Palliative program forward.
▪ **Critical Incidents/Complaints** ▪ Not all CI's submitted have been amended and completed/finalized. ▪ Late reporting and incorrect category of two Complaints. ▪ Home's policy 0102-13 requires revision to reflect LTCHA Regulations 107 (1)	▪ Recommend review of the current process to formally log all CI reports and complaints with status/follow up required and consideration to more frequent auditing to identify trends. ▪ Re-education for staff re the Homes process. ▪ Re- Education is required for all Managers on CI process and criteria for reporting ▪ Update policy to reflect current MOH standards.
▪ **Communication** ▪ There is a lack of formal referral processes in the home. ("word of mouth" is current practice) ▪ Clear understanding required amongst the Managers regarding accountabilities. Several management team members have pieces of responsibility/accountability of various programs leading to possible fragmentation of high risk areas.	▪ Establish formalized referral processes for all referrals which will include evidence (paper/electronic). Communicate to all staff. ▪ Recommend that managers have a clear understanding of their role and responsibilities within each of their assigned programs and knowledge of all programs within the home for better quality outcomes
▪ **Attendance Management** This area does not pertain solely to the nursing department. There is evidence that the current attendance management practices in the Home are not effective	▪ Recommend re-evaluation and revision of the current absenteeism processes of the Home. This area was recognized by the Home as requiring revision. Education to the management team in the area of

resulting in disruption of resident care and overall operations of the Home. The Home has a number of staff on extended sick leave.	managing staff attendance in conjunction with the County. ▪ The large number of paid staff absences is having a negative impact on the Homes financials as well as available staff to perform resident care.

3. Policies and Procedures (compliance to all applicable standards, regulations and legislations – LTCHA, OHSA)	
Issue(s)	**Recommendation(s)**
▪ Several policies were found to be non-compliant with applicable standards, regulations and/or legislation. The Home is aware of this deficiency. ▪ Content of policies, in some cases, is lacking and/or misleading. ▪ Policies and procedures are written in a passive voice with use of suggestive, rather than directive language. ▪ Missing policies – additional policies and procedures need to be included in your suite of manuals to ensure full compliance with all standards, regulations and legislation, as well as, best practices.	▪ Purchase and implement a suite of policy manuals (from a 3rd party provider), which are fully compliant with all applicable standards, regulations, legislation, and best practices. ▪ Ensure that 3rd party manuals are revised annually and all manuals reflect current legislation, regulations, standards and best practices. ▪ Education to support the implementation and roll out of all manuals is available with the purchase of the suite of manuals and available to assist your home to effectively implement all manuals. ▪ Audit tools and implementation packages are should also be available to homes that purchase the full suite of policy manuals and are a useful tool to assist Senior Leadership to assess the implementation of the policies in the home. ▪ If the Sun Parlor Home chooses not to purchase 3rd party policy manuals, then a complete revision of all policy manuals currently in use at the Home is recommended, although the skilled staff required to complete this task can be better utilized to deliver care, services and education

4. Quality	
Issue(s)	**Recommendation(s)**
▪ CQI Program – Not all Program evaluations were completed annually. Not all required committees are in place and are meeting regularly i.e. No Restraint Committee. The Home does not recognize the need for a committee structure for evaluation of quality ("LTCHA does not require committees as a standard".	▪ It is highly recommended that the Home develop a Committee structure to support an interdisciplinary approach to all Clinical Programs. (this was already under consideration)
▪ Gaps were identified in the analysis of data regarding the Quality programs (Falls, Restraints, PASD, Pain/Palliative	▪ The Home would benefit from the analysis of outcomes associated with Falls, Restraints, PASD, Pain Programs

5. Education and Training	
Issue(s)	**Recommendation(s)**
▪ Annual Program Evaluation for Education and Training completed Nov 28/17. As per ON Reg 79/10 (217) states licensee shall ensure at least annually the program is evaluated and updated in accordance with evidence-based practice and if there is none in accordance with prevailing practices.	▪ Program evaluations to be included in the annual evaluation calendar include updates as per evidence based practices.
▪ SURGE available at the Home but not fully utilized to its fullest capabilities. Home completes education face to face (outside of SURGE) in a classroom format and small huddles.	▪ Recommend full utilization of Surge to ensure accurate reports of compliance are generated. The home will have the capability of uploading their own education as well.
▪ Learning Needs assessment completed on Feb 16/18 with a 17.35% response rate. Home will complete education as required (outside of SURGE) in a classroom or huddle format.	▪ Suggest developing a Needs Assessment tool for each discipline to be analyzed annually to meet the learning needs of the staff within the home and develop an annual education plan. ▪ Suggest a combination of modalities i.e., classroom style, handouts, etc. for mandatory/high risk education. ▪ Recommend staff education and training is provided with evidence to all required staff

▪ The education falls under the responsibility of the life enrichment coordinator who does not have formal training in this aspect.	▪ We recommend re-evaluation of the designation of these responsibilities. A full time Educator may be of benefit to the Home and financially possible if some suggested staffing patterns are considered.
▪ There was no evidence to support the annual competency testing for safe lifting and transferring is completed.	▪ Implement an annual competency review of all required staff.
▪ Annual mandatory education (4 hours)	▪ The Home has Surge online learning tool but is used minimally in relation to mandatory education. Recommend increased utilization of this online tool to facilitate tracking and follow-up of staff education. A post education feedback tool may be utilized to measure staff engagement.

6. Health and Safety

Issue(s)	Recommendation(s)
▪ The Home is compliant with general health and safety compliance but there is no evaluation of workplace specific hazard assessments currently occurring.	▪ The Joint Occupational Health and Safety team is functioning well but review of departmental specific hazard assessments is required to be done on an annual basis. The Home has identified that they are acquiring a third-party contractor to review the status of the health and safety policies and procedures and will provide recommendations of the draft work inspection audit produced by the Sun Parlor Home.
▪ Annual testing of emergency codes requires inclusion of all codes. (purple, orange, white, yellow and black are in draft)	▪ Manager of Health and Safety/Staff Development in conjunction with the Joint Occupational Health and Safety team is to provide annual education and training of each emergency code along with annual testing of the emergency codes.

▪ Manager of Health and Safety/Staff Development has over 30 active disability claims which is hindering ongoing health and safety assessments.	▪ Recommend hiring administrative support to facilitate the management of workplace claims and enable the Manager of Health and Safety/Staff Development to perform ongoing health and safety assessments.

7. Dietary

Issue(s)	Recommendation(s)
▪ **Food Production** Items on various therapeutic diets are not consistently prepared and provided.	▪ Streamline resident diets to minimize the daily food production, i.e. the Home currently has 8 therapeutic diets in use. This will also decrease resident risk by eliminating potential error and non-compliance with MOHLTC legislations.
▪ **Menu Approval** Current summer/spring menu was not approved by the dietitian nor Resident Council prior to implementation as per MOHLTC regulations.	▪ Home is to ensure that all menus are reviewed and approved by the Residents Council and Registered Dietitian and clearly documented in meeting minutes.
▪ **Safe Food Handling** ▪ At the time of this review food and fluids were not <u>consistently</u> served at a temperature that is both safe and palatable to the residents. [r.73(1) (6)] ▪ Food samples of high risk foods are not kept for all textures for a minimum of 7 days as per local public health authority guidelines.	▪ Ensure temperatures are maintained as per local public health authority guidelines for safe food handling. ▪ Food samples are to be taken for all high-risk foods (e.g. meat and dairy products) in all textures.
▪ **Meal Service / Pleasurable Dining** Various regulatory requirements were not met such as resident supervision during meals, serving course by course, feeding assistance.	▪ As per Ministry of Health (MOH) guidelines, staff must be present prior to food and fluids being served to residents requiring assistance. The RPN may presently be in the vicinity serving medications but supervision without distraction is recommended. (ie: not serving medications as per the LTCHA).

