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
Mar 21, 2013	2013_189120_0018	H-000132-13	Other

Licensee/Titulaire de permis

UNGER NURSING HOMES LIMITED
312 Queenston Street, St. Catharines, ON, L2P-2X4

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

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST, BURLINGTON, ON, L7T-1E8

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 an Other inspection.

This inspection was conducted on the following date(s): March 7, 2013

During the course of the inspection, the inspector(s) spoke with administrator and registered staff regarding bed safety

During the course of the inspection, the inspector(s) toured all resident rooms to observe the various bed systems in the home, reviewed resident care plans and reviewed the home's bed safety audit report.

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

Findings of Non-Compliance were found during this inspection.

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

The licensee of a long-term care home has not ensured that where bed rails are used,

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment

During the inspection, 4 air mattresses were observed to be on 4 bed frames. According to registered staff of the home, the residents and their bed systems (air mattresses, rail use and bed frame) have not been evaluated to determine what zones of entrapment exist and whether the zones would pose a safety risk to the resident. Two out of the four residents require bed rails for safety according to their care plans. The other two residents did not have any information in their care plans regarding the type of mattress or whether bed rails are to be used. An air mattress located in one identified room was identified to be very loose on the bed frame and had a large gap (greater than 4 inches) between the mattress and foot board. The mattress could be pushed easily from side to side. It was not fastened to the decking of the bed with the straps provided. The 4 air mattresses are designed without any edge stabilizers and the edges therefore compress very easily when weight is applied. Residents sleeping close to the edge compress the mattress, increasing the space between the mattress and bed rail, where a body part such as an arm, leg or head can become lodged.

Post inspection, a bed entrapment audit in accordance with Health Canada's Guidelines titled "Adult Hospital Beds:Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" was conducted by an external company on March 8, 2013. All beds, except for those with an air mattress were tested and passed all 7 zones of entrapment. Beds with air mattresses are partially exempt from the guidelines due to the highly compressible nature of the mattresses and the technical difficulties with measuring certain dimensional gaps. In evaluating the safety of air mattresses, an evaluation needs to be conducted to ensure that the therapeutic benefit outweighs the risk of entrapment. Various alternatives are available for improving the safety of using air mattresses. In this case steps had not been taken or alternatives applied (such as not using rails, using bolsters, gap fillers, firmer mattress etc.) to reduce any potential risks prior to the inspection.

The administrator reported removing all air mattresses from circulation once the audit was completed. [s.15.(1)(b)]

Issued on this 21st day of March, 2013

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