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 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
Dec 4, 2018	2018_621547_0031	016679-18	Complaint

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Peter D. Clark Centre
9 Meridian Place OTTAWA ON K2G 6P8

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

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 2, 3, 5, and off site November 1-2, 2018.

This inspection was related to a complaint #IL-57905-OT made on a specified date, regarding concerns related to lifts and transfer techniques for mechanical lift used for residents in the home as well as the education provision to nursing staff that provide resident care.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Education Trainer, the Manager of Personal Care and the Acting Administrator.

In addition the inspector reviewed resident health care records, a policy and procedure for lifts and transfers, manufacturers instructions for lift equipment and daily lift inspection tools. The inspector observed the delivery of resident care and services and staff to resident as well as resident to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 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 :

1. The licensee has failed to ensure that PSW staff use safe transferring and positioning devices or techniques when assisting resident #001.

The inspector reviewed evidence related to resident care provision in the resident's room,

that was provided by resident #001's family. One item of this evidence provided by the family identified on a specified date and time when PSW #103 and PSW #117 were observed to apply a transfer sling to resident #001 while the resident was seated in a manual wheelchair. PSW #103 was in charge of operating the mechanical lift and elevated the resident above the wheelchair and inspector #547 noted the sling was not applied properly to the resident. Inspector #547 observed the base of the sling was in the resident's lower back area and the top of the sling was above the resident's head. Both PSW's were observed attempting to adjust the sling while the resident was suspended from the sling. Inspector #547 noted the resident was sliding downward while elevated in the mechanical lift above the floor. The PSW's were having difficulty manoeuvring the mechanical lift inside the resident's room to get the resident above the residents bed. It was noted that from the time the PSW's elevated the resident from the wheelchair until descended into the resident's bed took a minute and ten seconds whereby the resident's buttocks was dragging on the mattress by the time they got the resident over the bed as the resident was hanging out of the bottom of the sling.

On a specified date, inspector #547 interviewed a member of resident #001's family who indicated having reviewed the specified evidence and that PSW staff do not apply the resident's mechanical lift sling properly posing great risk for the resident of falling from the mechanical lift sling. The complainant indicated having reported this to the Manager of Personal Care after this incident occurred.

Inspector #547 interviewed PSW #103 regarding the lift and transfer concern for resident #001 from the evidence provided by the resident's family regarding the provision of care. PSW #103 was not aware of any concern involving resident #001 provision of care. PSW #103 indicated that transfers are always different, depending on the other PSW you are working with during a transfer. The regular PSW's do the transfers the way they prefer and PSW #103 will follow assuming they know best. PSW #103 does not recall any incident of a resident slipping out of a sling before, however that when a sling is not placed exactly the way it needs to be, they will stop moving and try to readjust the sling. PSW #103 indicated the resident has a specified action to the wheelchair to enable pulling the sling down and out from the resident so that the sling sits down low as required under at the resident's coccyx level. PSW #103 further indicated that depending again on the PSW you are working with, they may or may not use this specified action of the wheelchair to get the sling down low. PSW #103 does not recall an incident from a specified date whereby resident #001's sling was not placed low enough that the sling rode up the resident's back, but recalled that at times the resident's transfer is difficult from wheelchair to bed at night, but usually depends on the PSW you are working with

on how well it goes.

The Manager of Personal Care indicated to inspector #547 that the complainant provided them the same evidence related to resident care provision of a specified date and time when PSW #103 and PSW #117 put the resident to bed from the resident's wheelchair. The Manager of Personal Care indicated that both PSW staff did not apply the resident's sling properly under the resident's hips at the coccyx level as required for resident support and safety. The Manager of Personal Care further indicated that PSW staff were observed to also have issues with manoeuvring the lift inside the resident's bedroom and did not move the wheelchair out of the way, to quickly transfer the resident to bed. The Manager of Personal Care indicated that staff are to ensure proper application of resident slings for mechanical lifts and are required to ensure that the shortest distance possible from one surface to the other for resident safety.

As such, PSW staff did not use safe transferring and positioning devices or techniques when assisting resident #001 to bed on this specified date. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the retraining intervals for the purposes of subsection 76(4) of the Act are annual intervals.

In accordance with section 76 of the LTCHA, 2007 and section 218 and 219 of O.

Regulation 79/10, the licensee is to ensure that all staff at the home have received training on the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. Such training is to be provided prior to a staff member performing their responsibilities and annually thereafter.

Resident #001's plan of care identified the resident required a mechanical lift transfer from surface to surface that is to be completed by two nursing staff members.

On a specified date, a complaint was received to the Minister of Health and Long-Term Care regarding unsafe transfer and positioning techniques used for resident #001 posing significant safety risk for the resident performed on two specified dates. The complainant further identified concerns related to education that was provided to nursing staff regarding safe use of transfer equipment in the home.