▪ **Hydration Monitoring, Weight Change Monitoring, Bowel Management** ▪ Policy does not specify how to monitor residents exceeding their fluid restriction. ▪ Annual heights are not measured and recorded for all residents. ▪ Referrals not sent to the dietitian for all skin concerns (i.e. skin tears, pressure ulcers). ▪ Treatments and interventions to prevent constipation do not consistently include nutrition and hydration protocols. [r.51(1) (2)] ▪ The residents' plan of care is not based on an interdisciplinary assessment of continence, bladder and bowel elimination. [r.26 (3) (8)]	▪ Re-education on dining and snack service MOHLTC regulations. ▪ As per MOHLTC regulations, the Home must have an organized program of hydration monitoring. ▪ Re-education on the requirements of annual height measurements, referrals to the dietitian for skin and wound and bowel management, and care plan documentation.
▪ **Staffing** ▪ Roles and Responsibilities ▪ Staffing levels: <u>Food Handlers</u> Ministry of Health Requirements: 681.94 h/week (648.9h/week for LTC & 33.04 h/week for non-resident meals = café) Currently: 996 h/week <u>Nutrition Manager(s)</u> Ministry of Health Requirements: 69.28 h/week (65.92 h/week for LTC & 3.36 h/week for non-resident meals = café) Currently: 120 h/week	▪ It is recommended that the Home review and revise task distribution between the manager, supervisors, and dietitians for efficiencies. ▪ Existing front-line staff job routines need complete revision to reflect current daily duties. ▪ Recommended Staffing (Appendix B) ▪ Over Ministry of Health mins by about 314.06 h/week. Some tasks done by the food service workers could be allocated to other staff (cooks, nursing, food service supervisors). However due to the lay out of the home, they do require more staff in order to perform required daily tasks. ▪ Over Ministry of Health mins by about 50.72 h/week. Recommend clarifying roles between each supervisor and manager. Home does require hours above the minimum as they are required to create, revise and manage all departmental policies. If policies obtained from an external source could operate with less manager hours than currently staffed.

▪ **Usage of Technology** Utilizing Menu Stream and Synergy software's	▪ Effectively utilizing current technology to deliver dietary services, ie Menu Stream and Synergy.
▪ **Café** The Home currently budgets $50,000 income annually that is not achieved. Further clarification required of where this $50,000 is coded to in order for reconciliation to budget to occur or if it's an enhanced service only then reexamination of budget input.	▪ A review of the café be undertaken, and a business plan developed. ▪ A café is an attraction for the family and staff but there is no active planning for improvement or changes in response to customer feedback.

8. Environmental

Issue(s)	Recommendation(s)
▪ **Capital Expenditure** Capex is planned by both the Home and the County of Essex.	▪ Recommend that the Home's Capex be regularly reviewed by the leadership team and the County for prioritizing, ie residents' call bell systems, parking lot, and residents' furniture
▪ **Policies and Procedures** The Home does not have current environmental and preventative maintenance policies and procedures, i.e. ▪ Quality Control of Chemical Use for Housekeeping and Laundry, ▪ In need of a Preventative Maintenance Program (agreement for Pest Control is a verbal agreement. No monthly site visit report is provided to the Home). ▪ Lost and Found system has not been established ▪ Departmental goals for housekeeping laundry are required	▪ Purchase and implement a 3rd party suite of policy manuals, which are fully compliant with all applicable standards, regulations, legislation, and best practices.
▪ No departmental meeting but a communication book is utilized.	▪ The establishment of regular environmental departmental meetings to facilitate communication, home issues or procedure changes.

▪ SD (Safety Data) sheets were outdated and not readily available for staff.	▪ All Safety Data sheets for the Home are to be reviewed and ensured that they are current within three years. ▪ Following the review, these sheets were updated. Recommend a quarterly audit of the MSDS sheets to ensure they are up to date and all product sheets present.
▪ No department-specific training scheduled in housekeeping and laundry.	▪ Recommend ongoing interactive scheduled training (supplemented by outside vendors) for housekeeping and laundry staff in the areas of machine operations, appropriate chemical usage and use of other applicable equipment.
▪ Job routines are available but not sufficiently detailed.	▪ All housekeeping and laundry job routines should be reviewed at a minimum annually and as required to meet the needs of the Home.

9. Life Enrichment

Issue(s)	Recommendation(s)
▪ **Physiotherapy** The Home currently offers exercise programming twice a week, provided by the Home's Life Enrichment Assistants (LEAs). The Physiotherapy services are not utilized to the fullest by the contracted company Lifemark.	▪ It is recommended that the following changes and enhancements be made to the Home's physiotherapy programs: ▪ The consideration of an addition of one full-time physiotherapist (total 2) and one full-time physio aide (total 2). These positions should oversee and direct the Home's physiotherapy programs. The Home must ensure that physiotherapists from Lifemark are replaced for any absence to ensure continuation of resident services. ▪ The Home's LEAs should be an enhancement to the physiotherapy program rather than providing oversight and assuming responsibility. ▪ Enhance falls prevention programs to assist with residents' mobility.
▪ **Calendar** The Home's recreation calendar does not	▪ It was noted that the Home has many

accurately reflect programs occurring in the Home. The Life Enrichment department does not have comprehensive program outlines that correspond with program offerings.	positive aspects to the Life Enrichment programs, i.e. spiritual program, intergenerational program, resident outings, library and community partnerships. ▪ It is recommended that the Home's calendar reflects all programming that is occurring on a daily basis, i.e. the Home's annual car show is a successful event that was not captured on the residents' program calendar. All programs on the calendar need to reflect all domains (physical, intellectual, emotional, social and spiritual). ▪ The Home is required to have residents input on all in-house programming. ▪ The Home has a part-time volunteer manager. The volunteer program requires complete review and revision to ensure maximization of volunteer duties and resources. The Home currently has 30 active volunteers that primarily assist with resident feeding and portering in the Home. These valuable resources could be utilized in such areas as assisting with programming, outings and friendly-visiting.
▪ **Regulatory Compliance** The Home currently serves alcohol during pub night and social events to residents.	▪ It is recommended that the Sun Parlor Home purchase a liquor license and any staff involved in pub nights and social events involving alcohol be SMART served certified.
▪ **Care Conferences** The Life Enrichment department does not attend resident care conferences.	▪ Due to the significance and importance of resident care conferences, there should be in-person representation from the Life Enrichment department to ensure comprehensive review.
▪ **Departmental Structure** ▪ The Home currently has "grandfathered" Life Enrichment Aides who were providing services prior to July 1, 2010. ▪ Scheduling of staff does not provide for	▪ It is recommended that the Home keep an active file of any "grandfathered" employees (all departments) in order to address any MOHLTC inquiries regarding legislation changes effective July 1, 2010. ▪ The Home should review current staffing

fulsome evening and weekend programming.	patterns to ensure equitable coverage for evenings and weekends.
▪ **Technology** The Life Enrichment department currently completes all documentation in PointClickCare.	▪ To further enhance the program, it is recommended that the Activity Pro platform be considered. This program will assist in recording and scoring of resident engagement including attendance tracking and documentation, monitoring program success and accessing residents-at risk reports.

