



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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jun 1, 2, 13, 2011; 2011_021111_0007; Critical Incident (Log #0-000630)

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

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

HILLSDALE TERRACES
600 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

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

LYNDA BROWN (111), Chantal Lafreniere (197)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), one Registered Practical Nurse (RPN), two Personal support Workers (PSW's).

During the course of the inspection, the inspector(s) Observation of the resident, and review of the residents health record.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions

WN - Written Notification
VPC - Voluntary Plan of Correction
DR - Director Referral
CO - Compliance Order
WAO - Work and Activity Order

Définitions

WN - Avis écrit
VPC - Plan de redressement volontaire
DR - Aiguillage au directeur
CO - Ordre de conformité
WAO - Ordres : travaux et activités



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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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

- 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.**
- 2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.**
- 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.**
- 4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)**
- 5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.**
- 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).**

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

- 1. The circumstances precipitating the application of the physical device.**
- 2. What alternatives were considered and why those alternatives were inappropriate.**
- 3. The person who made the order, what device was ordered, and any instructions relating to the order.**
- 4. Consent.**
- 5. The person who applied the device and the time of application.**
- 6. All assessment, reassessment and monitoring, including the resident's response.**
- 7. Every release of the device and all repositioning.**
- 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).**

Findings/Faits sayants :

- 1. An identified resident with a restraint was not assessed for alternatives prior to application of the restraint.**
- 2. An identified resident with a restraint did not have the restraint applied as ordered resulting in injury.**
- 3. An identified resident with a restraint was not monitored when the restraint was applied.**



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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 by ensuring all residents with restraints are applied as ordered and are monitored when in place, to be implemented voluntarily.

Issued on this 13th day of June, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
<i>J. Brown (#111)</i> <i>C. Lafreniere (#194)</i>