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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2015	2015_189120_0004	H-001878/1879-15	Follow up

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

SHELBURNE NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
200 ROBERT STREET SHELBURNE ON L0N 1S1

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 Follow up inspection.

This inspection was conducted on the following date(s): January 7, 2015

An inspection (2014-266527-0015) was previously conducted on July 8-18, 2014 at which time non-compliance was identified with respect to bed safety. Two orders were issued on December 19, 2014, one related to bed system evaluations and the other related to resident assessments and safety hazards of bed rail use. For this follow-up visit, the conditions that were laid out in Order #001 were met, however one component related to training was not met under Order #002. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator and Restorative Care Co-ordinator. In addition, residents in random beds were observed, bed entrapment test results reviewed and three resident assessments evaluated.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2014_266527_0015	120
O.Reg 79/10 s. 15. (1)	CO #002	2014_266527_0015	120

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (4) The licensee shall ensure that the training required under paragraph 4 of subsection 76 (7) of the Act includes training in the application, use and potential dangers of physical devices used to restrain residents and personal assistance services devices. O. Reg. 79/10, s. 221 (4).

Findings/Faits saillants :

1. The licensee did not ensure that staff received training on how to minimize the restraining of residents, including training in the application, use and potential dangers of physical devices (bed side rails and accessories) used to restrain residents and personal assistance services devices (bed side rails).

A Health Canada document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and other Hazards" identifies the risks and potential dangers associated with using bed rails or a physical device (especially when entrapment issues have been identified) to either restrain residents or to provide the resident with a personal assistance services device (PASD) for repositioning, transfers or bed mobility. The licensee was required to use this document to establish practices and protocols for staff training and education in regards to bed rail application, use and potential dangers.

An inspection was previously conducted on July 11, 2014 at which time numerous residents were observed to be in bed with one or more bed rails engaged or in the elevated position. Many beds were also observed to be unoccupied with a bed rail elevated. Personal support workers and registered staff who provided direct care to residents were not aware of the reasons why they were applying bed side rails (either when a resident was in bed or not) and did not know what the hazards were associated with applying them. The general consensus was that bed rails were for "safety" and that applying them automatically was a practice that was taught in school. The term "safety" included the prevention of falls from bed as the leading reason. The licensee was issued an order on December 19, 2014 requiring them to assess all residents for bed rail use and safety hazards and to educate direct care staff with the information identified in the above Health Canada document.

During the follow up inspection on January 7, 2015, a number of the bed side rails were observed to be elevated on many unoccupied beds. According to the Restorative Care

Co-ordinator (RCC), 99% of the residents were assessed to require a bed rail while in bed and many would remain up throughout the day. According to the RCC, many of the residents had made requests to keep their bed rails elevated for "comfort reasons". The training and understanding of bed side rail use and potential dangers was not adequate based on the number of residents still using bed rails and the habit of staff leaving bed rails in the engaged position on unoccupied beds for no apparent reason. The management staff identified that staff had not received any training but had only received a memo summarizing bed safety issues. The licensee identified that additional training is planned within the next month. [s. 221(4)]

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 receive training on how to minimize the restraining of residents, including training in the application, use and potential dangers of physical devices (bed side rails and accessories) used to restrain residents and personal assistance services devices (bed side rails), to be implemented voluntarily.

Issued on this 19th day of January, 2015

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

Original report signed by the inspector.