10. Infection Prevention and Control (IPAC)

Issue(s)	Recommendation(s)
▪ **The Home has an IPAC Program.** There is a designated staff member to co-ordinate the IPAC program who has the required education.	
▪ **The home has a hand hygiene program with point of care hand hygiene agents.** Hand hygiene audits are completed monthly by 2 auditors (goal is 34 monthly). The home has completed education for 2 additional auditors to assist with the program. Compliance rates are discussed at PAC meetings. ICP feels that compliance is around 70% as a whole but had no evidence to this. Hand sanitizers are located in hallways, common areas, and dining areas.	▪ It is recommended that hand hygiene audits be specific to identify areas of improvement by moments and departments. Compliance rates should be calculated monthly, discussed as a standing agenda item at IPAC Committee meetings and a plan for correction discussed if needed. The home should have a target that they are working towards achieving for the year. ▪ Residents should be part of the hand hygiene program and offered hand sanitizer at meal times and at group activities. ▪ There are no hand hygiene stations in the resident rooms. It is recommended that stations be installed in resident rooms to assist with point of care requirements. ▪ An audit of the entire building should be completed to ensure hand hygiene stations are conveniently located in all areas of the home. Staff can assist in making recommendations for locations.

▪ **A Public Health representative is invited to the IPAC meetings** Public Health is only invited to PAC meetings.	▪ It is recommended that Public Health is invited to the home's IPAC Committee meetings. An email can be sent at the beginning of each year with the dates of the meetings, inviting PH to attend or send information. This email can be printed off as proof of the invite.
▪ **Infection Surveillance** ▪ Symptoms and infection tracking at every shift ▪ Infection information collected, analyzed and reviewed to detect trends.	▪ It is recommended that the process is more formal with documentation that can confirm that staff is monitoring symptoms of an outbreak on each shift. 24 Hour Symptom Surveillance sheets would meet this requirement. Re-education of front line staff for use. ▪ It is recommended that the tracking tool includes the organism that is causing the infection. This will assist the ICP in identifying trends and will assist in determining the origin of the infection. ▪ Infection information should also be discussed at the IPAC Committee. ▪ Education is required around UTIs. Staff must know case definition, correct methods of collecting samples, and the elimination of dipsticks. PHO has excellent materials to assist with this project.
▪ **Measures to prevent the transmission of infections by disinfection**	▪ It is recommended that staff be re-educated in the cleaning and disinfecting process ensuring that they are knowledgeable that tubs, bath lifts and shower equipment require cleaning then disinfecting. A communication tool needs to be developed and utilized to ensure confirmation that equipment is ready for use.

11. Financial Review

Issue(s)	Recommendation(s)
▪ **Payroll** Payroll System Software: ADP and Info HR (HRIS Software) ▪ There are two Employer ID / Business	▪ One business number / employer ID

Numbers. One for part time and one for full time. There does not appear to be a need for this. All payroll processes are done twice to capture both groups. ▪ There are several redundancies as it relates to employee profile/management. The payroll clerk is instructed to use several forms and transpose information onto all forms making workload greater. ▪ Unionized Staff: When scheduling employees off for vacation, sick, their bank balances are not always checked, which causes the employee to take more vacation time then they are entitled to.	should exist. (already identified by the Home) ▪ Streamline HR/Payroll forms. Several forms containing the same information is not efficient. One form containing all required information can be filled out and circulated to all applicable departments. ▪ Recommend that prior to scheduling time off, the employee balances are checked to avoid overpayment.
▪ **Benefits** Greenshield: EHC, Vision, Dental Sunlife: Life Insurance (except PT CUPE and ONA who have $10k policy with Employer) OMERS: Pension. ▪ Most employees do not understand how the Defined Benefit Plan (OMERS) works. ▪ Enrollment form labelled as "Sunlife" but is also used for Greenshield.	▪ Employees would benefit from learning more about OMERS. ▪ Review/ Audit employee benefits and entitlements regularly i.e. once a year. ▪ Use appropriate forms for Greenshield and Sunlife. If the form is the same, I would recommend that they obtain an updated version that notes Sunlife / Greenshield.
▪ **Accounts Payable and Receivable** ▪ Defacing invoices: Podiatrist invoice was defaced because of a billing error.	▪ Invoices should be paid in full with a credit processed for the amount of the billing error. The vendor should be contacted for the corresponding credit. requested for processing.
▪ Petty Cash: ▪ $1,000 cash kept in safe. Three individuals have access to the safe/petty cash box.	▪ Petty Cash should be counted at a minimum weekly and reconciliation completed.
▪ Foot Care Payments: Hand written receipts/vouchers for each service he	▪ Prior to paying, a cross verification process is recommended

provides but these and not matched or cross references with the monthly invoice that the podiatrist provides. ▪ Café: Met with the Food Service Manager. Café sales are an approximate weekly average of $900. The café has lax policies surrounding their cash handling. As sales occur throughout the day, any food service worker can use the register. At the end of the day, all cash is taken out of the register and put back into the "baggie" and placed in a locked cabinet behind the food service managers' desk. There is no count or reconciliation done at the end of the day. This process occurs Monday – Friday. On Saturday, a food service supervisor will balance all five "baggies" alone. A cash handling policy was developed during the review. ▪ During the "baggie" reconciliation process, if the cash does not balance to the sales from the register, the employee will take money out of another cash float. The float has approximately $200-300. There is no control / log, etc. of this cash. The FS Manager does not know why they have these funds currently or why the float is so high. ▪ **A/R Aging**: Approximately $165,000 in aging with approximately $125,000 of that over 120 days (91,137 is bad debt awaiting MOHLTC write off). According to documented month end procedures, there is an interest charge of 1.5% applied to balances over 30 days that is applied per month. A/R is not regularly reviewed with the Administrator.	▪ Recommend complete review of the café accounts receivable/ tracking process. ▪ The café is projected to earn $50,000 annually but no business plan exists for this service. Recommend examination of this service with development of a formal plan or clarification that the café is not projected to earn income. ▪ Recommend that the cash register be balanced at closing by two individuals and locked in a safe at the end of each day. ▪ All cash should be maintained in the safe. ▪ Cash/sales should be deposited at a minimum weekly. ▪ The additional funds of $200-300 that appear to be unaccounted for – should be deposited into an appropriate GL account and taken to the bank or donate funds to resident council if the Home does not know where the funds came from.

12. Accreditation	
Issue(s)	**Recommendation(s)**
▪ According to the Request For Proposal, accreditation was a potential area to be examined and recommendations provided.	▪ At the time of the review, it was indicated by the Home's administrator that this was not a priority to be examined. Extendicare is prepared to offer consultation in this area upon request.

