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
Jun 24, 2013	2013_189120_0041	H-000227-13	Critical Incident System

Licensee/Titulaire de permis

SPECIALTY CARE / WOODHALL PARK INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

SPECIALTY CARE WOODHALL PARK
10260 KENNEDY ROAD NORTH, BRAMPTON, ON, L6Z-4N7

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June ~~5~~ 6, 2013 BA

During the course of the inspection, the inspector(s) spoke with the Director of Care regarding the home's lift and transfer program.

During the course of the inspection, the inspector(s) observed a mechanical floor lift and two types of slings used in the home, reviewed training and orientation records, lift and transfer policies and procedures and the home's post incident investigative documents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Training and Orientation

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 :

Staff did not use safe transferring techniques when assisting an identified resident in 2013.

According to the Director of Care who conducted the post incident investigation, two personal support workers transferred an identified resident from their bed to a wheelchair using a mechanical floor lift by two personal support workers. The sling's straps were not all adequately attached to the lift's spreader bar and the sling was therefore not secured. As a result, one of the straps slipped off the spreader bar causing the resident's upper body to fall forward. The resident sustained an injury and was transferred to hospital.

Statements made by the two personal support workers post incident were reviewed and both identified transferring the resident without checking the sling straps to ensure they were properly secured prior to the transfer process.

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 safe transferring techniques are used when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

Personal Support Workers who use lift and transfer equipment as part of their responsibilities were not retrained in the safe and correct use of the lift equipment.

Two personal support workers were involved in an incident in 2013 whereby an identified resident sustained an injury after falling from an improperly secured sling while being transferred with a mechanical floor lift.

Staff training records were reviewed which identified that both personal support workers received orientation upon hire around the use of lifts and slings but had not received any re-training since then. The Director of Care was not able to provide documentation that lifts and transfer training was provided to all personal support workers in the last 2 years.

Post incident, records revealed that re-training was provided to most personal support workers on May 10, 23, and 29, 2013 with additional sessions scheduled for June 2013.

Issued on this 24th day of June, 2013

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

B. Susnik