Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2019	2019_539120_0025	032400-18, 003604-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Linhaven
403 Ontario Street St. Catharines ON L2N 1L5

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 12, 2019 (on-site), July 15, 16, 2019 (off site)

A follow up inspection related to bed safety was conducted concurrently with this critical incident inspection.
Critical incident log #032400-18 is related to resident injury involving the use of a transfer device.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Associate Director of Resident Care, Registered Practical Nurse/Resource Nurse, registered staff, Personal Support Workers and a family member.

During the course of the inspection, the inspector observed random resident bed systems, reviewed bed safety training materials and staff attendance records, resident bed rail assessments and sleep observation data, bed safety policies and procedures, tested two different types of transfer devices (one used during the incident), toured a resident home area, observed transfer equipment and associated devices in use, reviewed clinical records, manufacturer's instructions for care and use of transfer devices, home documentation related to staff lift and transfer training processes, available policies and procedures, transfer devices inventory and inspections, transfer devices purchase records and transfer equipment inspection records.

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

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	2018_539120_0043	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	Légende 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. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that all staff used transfer devices in accordance with manufacturers' instructions.

Various types of transfer devices for use with transfer equipment were being used by staff of the home. The devices were all purchased from one specific manufacturer. In February 2019, a transfer device was used to transfer resident #001, which included four attachment points. During the transfer process, the device failed and the resident fell out of the device and sustained an injury requiring admission to hospital. According to staff #102, who was present during the transfer, the device was checked for condition prior to use and no flaws were observed.

When the suspect device was checked during the inspection, one attachment point was noted to be different from the other three points. The device tag was completely worn and not legible. Therefore key instructions and device information was not available to the user such as serial number, weight capacity, size, date of manufacture and handling instructions. The management staff were not able to provide any documentation or confirmation as to when the device was put into service. Purchase records from the manufacturer were provided between 2014 and 2019, but the device was not listed. According to a representative from the manufacturer who was contacted in July 2019, the device type was last manufactured in 2009, and if the device was in use since that time, the attachment points could fail. It was estimated that the device used for resident #001 was well over six years and beyond it's operational life expectancy. In addition, the staff who were required to inspect the device before use, did not ensure that the tags or labels were legible.

The device used for resident #001 was assessed by a representative from the manufacturer three days post incident, and the device was deemed to have been expired and was replaced. Following the assessment, the representative was requested to teach

several staff members how to conduct a full device inspection. In April 2019, several trained staff members conducted an audit of all similar devices in the home and removed approximately 50 from service. Staff member #101 reported that the devices removed were deemed to have been "expired" according to the device manufacturer. The term "expired" was identified to include any device that had a worn tag or had any specific defects. No specific instructions were given to the staff members regarding how to check the condition of the device attachments. According to the licensee's policy entitled "Lift and Transfer - Back to C.A.R.E" (RKMOO-011), dated May 2016, direction for staff conducting device inspections before use did not include directions regarding worn labels or tags.

According to the manufacturer's device user guide, dated March 2005 (Page 14) and "Maxi Move - Instructions for Use", dated January 2014 (Page 6), if the device label is missing or cannot be read, the device should be withdrawn from use and the expected operational life for devices is approximately two years from date of purchase and depends on frequency of use, resident weight, and other factors. Both manuals also include the need to fully inspect the devices prior to each use. Other manuals from the same manufacturer for care and use of the devices include instructions for a monthly device inspection and documentation process.

The licensee failed to ensure that the device used on resident #001 was maintained or used in accordance with manufacturers' instructions. [s. 23.]

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 all staff use devices in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 9th day of August, 2019

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

Original report signed by the inspector.