The above provides for an overall summary of the issues identified throughout the review. This report also provides additional specific information that is intended to provide evidence to support statements and recommendations made. This information has been summarized by members of Extendicare consulting team who participated in this review. The detail contained in the following pages is intended to provide additional information and provide specific details. It is imperative that these high-level risk issues be addressed to prevent reoccurring issues and incidents from happening in the future.

High Risk Issues

There were a number of high risk issues noted throughout the review that were determined by the team to require immediate attention from a resident care, safety and infection control perspective. Those issues were brought to the attention of management during the course of the review. These issues include but are not limited to the following:

- Restraints/PASD
- Bed Rail Use
- Continence Program
- Safe Transferring
- Falls Management
- Medication Management
- Safety
- Policies and Procedures

Details pertaining to these issues are captured in the summary provided below.

The column to the left summarizes issues and the column on the right provides initial recommendations.

Restraints/PASD	
Issue(s)	**Recommendation(s)**
▪ Use of prohibited restraints (posey belt, thigh straps) LTCH Reg. 112 ▪ All restraints in the Home are not analyzed and evaluated monthly and include a written record.	▪ Discontinue use of restraints that limit movement or any device that cannot be removed immediately by staff ▪ Complete an analysis of all restraints in use in the home monthly, and develop an action plan for reduction of physical

Restraints/PASD

	restraints ▪ It is highly recommended that the Home immediately introduce an interdisciplinary approach to Restraints and PASD management. This includes: ▪ Include physio in the Least Restraints program ▪ Develop systems to obtain handwritten consents for the use of restraints/PASD, prior to the implementation ▪ Physician orders are resident specific; however, the orders need to include time frame for use of restraint ▪ Improve the PASD program to ensure PASD's are removed when not in use. All PASD's are to be removed when no longer required or unless resident requests it to be retained. This process is not in place ▪ Other improvements to the program recommended: ▪ Clarification of policy statement for PASD to include that the device must meet the criteria for PASD.

Bed Rail Use

Issue(s)	Recommendation(s)
▪ Bed rail use is not consistently documented in care plan and no interventions noted to mitigate risk of entrapment are noted. Bed Entrapment tracking tool (soft copy) is confusing and not well understood by maintenance staff. Difficult to assess when the last bed entrapment was completed on a specific bed.	▪ All maintenance staff should be re-educated on bed entrapment assessment/tool through Cardinal Health. The education was tentatively booked after August 7, 2018. Recommend inclusion of hard copy of worksheet to show evidence of when assessment done and action plan. Tracking tool is to be kept up to date. ▪ Develop a specific PASD assessment in PointClickCare. Residents using bed rails of any kind require a bedrail risk assessment, as well as PASD or restraint assessment, quarterly.

Continence Program

Issue(s)	Recommendation(s)
▪ There is not a formalized program with Lead.	▪ Develop an interdisciplinary team to meet minimum of quarterly. Include as part of the skin and wound care team. ▪ Implement and complete toileting diary on admission in order to establish individualized patterns of continence

Safe Transferring

Issue(s)	Recommendation(s)
▪ Lack of systems to ensure equipment is safe prior to use and this is documented.	▪ The Home is encouraged to develop a process for completion and documentation of pre-start checks of all mechanical lifting devices. All lifting devices should have a 6 point check list visible on each lift to remind staff. In addition, monthly audits of the integrity of slings for use with mechanical lifts should be implemented. Annual competency testing of staff knowledge and application of safe lifting techniques with return demonstration ▪ The Home is encouraged to develop a formal "lock out/tag out" process for managing malfunctioning equipment ▪ Implement pre-start up checklist for all lifts prior to use. Implement a Sling Replacement plan including sling audits to assess for any disrepair and remove from service.

Falls Management

Issue(s)	Recommendation(s)
▪ There is not a formalized program with Lead .	▪ A Falls Lead should be assigned, and the roles and responsibilities clearly communicated to the Lead. Consistent falls prevention meetings with an interdisciplinary approach should occur, regularly, minimum of quarterly. An interdisciplinary approach to falls management should be initiated. This includes: ▪ Documented post fall huddles as soon as possible after every fall

Falls Management

	▪ Implement formal process for referral to physio post fall ▪ Ensure review of risk management to ensure post fall process is followed and completed, including post fall assessments, prior to sign/lock of risk management ▪ Re-evaluation of falls prevention interventions for residents who fall frequently and this should be documented in the progress notes

Medication Management

Issue(s)	Recommendation(s)
▪ Minimize risks associated with medication administration	▪ The Home is encouraged to develop process for independent double check of high risk medications, including Insulin, and high dose opioids. Involve RPN's in process of processing of orders and review of 3MMRs. Consistent audit process to assess for med carts left unattended and unlocked, controlled substances, omissions of High Alert medications. In light of the Wetlaufer case anticipated recommendations, this would be a proactive measure that the Home should consider. ▪ There is a good process in place for managing medication incidents. There is an assigned lead and medication incidents are reviewed to develop corrective action. The program would be enhanced by discussion at monthly medication management meetings which includes feedback to the staff regarding their suggestions to improve medication administration. ▪ The Home would benefit from developing consistent routines for management of expiry dates on eye drops. Recommendation to have all eye drops start on first day of month

Safety	
Issue(s)	**Recommendation(s)**
▪ Provision of PPD's to staff for safe completion of duties with audit to ensure equipment is still in place.	▪ Provide/wear PPE's when using liquid oxygen, cleaning and disinfecting of equipment ▪ Proper storage of Hazardous substances

Policies and Procedures (please see list of the specific policies attached)	
Issue(s)	**Recommendation(s)**
All Sun Parlor Home Policies and Procedures that were provided were reviewed by the Extendicare National Policy and Performance Improvement Consultant and other Subject Matter Experts on our team, including Registered Dietitian Consultants, the National Director for Infection Prevention and Control, Fire Prevention and Life Safety Consultant's, as well as, Occupational Health and Safety and Labour Relations experts. General observations include the fact that many of the policies used inconsistent, unclear and/or confusing language, some were incomplete and/or completely non-compliant with existing standards, regulations, legislation and best practices. In some cases, the identified policy non-compliance puts the Sun Parlor home at risk for legal action and challenges, as well as, findings of non-compliance during regulatory inspections, including MOHLTC and Ministry of Labor inspections and human rights violations under the Ontario Human Rights Code. Further, the complete absence of some policies, for example, a policy directing staff on how to respond to a bomb threat is both a life safety concern, as well as, a compliance issue with the LTCHA, S230(4) which requires all homes to have an emergency plan in place to deal with bomb threats. Some of the high-risk, non-compliant policies include, but are not limited to:	▪ Purchase and implement a 3rd party suite of policy manuals, which are fully compliant with all applicable standards, regulations, legislation and best practices.

Policies and Procedures (please see list of the specific policies attached)

- **Code Blue**
  Identified risk – Not compliant with the Health Care Consent Act

  Policy directs staff to determine the "ACHD" (Advance Care Health Directive). The only advance directive that is legal in Ontario is a DNR and that is only to be used when the resident is found VSA. In all other cases, staff must obtain consent for treatment from the capable resident or the SDM (if resident is incapable of providing consent). In an emergency situation wherein, the resident is not capable of providing consent and the SDM is not available, the practitioner must provide all emergency treatment as appropriate to treat the resident's condition until consent for further treatments can be obtained.

- **Code Black (Bomb threat policy does not exist)**
  Identified risk - Not compliant with the requirements of the LTCHA and best practices related to Emergency Preparedness and Response.

