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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 4, 2016	2016_189120_0047	021574-16	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Wenleigh Long Term Care Residence
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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 20, 2016

Critical Incident 2833-000019-16 related to improper use of lift and transferring equipment and accessories.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Resident Care and Associate Director of Care.

During the course of the inspection, the inspector toured two home areas on the 2nd floor and observed the availability and condition of mechanical floor lifts and slings, reviewed the written plan of care for 3 residents, the licensee`s investigative notes related to the incident, lift and transfer training and education records for staff using lifts and slings, reviewed lift and transfer policies and procedures and lift and sling inspection records.

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	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. 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #101 fell and sustained an injury after a personal support worker failed to use safe transferring practices while independently transferring the resident from their bed to their wheelchair in July 2016. The employee failed to ensure that all 8 straps on the sling were adequately attached to the hooks on the spreader bar of the mechanical floor lift. As a result, the resident tipped out of the sling on their left side and onto the floor, with the sling partially wrapped around the lower half of their body. The resident was subsequently sent to hospital and treated.

The employee who transferred the resident failed to follow both the sling and lift manufacturer's instructions and the licensee's policy titled "Mechanical Lifts and Resident Transfers" initially dated November 2014 and revised July 2016. The policy included the requirement for two staff members to be present when using a mechanical floor lift to either transfer or lift a resident. In addition the manufacturer's instructions required that all straps on the sling be attached to the floor lift spreader bar.

The employee was a long term employee, had transferred resident #101 and other residents using the same floor lift and sling that same morning and on other days and had received orientation and training on the use of lifts and slings in 2016. [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. 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 did not ensure that staff used all equipment and accessories in the home in accordance with manufacturers’ instructions.

The licensee's mechanical lift and resident transfer policy and procedures and training processes were reviewed after a resident (#101) was injured in July 2016 related to an employee not using safe transferring practices when using a mechanical floor lift.

1. The licensee's policy titled "Mechanical Lifts and Resident Transfers" initially dated November 2014 and revised July 2016 did not include how and when residents should be fitted for slings and by whom. The most current written plan of care for resident #101 and 2 other randomly selected residents did not include what size of sling was required. The sling that was supplied to the PSWs for use with resident #101 was a blue, medium sized mesh sling with 8 attachment straps manufactured by Waverly Glen (now called Prism Medical). No manufacturer`s manual was provided by the licensee for this particular sling for use instructions. The label on the sling identified it as a "universal" sling with a maximum weight load of 800 lbs. It was the only sling available with 8 straps of this size from Waverly Glen within the resident's home area. The ADOC confirmed that a small sling from this manufacturer was not available in the home and was not trialled with the resident prior to selecting the medium sized sling. The ADOC felt that the sling size was appropriate for the resident. According to Prism Medical, the appropriate size of the sling must be based on the residents height and weight and not on the maximum load of the sling, which was 800 lbs. Based on the sling size chart from Prism Medical and the resident’s height and weight, the resident could have been a small or a medium and the final selection would have been based on various factors. The other slings observed in use within resident's home area were labeled either "T.H.E. Medical" or "Tollos". These slings were quite different and were labeled as "combi" or "hygiene" slings and had either 4 or 6 straps. The manufacturer`s instructions for the use of these slings was unfortunately limited and did not include how to ensure the size of the sling would be appropriate for the resident and did not identify how the various straps should be hooked up to the 6 point spreader bar or what the various coloured loops were for. The licensee however should have requested more detailed information from the manufacturer upon purchase of the slings and developed written use instructions for their staff prior to use.

2. A random review of slings was conducted, two of which did not have a label were observed in rooms on the second floor. The label had either disintegrated or was pulled

off. According to Prism Medical, when the label is no longer legible or is missing, the sling should be removed from use. The licensee`s policy did not address this concern with the exception that if the size was not clearly visible, then the sling should be removed from service.

3. The licensee's monthly sling audit form did not include a serial number or unique identifier for each sling inspected. The audit did not include ensuring that the sling was adequately labeled, especially with the date that it was put into service and the identifying number (serial # or other). A sling observed in one identified bedroom on the second floor was marked with a different room number using a black marker and the original label was missing. A sling observed in another room on the second floor was labeled "credit valley" and the original label was missing. According to Prism Medical who was provided with the serial number listed on the universal sling used with resident #101, it was manufactured in 2007 and if used shortly after manufacture and on a daily basis, the sling should have been taken out of service by 2010-2011.

4. The licensee did not ensure that staff were provided with the appropriate sling for the appropriate mechanical floor lift. The mechanical floor lift used with the Waverly Glen universal sling was identified with a label bearing the marks "T.H.E Medical" and "Ultralift". The manufacturer's instructions provided by the licensee for the mechanical floor lift specified that "Attaching improper items to the lift can cause injury. Use only T.H.E. Medical approved items on the lift". The instructions under Section 9 of the T.H.E Medical floor lift manual titled "Accessories and related products" did not depict the use of any sling with 8 straps. The spreader bar was equipped with a separate row of hooks (3) hanging off each end of the spreader bar. The row of hooks moved independently from the spreader bar. The hooks were spaced out several inches from each other. The Waverly Glen universal sling is used on a different style of spreader bar, called a carry bar and has only one fixed hook on each end. Each side of the sling, with 4 straps each, would all be required to be attached to one hook on each side of the carry bar. The end result is that the resident is secured more tightly within the sling. [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 staff use all equipment and supplies in the home in accordance with manufacturer`s instructions, to be implemented voluntarily.

Issued on this 4th day of August, 2016

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

Original report signed by the inspector.