Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 20 & 31, 2011	2011-120-8521-20Jan112654	H-00066 – Critical Incident

Licensee/Titulaire

The Elliott, 170 Metcalfe Street, Guelph, ON N1E 4Y3

Long-Term Care Home/Foyer de soins de longue durée

The Elliott Community, 170 Metcalfe Street, Guelph, ON N1E 4Y3

Name of LTC Homes Inspector(s)/Nom de l'inspecteur(s) de les foyers de soins de longue duree

Bernadette Susnik, Environmental Health #120

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct an inspection related to a Critical Incident Report that was submitted to the Ministry of Health and Long-term Care.

During the course of the inspection, the above noted inspector spoke with the Administrator, Charge Nurse, Director of Recreation, Environmental Services Supervisor, registered nursing staff and personal support workers.

During the course of the inspection, the resident involved in the incident was seen and their ceiling lift was visually observed, tags/labels on slings throughout the home were checked and the following documents were reviewed: the resident's plan of care, sling and lift inspection logs and maintenance service reports, sling and lift use policies and procedures and sling and lift user manuals. Copies of the Arjo Sling Inspection report were acquired and photographs of the incident were provided. A demonstration of a lift transfer was re-created using the same style sling that was used during the incident.

The following Inspection Protocols were used during this inspection:

- *Accommodation Services - Maintenance*
- *Safe and Secure Home*

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activities

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN#1: ***The licensee has failed to comply with O. Reg. 79/10, s. 90(1)(b).*** As part of the organized program of maintenance services under clause 15(1)(c) fo the Act, every licensee of a long-term care home shall ensure that,

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

Findings:

1. The sling that was used (NM Combi Deluxe Mesh) on an identified resident was not in good condition. A strap ripped away from the sling material, causing a resident incident. The sling was not routinely inspected by any staff member, and specifically was not inspected prior to use as per the manufacturer's instructions, to ensure that all of the straps and stitching were securely in place.
2. The various styles of slings used in this home were not part of a preventive maintenance program as per the manufacturer's instructions and as a result were found to be in disrepair. The slings are required to be inspected prior to use and the manufacturer recommends that the sling straps are thoroughly inspected once every 2 months. The home does not have any records of these types of inspections. Two informal audits were done by staff, once in November 2009 and once in July 2010, whereby the slings were counted and numbered, but they were not inspected for safety.
3. 48 slings were inspected by a technician from Arjo on January 11, 2011. 35 slings failed the manufacturer's safety inspection and were removed from circulation on January 11, 2011.
4. An additional 4 slings were identified by the above noted LTC Homes Inspector on January 20, 2011. They were found stored in the Wellington Home area storage room, sitting on a shelf. Two slings were noted to have worn out tags (sign of sling failure) and one was dated 2004. The manufacturer recommends that slings not be in use for more than 5 years.

Additional Required Actions:

VPC - pursuant to the *LTC Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 90(1)(b) in respect to ensuring that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #2: ***The licensee has failed to comply with O. Reg. 79/10, s. 216(3).*** The licensee shall keep a written record relating to each evaluation under subsection (2) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Findings:

The last known lift and transfer training in-service that was offered to personal service workers and nursing staff was in July 2010. This in-service was offered by a representative from the Arjo company, which has sold slings and lifts to the home. No formal documentation exists as to what was taught at this in-service and no staff attendance was taken. The course content was not evaluated by staff of the home to determine if additional training needed to be provided. The in-service was offered during the day shift only, and night and evening shift employees did not attend. No training has been offered to any staff with respect to how to inspect a sling to ensure they are safe to use.

Additional Required Actions:

VPC - pursuant to the *LTC Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 216(3) in respect to ensuring that a written record relating to each evaluation is kept, which includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. The plan is to be implemented voluntarily.

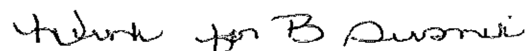
WN# 3: *The licensee failed to comply with O. Reg. 79/10, s. 23*. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturer's instructions.

Findings:

A strategy for ensuring that each resident is assessed, based on manufacturer's recommendations for correct sling size and type, has not been implemented. Staff are not aware of and do not follow the manufacturer's instructions with respect to sling use.

The resident injured in the accident was not assessed for the correct sling size and type for their body mass and specific needs. Personal Service Workers (PSWs) transferring the resident used a sling that was not the right size for their height and weight. The resident's plan of care indicates only that resident is to be transferred using the ceiling lift and no information was available to staff regarding sling type or size. Several other PSWs also reported during the inspection that they do not always have the correct sling size for the resident they are transferring and that they do not always know how to determine sling size (some sling types in use are not labeled with a size – S, M, L, XL).

VPC - pursuant to the *LTC Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 23 in respect to ensuring that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturer's instructions, to be implemented voluntarily.

Signature of Licensee of Designated Representative Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.  Revised for the purpose of publication - Sept 29, 2011
Title: Date:	Date of Report :(if different from date(s) of inspection).