  The policy relating to "Suspicious Packages" does not adequately guide staff in how to deal with the overall emergency of dealing with a bomb threat. While a suspicious package may be a bomb, it could also contain biological contaminants or other dangerous substances and have nothing to do with a bomb. Further, staff must have a policy and procedure in place to direct them on how to handle a bomb threat which may be communicated to the home via telephone, email, letter, social media or by any other means.

- **Personal Health Information Protection Act**
  Identified risk – Not compliant with the Personal Health Information Protection Act

Policies and Procedures (please see list of the specific policies attached)

PHIPA, Section 16(1)part(c) requires Health Information Custodians to, "describe how an individual may obtain access to or request correction of a record of personal health information about the individual that is in the custody or control of the custodian". This policy does not contain this information.

- **Fire Prevention and Safety – Maintenance Procedures and Emergency Plan**
  Identified risk – staff may choose not to comply when the language is "suggestive" as opposed to "directive", thus putting residents, staff and visitors at risk from an emergency preparedness and response perspective.

  The language used in policies must be directive not suggestive. The use of words such as "should" are not recommended. Policy statements should use directive words such as, "will", "must", and "shall".

- **Activities – Program evaluation**
  Identified risk – Not compliant with the Ministry of Health and Long Term Care, Long Term Care Homes Act

  Does not speak to the MOHLTC annual program evaluation requirement which must be completed by the department lead.

- **Physiotherapy**
  Identified risk – Not compliant with the Health Care Consent Act

  Consent must be obtained from the capable resident and only if not capable, then the SDM should be contacted for consent. Use of the term "POA" may be confusing to staff as not all residents may have a POA identified – in this case, the

Policies and Procedures (please see list of the specific policies attached)	
staff must turn to the highest ranking SDM as per the Health Care Consent Act (HCCA, 1996) ▪ **Absenteeism – Attendance at Work** Identified risk – Not compliant with the Ontario Human Rights Code Under the Ontario Human Rights Code, it is illegal to ask staff to produce a doctor's note that states a diagnosis. This policy needs to be rewritten to reflect the need to obtain relevant information to assess the employee's needs for accommodation and to remove any reference to asking employees for a note with a diagnosis. ▪ **Interdisciplinary Team Care Conference** Identified risk – provides no direction, contains no procedures. This policy provides no direction to staff on how to conduct the care conference, or where to document the discussions and does not provide information to staff on the situations in which a six-week care conference may not be necessary. Details pertaining to these issues are captured in Appendix A.	

CLOSING SUMMARY

Based on Extendicare's presence in the Sun Parlor Home, we believe that we can provide significant support and consultation to the Home in roll out of new policies and procedures which will increase the quality of resident care and processes for the LTC Home. While our operational review will guide the Home in developing a plan of action, the Leadership team in the Home requires expertise in guiding them to achieve and sustain process changes.

Extendicare has provided you with the following appendices:

- Appendix A – Existing Policy Review Matrix
- Appendix B – The Sun Parlor Home Staffing Analysis
- Appendix C – Per Resident Day Supply Cost Analysis

APPENDIX A
Existing Policy Review Matrix

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
100-01	Code Blue		X		Policy is misleading – directs staff to determine the "ACHD" (Advance Care Health Directive). The only advance directive that is legal in Ontario is a DNR and that is only to be used when the resident is found VSA. In all other cases, staff must obtain consent for treatment from the capable resident or SDM (if resident is incapable of providing consent).
100-02	Code Pink	X			However, staff may not realize they are responding to the same type of emergency as a Code Blue and may not immediately respond with the appropriate equipment (O2, airway, etc). You may want to consider revising the Code Blue emergency code policy and instructing staff that if it's a child or infant, announce, "Code Blue – Infant/Child and then the location"
100-03	Code White	X			
100-04	Code Green	X			
100-05	Code Red	X			Typos in policy. Grammatical errors and unclear language used in policy.
101-14	Weapons	X			Grammatical errors and unclear language used in policy. Numbering of policy is not consistent. Suggest the development of the following emergency codes: Brown (Chemical Spill); Purple (Hostage Situation); Orange (External/Natural Disaster); Yellow (Missing Resident); Grey (Air Exclusion); Black (Bomb Threat); Silver (Active Assailant). Also, the Home needs to develop a Pandemic Plan and a Loss of Essential Services policy to ensure that there are comprehensive policies to guide staff in dealing with these emergency situations.
0101-12	Staff Email Protocol			X	Protocol should make it clear that staff must not put any resident personal information in an email, including Personal Health Information.

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0102-01	Absenteeism – Attendance at Work		X		It is illegal to ask staff to produce a doctor's note that states a diagnosis.
0102-02	WCB – Modified Work			X	
0102-03	Purchasing Procedure			X	
0102-06	Recruitment/Employment Status			X	
0102-07	College of Nurses of Ontario	X			
0102-08	Resident Census	X			
	County Policy – Employee Harassment				Not provided.
0102-09	Personal Health Information Protection Act		X		PHIPA, Section 16(1) part(c) requires Health Information Custodians to, "describe how an individual may obtain access to or request correction of a record of personal health information about the individual that is in the custody or control of the custodian". This policy does not contain this information.
0102-10	Identification and Security Cards, Keys and Clocking Procedures			X	
0102-11	Flag Flying Protocol			X	
0102-12	Disability Management/Early and Safe Return to Work Programs	X			
0102-13	Dress Code	X			But wording is unclear, and language is not consistent with IPAC "disease organism" (should be "pathogen")
0102-14	Quality Improvement Plan				The policy title is "Quality Improvement Plan" yet the policy speaks to the requirements of a CQI Committee. Suggest renaming policy CQI Program and including language around the need to establish and maintain a CQI Committee and outline all the associated roles, responsibilities and procedures. A Quality Improvement Plan is a deliverable of the CQI Committee as part of a CQI Program.
0102-14-01	Quality Improvement Record	X			
0102-14	Visiting and Management of Front Entrance	X			Has the same policy number as the Quality Improvement Plan policy number. Needs renumbered.

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0102-15	Automatic External Defibrillator			X	
	Food and Nutrition Services Policies				Assessed by Dietary Consultant
0101-01	Mission Statement			X	
0101-02	Philosophy			X	The policy is called “Philosophy” in the index but the policy is titled “Values”
0101-03	Goals			X	This policy is called “Goals” in the policy index but the policy is actually titled “Vision”.
0101-04	Organizational Charts	X			
0101-05	Banking – Storage of Monies and Cheques		X		Policy statement, “No monies or cheques shall be left unattended in the bank at any given time.” is misleading. It conveys the idea that money/cheques put in the bank will be attended 24/7. I assume this is not the case and the bank is kept locked at all times.
0101-06	Long Distance Phone Calls			X	
0101-07	Payroll Enquiries			X	
0101-08	Call-ins – Nursing Department			X	Very poorly worded – misleading. States, “When the Relief Receptionist is on duty, the Nurse in Charge is responsible for replacement of staff within the Nursing Department.” and then the policy goes on to detail the receptionists duties to replace staff.
0101-09	Asbestos – Sun Parlor Home Asbestos Free			X	
0101-10	Employment Status Notification Form			X	
0101-11	Mobile Device Use			X	
0101-12	Staff Email				Duplicate
0101-13	Heat Advisories	X			
0501-01	Introduction	X			
0501-02	Delegation of Responsibility	X			
0501-03	Orientation/Training	X			
0501-04	Definition of Terms	X			
0501-05	Refusal of Unsafe Work	X			
0501-06	Concerns Reporting	X			
0501-07	Discipline and Enforcement	X			

