Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 18, 2012	2012_072120_0034	Critical Incident

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Directors of Care and Maintenance Supervisor regarding a critical incident.

During the course of the inspection, the inspector(s) reviewed the resident's bed system, the resident's clinical records and the home's policies and procedures.(H-000628-12)

The following Inspection Protocols were used during this inspection:

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has 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 manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. Staff did not use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturer's instructions.

Slider sheets, which are considered a positioning device were not used according to manufacturer's guidelines.

The home incorporated the use of specially designed sliding sheets, which are comprised of a bottom and top sheet with special low-friction backing, for various residents in early 2012. The sheets are designed specifically to assist staff in positioning residents while they are in bed. In 2012, an identified resident sustained an injury requiring a visit to the hospital. The resident received slider sheets as they required assistance in bed. A personal support worker confirmed that the resident was able to wiggle around/move in their bed. In 2012, the resident was in bed, seated on a set of slider sheets, with the head of their bed elevated. The resident moved in bed and slid down. A PSW found the resident with an extremity stuck in the opening of the bed rail. The manufacturer's disclaimer states that there is a risk of residents sliding out of bed because of the slippery nature of the product. The manufacturer's instructions clearly state that they are not to be used for residents who make frequent movements or position changes in bed and that there is a risk of residents sliding out of bed because of the slippery nature of the product. The sheets were not removed from the resident's bed until 5 days after the incident, when registered staff identified and documented that the resident may not be a good candidate for the sheets. The resident was identified to continue to pull themselves from side to side using their side rails when reaching for items on the bedside table.

Additional Required Actions:

VPC - pursuant to the Long-Term Care 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 to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. [O. Reg. 79/10, s. 15(1)(a)] The licensee has not ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

An identified resident received a therapeutic air mattress in 2011 for medical reasons. The air mattress was placed on a bed frame with quarter length rails which are to be raised (in use) while the resident is in bed to mitigate falls, as directed by their plan of care. According to the Associate Directors of Care, no risk assessment was conducted to determine if the mattress would pose any sort of entrapment risk or other hazard to the resident while in bed with bed rails in use.

On a particular date in 2012, the resident was seated on their mattress with the head of the bed elevated, bed rails in place and their mattress covered with a set of slider sheets. The resident moved and slid down in the bed. A personal support worker found the resident with an extremity stuck in the opening of the bed rail. The resident sustained an injury as a result of this incident.

During the inspection, it was identified that the resident's air mattress did not have re-enforced side wall rigidity or any side bolsters (measures to reduce mattress compressability and entrapment zones). The air mattress air pressure was not set for the resident's weight, but for someone who would weigh at least 25-100 pounds more. The increased pressure would have caused the resident to sit higher up on the surface of the mattress. The slider sheet caused the resident to slide down when they went to move and because the resident wasn't seated in a basin (caused by raising the knee area) they continued to slide down and over to the side of their mattress. The combination of the mattress style, type, pressure, resident position, use of bed rail and the use of the slider sheets were all contributing factors to the incident.

The home does not have any policies or procedures for appropriate use of therapeutic surfaces or sliding sheets. No guidance documents were available to staff for assessing residents who are both on a therapeutic mattress and require the use of bed rails. No guidance tools are available to staff who might have to conduct an assessment for a resident requiring an air mattress.

Additional Required Actions:

VPC - pursuant to the Long-Term Care 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 to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. [LTCHA 2007, S.O. 2007, c.8, s. 6(1)(c)] The resident's plan of care does not set out clear directions to staff and others who provide direct care to the resident.

The plan of care for an identified resident did not include any information or directions for staff regarding their therapeutic air mattress or slider sheets prior to the incident in 2012. The resident had sustained an injury related to their bed system, which includes the air mattress, bed rails and the slider sheets which were placed on their therapeutic air mattress surface. Post incident, the plan of care was amended to include that the resident has a therapeutic air mattress and that slider sheets had been discontinued.

Issued on this 28th **day of May, 2012**

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

B. Sweid