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
Aug 23, 2013	2013_189120_0042	H-000314-13/H-000344-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

BERNADETTE SUSNIK (120), SHARLEE MCNALLY (141)

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): June 10, 11, 12 & 13, 2013

During the course of the inspection, the inspector(s) spoke with residents, director of care, non-registered and registered staff

During the course of the inspection, the inspector(s) reviewed resident health care documents, staff mechanical lift training records, mechanical lift and transfer policies and procedures, the home's investigative documents and observed the home's mechanical lifts and associated accessories and how they are used.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

Resident #102 was not treated with courtesy, respect and dignity by a health care aide (HCA) on a specified date in 2013. The resident was completely dependent on staff for most activities of daily living such as dressing, toileting, grooming and mobility. The resident made a request to be assisted with one of these tasks and the HCA made an inappropriate response that left the resident feeling disrespected and undignified. The HCA then proceeded to adjust the resident's bed without the resident's permission and did not leave the resident's call bell within easy reach before they left the room. The resident stated that they felt helpless and could not call for assistance.

The home's investigation identified that the HCA went on their break and requested that two other HCAs assist the resident. After waiting approximately 15 minutes, two other health care aides assisted the resident and completed the resident's care. The resident further stated that they were very upset in the way they were treated and that their specific individual needs were not recognized by the first HCA.
[s. 3(1)1]

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 residents are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

Resident #101 was transferred by a health care aide using several unsafe transferring techniques on a specified date in 2013. The worker used a commode chair to transport the resident from their room to the tub room. The chair is not an appropriate transport device according to the manufacturer.

The resident was then assisted onto a tub lift seat(which consists of a fixed seat, a lap belt, a removable padded back rest and two rotating support arms,) by the health care aide and the lift was raised over the tub side and then the resident was lowered into the tub. It is unclear at this point how the resident was seated on the lift seat.

After the resident was bathed, the worker lowered the mechanical tub, raised the lift and resident up and over the tub side, slightly lowered the lift and then wheeled the lift away from the tub. The lift was not lowered to it's lowest position but was left partially raised so that the worker could completed the resident's foot care. The wheels of the lift were not locked.

Once the foot care was completed, the worker left the resident in the raised position and proceeded to rinse the tub. While the worker reached for the spray nozzle, the resident apparently shifted in the chair and the entire lift tipped over onto it's left side. The resident's right side was facing the floor when they were released from the belt that was applied earlier. The registered nurse identified three small bruises on the resident's right shin post incident.

Based on several re-enactments of the scenario using the lift, staff interviews and a review of staff documented statements, several conclusions were made. Firstly, the resident was positioned incorrectly at some point on the tub lift seat, sitting with their back against the lift and not against the back rest located on one of the support arms as required by the manufacturer. Secondly, the resident was raised and lowered without 2 staff members present as required by the home's policies and procedures and thirdly, care was provided to the resident while the lift was in the raised position instead of the lowest position with the wheels locked as required by the manufacturer.

The worker received lift and transfer training in 2011, 2012 and 2013. [s. 36.]

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 safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 28th day of August, 2013

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

B. Sosnik