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0501-09	Musculoskeletal – Ergonomics Program	X			
0501-10	Job Hazard Analysis	X			
0501-11	Storage and Use of Hazardous & Corrosive Materials	X			
0501-12	Pouring of Hazardous and Corrosive Materials	X			
0501-13	Fire Prevention and Safety	X			
0501-14	Fire Prevention and Safety Legislative Reference	X			
0501-15	Fire Prevention and Safety – Maintenance Procedures and Emergency Plan		X		Language used in policies must be directive not suggestive. The use of the words, such as “should” are not recommended. Policy statements should use directive words such as, “will”, “must”, and “shall”.
0501-16	Fire Procedure	X			
0501-17	First Aid Room	X			
0501-18	Incident Reporting – Staff/Volunteer	X			
0501-18-02	Incident Investigation	X			
0501-19	Workplace Hazardous Materials Information System	X			
0501-20	Employee Incident Report Review	X			
0501-21	Smoking	X			
0501-22	Noise Protection	X			
0501-23	Needle Stick Injury	X			
0501-24	Critical Injury Reporting Policy	X			
0501-25	Electrical Equipment Lock Out and Tagging	X			
0501-26	Snow removal of Sidewalks and Parking Lots	X			
0501-27	Procedure Regarding Suspicious Packages	X			
0501-29	Respiratory Protection Program Fit Testing	X			

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0501-30	Slip, Trip and fall Prevention Program	X			
0501-31	Management Workplace Inspections	X			
0501-32	Reduced Fragrance Policy	X			
0501-33	Grass cutting and Grounds keeping	X			
0501-34	Ladders	X			
0501-35	Welding and Hot Work	X			
0501-36	Personal Protective Equipment	X			
0501-37	Cytotoxic Handling	X			
0501-38	Internal Responsibility System (IRS)	X			
RESIDENT ACTIVATION SERVICES					
0202-01-01	Overview				
0202-01-02	Philosophy and Goals				
0202-01-03	Activities				
0202-02-02	Orientation - Volunteers	X			
0202-02-03	Orientation – Life Enrichment	X			
0202-03-01	Life Enrichment Role in New Admission	X			
0202-04-01	Activities	X			
0202-04-02	General Overview – Activities Programs		X		Policy should include direction around ensuring resident safety and security and reporting significant changes in resident status to the nurse immediately.
0202-04-04	Program Evaluation		X		Doesn't speak to the MOHLTC annual program evaluation requirement which must be completed by the department lead.
0202-05-05	Physio Therapy		X		Consent must be obtained from the capable resident and only if NOT capable, then the SDM should be contacted for consent. Use of the term "POA" may be confusing to staff as not all residents may have a POA identified – in this case, the staff must turn to the highest ranking SDM as per the Health Care Consent Act (HCCA, 1996)
0202-05-07	Occupational Therapy	X			
0202-05-08	Speech Therapy	X			
0202-05-09	Accessing the Assistive Devices Program	X			

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0202-05-10	Pressure Reducing Surfaces for Mobility Aids	X			
0202-05-11	Pressure Reducing Surfaces for Mobility Aids	X			
0202-05-17	Range of Motion Ex n'Flex Leg Exerciser	X			
0202-05-18	Restorative Feeding Assessment (under review)	X			
0202-06-01	Publicizing Programs	X			
0202-06-05	Music Therapy (ON HOLD)	X			
0202-06-15	Outings	X			
0202-06-16	Parties and Entertainment	X			
0202-06-23	Serving of Alcoholic Beverages During Programs	X			
0202-08-01	Religious and Spiritual Services	X			
0202-08-02	Pastoral Care Advisory Committee Terms of Reference	X			
0202-08-03	Pastoral Care Advisory Committee	X			
0202-07-01	Resident's Council Terms of Reference	X			
0202-07-02	Constitution	X			
0202-07-03	By-lays	X			
0202-07-04	Resident Concerns Process	X			
0202-09-01	Clothing Shows	X			
	Resident Abuse	X			
0202-09-02	Resident Memorial Procedure	X			
0202-09-08	Power Mobility Driving Assessment	X			
0202-09-09	Mobility Equipment Repair	X			
0202-09-10	Using Temporary Mobility Equipment	X			

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0202-09-11	Mobility Device Maintenance Program - reviewing	X			
0202-09-12	Staff Assisted Resident Purchases	X			
0202-09-13	Acceptable Dining Establishments	X			
0102-13	Resident Incident Reporting		X		Very disorganized and difficult to follow. Policy identified other agencies which are to be notified of various types of occurrences and the mandatory reporting to the MOHLTC is difficult to ascertain. ALSO – needs to be renumbered (0102-13 is also the policy number for the Dress Code policy).
0103-42	Code L		X		Not consistent with IMS emergency colour code framework. Recommend adopting the OHA IMS emergency colour code framework and identifying a lost resident as “Code Yellow”.
0104-01	Falls Prevention and Management			X	As a proactive measure, prevention should be the first line of defense against injury and falls. This policy focuses first on fall management and fall prevention comes later in the policy. Recommend that this be rewritten, and a more proactive approach emphasized.
0104-02	Pain Management	X			Policy should identify non-pharmacological approaches to pain management and also direct staff to complete pain assessments (rather than “identify additional opportunities to assess pain”). Not consistent with best practice.
0104-03	Skin and Wound Care Program			X	Not consistent with best practices for prevention of skin breakdown. Confusing as to how to assess risk of skin breakdown – PURS or Braden? (policy gives staff a choice).
0104-03-01	Skin and Wound Committee	X			Recommend identifying meeting frequency.
0104-03-02	Air Mattress Policy and Procedure	X			
0104-03-02	Negative Pressure Wound Therapy		X		Incorrectly numbered. Repeat policy.
0104-03-03	Negative Pressure Wound Therapy			X	
0104-04-01	Continence Care and Management	X			Very basic. Does not contain any best practices for bowel and/or bladder retraining.

