Ontario

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

Rapport d'inspection prévue 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**
September 10 and 14, 2010	2010_133_8567_10Sep103058	Critical Incident (log # 0-001046)

Licensee/Titulaire

Bruyere Continuing Care Inc.
43 Bruyere Street
Ottawa, Ontario
K1N 5C8
Fax: 613-562-6367

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

Residence Saint- Louis
879 Chemin Park Hiawatha
Ottawa, Ontario
K1C 2Z6

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

Jessica Lapensee (ID# 133)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to a resident's injury which resulted in a transfer to hospital.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care, the Coordinator of Auxiliary Services, the Nurse Educator, a Physiotherapist, a Registered Nurse, Auxiliary Services staff and a resident.

During the course of the inspection, the inspector went to see the resident to discuss the incident and to observe the piece of equipment that replaced that which was involved in the critical incident.

The inspector reviewed training records for the staff involved in the critical incident. The inspector reviewed the directives to staff around use of the equipment that was involved in the critical incident.

The inspector interviewed Auxiliary Services staff to clarify their program for handling the type of equipment involved in the incident. The inspector reviewed inspection records from Auxiliary Services staff that related to the piece of equipment involved in the critical incident.

The inspector reviewed the licensee's policies relating to the safe use of the kind of equipment involved in the critical incident. The inspector reviewed the user manual for the specific model of equipment that was involved in the critical incident. In addition, the inspector reviewed 3 other user manuals for the type of equipment involved in the critical incident.

The following Inspection Protocols were used during this inspection:

1) Safe and Secure Home
2) Accommodation Services - Maintenance

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

2 WN
1 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 envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

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'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue 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.107 (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
(1) A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
(2) A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

Findings:

1) As per subsection (3) the licensee is required to report an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident, followed by a report in writing within 10 days. The licensee did make a verbal report August 5, 2010 about the critical incident related to a resident who fell out of a mechanical lift sling while being transferred from bed to a wheelchair and who was subsequently transferred to hospital due to the injuries she incurred. A report in writing was only submitted to the Director on August 18, 2010, 13 days after the licensee became aware of the incident.

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WN #2: 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 uses all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufacturer's instructions.

Findings:

1) As per the Arjo "Maximove Operating Instruction" manual, the "ARJO Slings User Guide" (MAX02360.INT Issue 1 March. 2005), the ARJO "Slings Information" (MAX01510.INT Issue 3) and the ARJOHUNTLEIGH "Passive Clip Sling Operating and Product Care Instructions" (MAX81785M-INT Issue 1 February 2009), staff using an Arjo lift sling must ensure that the sling attachment clips have clicked into proper position before the commencement of the lifting cycle. As reported to the inspector by the Administrator and the Director of Care, the staff involved in the critical incident did not hear all four sling clips click into place before they lifted the resident up off their bed.

2) As per the Arjo "Maximove Operating Instruction" manual, the "ARJO Slings User Guide" (MAX02360.INT Issue 1 March. 2005), the ARJO "Slings Information" (MAX01510.INT Issue 3) and the ARJOHUNTLEIGH "Passive Clip Sling Operating and Product Care Instructions" (MAX81785M-INT Issue 1 February 2009), staff using an Arjo lift sling must ensure the plastic reinforcement pieces for head support are in place. As reported to the inspector by the Administrator and the Director of Care, the staff involved in the critical incident used the lift sling without having inserted the plastic reinforcement pieces for head support.

3) As per the Arjo "Maximove Operating Instruction" manual, the "ARJO Slings User Guide" (MAX02360.INT Issue 1 March. 2005), the ARJO "Slings Information" (MAX01510.INT Issue 3) and the ARJOHUNTLEIGH "Passive Clip Sling Operating and Product Care Instructions" (MAX81785M-INT Issue 1 February 2009), staff using an Arjo lift must ensure the proper sling size is used. As reported to the inspector by the Administrator and the Director of Care, the staff involved in the critical incident used a large sized sling when a medium sized sling was more appropriate given the resident's height and weight.

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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 with ensuring that staff use the type equipment involved in this incident in accordance with manufacturer's instructions, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **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.**
Aug 3/11 ← JMcPaland for J. Lapensee	
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).