Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 14, 2014	2014_183135_0002	L-000918-13	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CARE, LONDON
268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2

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

ST. JOSEPH'S HEALTH CARE, LONDON - MOUNT HOPE CENTRE FOR LONG TERM CARE - ST. MARY'S
21 GROSVENOR STREET, P.O. BOX 5777, LONDON, ON, N6A-1Y6

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 28-29, 2014.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Resident Care Coordinator and Coordinator Facilities Engineering.

During the course of the inspection, the inspector(s) reviewed resident's clinical records, critical incident report and home's investigation. Observations took place in resident home area related to resident care equipment.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 15. Bed rails
Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(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. The licensee failed to ensure, where bed rails are used that the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident when the following occurred:

A critical incident report was submitted by the home indicating that resident #01 was found by a staff member.

During an interview the Coordinator of Resident Care confirmed that the resident's side rails were used as the resident was at high risk for falls.

Record review revealed the resident had not received a full assessment to determine if their bed system (bed frame, mattress and bed rails) was appropriate for their needs.

Existing assessment tools available to staff at the home are related to transfers and overall mobility and not specifically geared to bed safety. Bed safety assessments would require review of residents for sleep habits and patterns, the sleep environment, mobility in bed, cognition, communication, continence, risk of falls, medication and underlying medical conditions.

During an interview the Coordinator of Resident Care confirmed her expectation that when bed rails are used the resident is assessed and his or her bed system evaluated in accordance with evidence based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

2. January 28, 2014, the Coordinator Facilities Engineering provided documentation that 36 of the beds on St. Mary's 1st floor were assessed December 5, 2013, to determine compliance with Health Canada's Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards 2008.

The entrapment zones, if not managed, become areas where bodily parts can become lodged and trapped. The audit, identified 23 (63.8%) of the St Mary's 1st. floor beds failed the bed entrapment zones between the rail and mattress. The home's air mattresses automatically fail the zones of entrapment based on their design.

Since the audit, the home has not instituted any measures to minimize or mitigate

potential risk to the residents and have not conducted any clinical assessments of the residents that currently sleep on failed beds to determine if the bed system they have been provided is appropriate for their individual needs.

The management of the home met January 28, 2014, to determine plans to audit the remaining beds as the Coordinator Facilities Engineering revealed he suspects that 63% of those beds will likely fail the zones of entrapment. Once those beds are audited the home plans to outline specifically what will be instituted to mitigate risk to residents who continue to sleep in beds that have identified safety risks.

During an interview, the Coordinator Facilities Engineering confirmed his expectation that when bed rails are used, the resident be assessed and his or her bed system evaluated and steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 14th day of February, 2014

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

Bonnie MacDonald