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0104-04-02	Bladder and Bowel Continence Assessment	X			
0104-04-03	Continence Care Products			X	Incorrect spelling. Lacks information to guide staff in the proper sizing of incontinent products.
0104-05	Resident Incident Reporting Policy		X		Gives staff no direction on completion of mandatory reporting items via CIS.
0104-06	Accept Responsibility – Resident Meds			X	Required documentation/forms should be identified in the policy and attached as an appendix.
0104-07	IDTC Procedure			X	Policy does not direct staff where or what to document.
0104-08-01	Staff Report – Whistle Blower		X		Policy does not speak to the duty to report - Appendix A does include this information but the duty to report needs to be included in the policy statement as a directive. (ie Staff will report the following immediately to the Director…)
0104-08	Resident Abuse		X		Policy statement needs to state, “there is zero tolerance for abuse and NEGLECT”. Currently policy statement only speaks to zero tolerance for “abusive behaviour”.
0104-08	Resident Abuse			X	Duplicate
0104-09	Laundering	X			Suggest adding, “resident personal belongs will be labelled ***with the consent of the resident/SDM.***
0104-10	Health Cards			X	
0104-11	Purchase Resident Items			X	
0104-15	Appointments and Transportation				
0104-17	Responsive Behaviour Policy		X		Documentation and communication methods should be identified – remove language “behaviour monitoring MAY BE completed using POC…”. Policy must be directive, identify a tool and then mandate that staff use it, how often, etc.
0104-18-02	Death Pronouncement by RN		X		The 10th death threshold no longer applies.
0104-19	Minimizing Restraining		X		Should include more direction for staff around the need to trial and evaluate alternatives to restraints and to ensure these strategies are identified on the care plan
0104-19-01	Physical Restraints	X			
0104-19-04	Emergency Restraints May 2016	X			
0104-19-05	Co-tag		X		Policy should require staff to test that the bracelet and alert system is functioning on a daily basis.
0104-19-06	Use of PASDs	X			
0104-20	Coaguchek policy		X		Should include directions on when and how to use the coagucheck device to check the residents INR.

Policy Number	Policy Name	Compliant	Non – Compliant	N/A	Deficiency identified
0104-22	Heights policy	X			
0104-23	Administration of topical PSW policy	X			Policy should include directions on how Registered staff will assess the competence of the unregulated care provider to administer the topical medication. (ie..teaching and return demonstration)
0104-23-01	Medication Dispensing policy	X			
0104-23-02	Topical Med Administration	X			Recommend collapsing policy 0104-23 and 0104-23-02 into one policy.
0104-24	ADL Summary	X			
0104-25	Dealing with Complaints		X		The LTCHA Section 225(1) requires that the MOHLTC toll-free reporting number be posted and that staff, residents, volunteers, visitors are made aware of their right/duty to report directly to the Director.
0104-28	Sensory Aids	X			
0104-29	Bed System Assessment Policy	X			
0104-36	Oral Care	X			
0104-39	Oxygen	X			
0104-39-01	CPAP	X			
0104-45	Catheter Draining Systems	X			
0104-60	Dining Room and Snack Service		X		Policy requires the completion of the “Heat Risk Tool” as part of the dining room and snack service policy? WHY?
0104-64	SubQ Lock	X			
0104-65	PICC line	X			
0104-66	IV Therapy	X			
0104-67	Tracheostomy Care	X			
0104-76	Monthly vital signs policy	X			
0104-77	Medicinal Cannabis	X			
0104-81	Government Stock	X			
0104-82	Liquid Nitrogen policy	X			
0104-83	Enteral Feeding	X			
0104-2016	Monthly vital signs – Wrist policy	X			

APPENDIX B
The Sun Parlor Home Staffing Analysis
(Direct Hours Comparison)

Staff Position		Total $	Hourly	ECI Assist Proposed Hrs.		Annual Savings		Comments
	Bi-weekly Direct	(Annual)	Rate	Bi-weekly	Annual	Hours	$ Amount	
Administrative								
Administrator	70.0	136,938	75.03	70	1,825	-	-	
Administrative Assistant	70.0	64,964	35.60	70	1,825	-	-	
Admin (Accounting)	70.0	46,118	25.27	70	1,825	-	-	
Manager Health & Safety	70.0	83,877	45.96	70	1,825	-	-	
Clerk	-	-	-		-	-	-	
Clerk	-	-	-		-	-	-	
Total Administrative	**280.0**	**331,897**	**25.69**	**280**	**7,300**			
Dietary								
Manager Food & Nutrition	70.0	92,981	50.95	70	1,825	-	-	
Food Services Supervisor	140.0	129,928	35.60	70	1,825	1,825	64,964	
Prod Chef	-	-	-	-	-	-	-	
Cook	240.0	151,110	24.15	224	5,840	417	10,074	1 (6-2) shift, 1 (10-6 shift)
Dietary Aide	1,200.0	745,851	23.84	1,140	29,721	1,564	37,293	total between cooks and DA is 1364 biweekly as per the Act
Clerk	-	-	-	-	-	-	-	
Total Dietary	**1,650.0**	**1,119,870**	**25.69**	**1,504**	**39,211**	**3,806**	**112,331**	
Hskpg/Laundry								
Manager		-			-	-	-	
Supervisor		-	23.56		-	-	-	

Staff Position	Total $	Hourly	ECI Assist Proposed Hrs.		Annual Savings			Comments
	Bi-weekly Direct	(Annual)	Rate	Bi-weekly	Annual	Hours	$ Amount	
Hskpg Aide	1,216.0	734,555	23.17	1,060	27,636	4,067	94,236	recommend 7 (7-3) and 4 (3-8pm)
Laundry Aide	752.0	460,146	23.47	168	4,380	15,226	357,348	recommend 1 (6-2) and 1 (4-8) shift daily
Housekeeping Students	37.0	14,470	15.00			965	14,470	
Total Hskpg/Laundry	**2,005.0**	**1,209,171**	**24.57**	**1,228**	**32,016**	**20,258**	**466,053**	
Maintenance								
Director Bldg Services	90.0	113,253	56.07	70	1,825	195	10,933	
Supervisor/Lead Hand								
Mtce Worker 1	296.0	190,536	24.69	240	6,257	1,460	36,047	reduction to 3 FT maintenance persons.
Mtce Worker 2					-	-	-	
Mtce Elec/Heat		-			-	-	-	
Mtce Clerk		-			-	-	-	
Total Maintenance	**386.0**	**-**	**-**	**310**	**8,082**	**1,655**	**46,980**	
Programs								
Life Enrichment Manager	70.0	74,304	40.71	70	1,825	-	-	
Life Enrichment Aide	624.0	395,814	24.33	544	14,183	2,086	50,745	6 FT (480 biweekly) 2 PT (64 biweekly)
Pastoral Care (contract)	24.0	14,517	23.20	24	626	-	-	
Physiotherapist (contract)	75.0	106,371	54.40	113	2,933	(978)	(53,186)	as per recommendation
Physiotherapist Aide	32.0	20,298	24.33	150	3,911	(3,076)	(74,850)	as per recommendation
Dietician	103.0	139,639	52.00	103	2,685	-	-	
Volunteer Coordinator	32.0	21,224	25.44	32	834	-	-	
		-			-	-	-	
Total Programs	**960.0**	**772,167**	**30.38**	**1,036**	**26,997**	**(1,968)**	**(77,290)**	