On a specified date, the inspector reviewed evidence provided by resident #001's family related to resident care provision from inside resident #001's room of a specified date and time when PSW #105 operated the mechanical lift for the resident's transfer from wheelchair to bed. PSW #105 was observed to have difficulty manoeuvring the mechanical lift device inside the resident's room. PSW #105 indicated during this transfer to need more training, and repeated this several times.

The complainant showed inspector #547 another specified piece of evidence also related to similar care provision on another specified date and time from inside resident #001's room when two PSWs were preparing to transfer resident #001 from wheelchair to bed. PSW #103 was observed to operate the mechanical lift device raising resident #001 from the wheelchair with a sling. The base of the resident's sling was positioned in the resident's lower back above the pant line exposing the resident's lower back. It was also noted the sling was not supporting the resident's head and neck, as it was positioned too high above the resident's head. PSW #103 and PSW #117 continued with the transfer that took over one minute in time, with the sling sliding up resident #001's back. The complainant indicated the Manager of Personal Care was shown this same piece of evidence after the incident occurred.

The Manager of Personal Care indicated to inspector #547 to have reviewed the same piece of evidence provided by resident #001's family from these same specified dates of transfers with mechanical lifts in the home. The Manager of Personal Care indicated having developed a lifts and transfer education team in the home since reviewing this

evidence and had the equipment vendor come to the home at a specified time to provide an in-service to lifts and transfer team and education staff to review the sling application to residents prior to lift transfer. The Equipment vendor indicated at their training session to ensure the base of the sling to be at the coccyx level for the resident and the top of the sling at the top of the resident's head for safe transfers. The Manager of Personal Care indicated the feedback from the education and lifts and transfers teams after this training session, that all nursing staff will require updated education related to mechanical lifts and transfers.

On a specified date, the education trainer for staff in the home indicated to inspector #547 that nursing staff providing care to residents did not receive annual training on the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities at this time. The education trainer indicated having recently attended a training session provided by a vendor company related to sling application to resident's for mechanical lift transfers, and would be initiating training for all nursing staff in the next month.

PSW #105 indicated to inspector #547 having been in the home for several years, but could not recall when the education for use of two specified lifts was, but that it was received. PSW #105 indicated that each PSW does the mechanical lift transfers a little differently which makes transfers challenging. PSW #105 further indicated resident bedrooms are small, and also have carpeting that makes manoeuvring the mechanical lift device difficult and that PSW's could use more training.

The inspector reviewed another piece of specified evidence regarding a recent incident that occurred whereby resident #001 was stuck in the transfer sling raised over the resident's bed while being transferred to bed when the specified lift malfunctioned. The resident's family member indicated nursing staff did not know what to do to lower the resident safely into bed. Resident #001 was observed hanging by the sling above the resident's bed and the nursing staff being PSW #100, #101, and #102 and RPN #106 were unable to lower the resident from this specified lift. The nursing staff were looking for a release button on the lift stand. The resident remained in the sling for over 10 minutes hanging above the bed. PSW #101 and RPN #106 then figured out the crank at the top of the lift stand required to be manually wound to descend the resident safely to the bed.

RN #104 indicated to inspector #547 to have worked when the incident occurred with the malfunction with the specified lift for resident #001. RN #104 indicated the issue was the

nursing staff could not located the release button for the lift stand as there is one on another specified lift used in the home. The lift used during this incident is a newer lift in the home and they were not aware that there was a crank at the top of the lift stand to manually lower the resident in the event of mechanical malfunction. Once they located this crank, the resident was manually lowered to the bed. RN #104 indicated after this incident, they had a debriefing with the Manager of Personal Care for all those involved, when they realized nursing staff were not aware of this manual crank function of the lift device, and began training that evening with PSW #107 for all nursing units.

Inspector #547 interviewed PSW staff regarding this specififed lift and PSW #115 and #116 working with resident #001 indicated they were shown how to do the emergency release of the lift after the incident that occurred on a specified date by PSW #107 when the lift malfunctioned with resident #001. PSW #115 and #116 indicated they were not shown how to release the resident from the mechanical lift in case of emergency before that evening. They were familiar with another lift action, but this lift was new. PSW #115 and #116 indicated they received the training on the new lift a week earlier in the home, the home's computerized training module however did not recall information related to the emergency release crank.

PSW #103 indicated to inspector #547 during an interview that when the PSW's were taught originally how to use the specified lift, they were not shown how to release the key and crank the resident down in case of emergency. PSW #103 has recently been taught this procedure after an incident occurred with resident #001 when the nursing staff did not know how to descend the lift tower with the resident in a sling when the lift malfunctioned. Since this incident, PSW #103 was shown how to do this procedure however thought it should have been part of the original training, and it was not.

As such, retraining intervals for the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities, was not provided to nursing staff members annually that posed risk to resident #001 related to mechanical lifts and transfers. [s. 219. (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 retraining intervals for the safe and correct use of equipment, including mechanical lifts, assistive aids and positioning aids that are relevant to staff member's responsibilities shall be completed annually, to be implemented voluntarily.

Issued on this 11th day of February, 2019

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

Original report signed by the inspector.