Staff Position	Total $	Hourly		ECI Assist Proposed Hrs.	Annual Savings			Comments
	Bi-weekly Direct	(Annual)	Rate	Bi-weekly	Annual	Hours	$ Amount	
Nursing								
Director of Nursing	75.0	115,146	58.89	70	1,825	130	7,676	
ADOC	150.0	180,046	46.04	140	3,650	261	12,003	
Staffing Coordinator		-			-	-	-	
Ward Clerk	520.0	321,982	23.75	304	7,926	5,631	133,746	2 ward clerks on days, 1 on evenings M-F. 1 day, 1 evenings S&S.
RN	840.0	959,658	43.82	840	21,900	-	-	move 2 RN's to the floor for days and evenings and retain 1 "charge RN" for days and evening. No change to night shift
RPN	1,470.0	1,111,042	28.99	1,120	29,200	9,125	264,534	
Health Care Aide	7,007.0	4,512,258	24.70	5,992	156,220	26,463	653,624	reduction of 1 day float psw and 3 night psw's (retain 1 psw per unit and 3 floats)
MDS/RAI Coordinator	210.0	239,915	43.82	160	4,171	1,304	57,123	recommend 2 FT positions.
Infection Control Facilitator		-			-	-	-	
Coord Clinical Learning/Practice		-			-	-	-	
BSO - Supervisor	70.0	75,701	41.48	70	1,825	-	-	
BSO - Coordinator	70.0	46,994	25.75	70	1,825	-	-	
BSO - RN		-			-	-	-	
BSO - PSW		-			-	-	-	
BSO - Therapy Recreation		-			-	-	-	
Total Nursing	**10,412.0**	**7,562,741**	**30.47**	**8,766**	**228,542**	**42,914**	**1,128,706**	
TOTAL SUN PARLOR HOME	**14,043**	**9,875,976**		**11,620**	**302,937**	**62,858**	**1,564,449**	
* based on 8hrs pd for CUPE and 7.5 hrs pd for ONA 7hrs pd for OOS					**Benefits**	*26.50%*	**414,579**	
						NET SAVINGS	**1,979,028**	

APPENDIX C
Per Resident Day (PRD) Supply Cost Analysis

Figure 1: The Sun Parlor Home (Analysis of 2017 Projection)

Department	Wages	Benefits Amount	Benefits %	Supplies Amount	Supplies PRD
Administration	$ 540,400	$ 190,100	35.2%		
Nursing	$ 10,559,300	$ 2,624,200	24.9%	$ 425,550	$ 5.66
Life Enrichment	$ 546,800	$ 205,600	37.6%	$ 28,200	$ 0.38
Dietary	$ 2,028,900	$ 572,300	28.2%	$ 80,250	$ 1.07
Laundry	$ 836,100	$ 237,600	28.4%	$ 42,300	$ 0.56
Housekeeping	$ 1,163,800	$ 334,560	28.7%	$ 35,800	$ 0.48
Maintenance	$ 505,400	$ 165,400	32.7%	$ 36,000	$ 0.48
Total	**$ 16,180,700**	**$ 4,329,760**	**26.8%**	**$ 648,100**	

$ 2.58 (Dietary, Laundry, Housekeeping, Maintenance)

Figure 2: Nursing Supplies for Extendicare owned homes

Beds	Nursing Amount	Nursing PRD
150	$ 237,342	$ 4.481
150	$ 232,473	$ 4.263
150	$ 211,836	$ 3.905
150	$ 238,414	$ 4.462
153	$ 797,003	$ 14.637
160	$ 211,937	$ 3.649
169	$ 221,383	$ 3.648
170	$ 407,913	$ 6.657
174	$ 220,677	$ 3.577
175	$ 260,934	$ 4.165
180	$ 241,638	$ 3.713
192	$ 228,499	$ 3.339
192	$ 338,337	$ 4.895
193	$ 349,021	$ 5.052
203	$ 305,918	$ 4.169
234	$ 413,974	$ 4.952
242	$ 454,300	$ 5.254
242	$ 377,750	$ 4.455
256	$ 308,185	$ 3.319
288	$ 414,509	$ 4.073
TOTAL	**$ 6,472,042**	**$ 4.833**

Figure 3: Dietary, Laundry, Housekeeping and Maintenance Supplies for Extendicare owned homes

Beds	Dietary		Laundry		Housekeeping		Maintenance		Grand Total	
	Amount	PRD	Amount	PRD	Amount	PRD	Amount	PRD	Amount	PRD
150	$ 39,258	$ 0.741	$ 14,868	$ 0.281	$ 37,603	$0.710	$ 10,818	$ 0.204	$ 102,548	$ 1.936
150	$ 25,356	$ 0.465	$ 14,723	$ 0.270	$ 34,574	$0.634	$ 4,915	$ 0.090	$ 79,568	$ 1.459
150	$ 28,487	$ 0.525	$ 24,042	$ 0.443	$ 49,780	$0.918	$ 8,059	$ 0.149	$ 110,368	$ 2.034
150	$ 9,557	$ 0.179	$ 20,890	$ 0.391	$ 45,445	$0.851	$ 7,064	$ 0.132	$ 82,956	$ 1.553
153	$ 44,873	$ 0.824	$ 25,458	$ 0.468	$ 32,760	$0.602	$ 7,955	$ 0.146	$ 111,046	$ 2.039
160	$ 39,550	$ 0.681	$ 13,000	$ 0.224	$ 34,490	$0.594	$ 19,315	$ 0.333	$ 106,356	$ 1.831
169	$ 34,803	$ 0.574	$ 24,060	$ 0.397	$ 34,511	$0.569	$ 17,928	$ 0.295	$ 111,302	$ 1.834
170	$ 32,944	$ 0.538	$ 17,142	$ 0.280	$ 31,473	$0.514	$ 9,795	$ 0.160	$ 91,354	$ 1.491
174	$ 34,359	$ 0.557	$ 26,439	$ 0.429	$ 28,443	$0.461	$ 25,488	$ 0.413	$ 114,730	$ 1.860
175	$ 30,263	$ 0.483	$ 17,868	$ 0.285	$ 41,627	$0.664	$ 17,192	$ 0.274	$ 106,950	$ 1.707
180	$ 34,114	$ 0.524	$ 23,675	$ 0.364	$ 28,204	$0.433	$ 5,295	$ 0.081	$ 91,288	$ 1.403
192	$ 34,014	$ 0.497	$ 28,170	$ 0.412	$ 44,036	$0.643	$ 15,075	$ 0.220	$ 121,294	$ 1.772
192	$ 53,317	$ 0.771	$ 27,718	$ 0.401	$ 63,707	$0.922	$ 15,913	$ 0.230	$ 160,655	$ 2.324
193	$ 28,170	$ 0.408	$ 26,112	$ 0.378	$ 35,320	$0.511	$ 13,263	$ 0.192	$ 102,865	$ 1.489
203	$ 50,241	$ 0.685	$ 18,374	$ 0.250	$ 39,345	$0.536	$ 17,310	$ 0.236	$ 125,271	$ 1.707
234	$ 50,593	$ 0.605	$ 28,554	$ 0.342	$ 41,124	$0.492	$ 9,883	$ 0.118	$ 130,155	$ 1.557
242	$ 45,080	$ 0.521	$ 27,479	$ 0.318	$ 48,717	$0.563	$ 16,013	$ 0.185	$ 137,289	$ 1.588
242	$ 54,060	$ 0.638	$ 33,335	$ 0.393	$ 49,754	$0.587	$ 18,771	$ 0.221	$ 155,919	$ 1.839
256	$ 50,686	$ 0.546	$ 33,212	$ 0.358	$ 54,178	$0.584	$ 19,222	$ 0.207	$ 157,298	$ 1.694
288	$ 72,428	$ 0.712	$ 34,571	$ 0.340	$ 45,352	$0.446	$ 16,535	$ 0.162	$ 168,886	$ 1.660
TOTAL	**$ 792,152**	**$ 0.574**	**$ 479,690**	**$ 0.351**	**$ 820,443**	**$0.612**	**$ 275,811**	**$ 0.203**	**$ 2,368,097**	**$ 1.739**