Sleeping Inn Care Home Incident Scenario

All names and details, while representative of some real work situations, have been fabricated for the purposes of this training session.

Sleeping Inn Care Home is an 85 bed level 3 and 4 care facility. The single story (plus basement) building was constructed in 1969. There is also a small 6 bed locked down unit. All residents have a private room and their own washroom. Bath facilities are located on each of the 4 wings. A central dining room is used by all the general population of residents. This room is also used as a space for crafts, activities and entertainment. Residents are able to enjoy the outdoor gardens, gazebo and seating areas. Financial constraints have allowed for the purchase of some new equipment but only essential work has been done to the structure of the building.

On any given day there is 3 care staff absent mostly due to illness, vacation or WCB claims. In addition there is a higher than expected rate of staff turnover. Many workers move between health care facilities in the area. Recruitment and hiring efforts are ongoing. Orientation is held the 2nd full week of each month. It consists of 1 day general orientation, followed by 1 day of TLR. New workers then are sent to their respective work units for specific orientation. Current workers are randomly assigned as mentors for new staff. Many staff don't like to be mentors as they feel it slows them down and the new staff often ask too many questions.

Sleeping Inn Care Home's injury frequency rate (# of workers /100 who are injured) is above that of the industry in general. Most injured workers are those who are directly involved in resident care and have shoulder, back and hand injuries resulting from "bodily reactions and exertion" or "contact with objects and equipment", according to the WCB statistics.

The Incident

On a Friday day shift, two Sleeping Inn Care Home workers, Melissa and Sara, were assigned care for 86 year old Mary P as well as several other residents. Breakfast was at 8:00 am and all residents needed to be in the dining room by then. At 7:40 in the morning they were about to move Mary from her bed to the wheelchair. The task required 2 staff members and a total lift which was available in the home.

Melissa had 22 years of experience; Sara only started one week ago and had just completed her 30 week Continuing Care Assistant training program at the local community college. Sara remembered her TLR training and asked Melissa if this was the proper sling to use. Melissa impatiently replied that the correct sling was not available, so they always just used whatever sling they had. In this case it was a hygiene sling. Melissa never seemed pleased to answer questions, usually saying that "it's the way we do it here" or "I always do it this way". They were in such a hurry to get their work done that Sara hadn't had time to do her assessments before starting the lift. She didn't dare mention this to Melissa. As they began getting Mary out of bed Sara was wondering if she should just stop asking questions. While raising Mary the boom on the lift gave a sudden jerk when the sling was just a few inches off the bed. Mary slipped through the bottom of the sling. Sara attempted to catch her. Fortunately Mary landed on the bed and was not injured.

While lunging for the resident Sara felt a sharp and painful twinge in her back. During this event, the scatter mat slid along the floor causing Sara to lose her balance and slip right out of the sandals she was wearing. Sara fell to the floor, striking her head on the corner of Mary's dresser on the way down.

The Resident Care Coordinator (RCC) was immediately summoned to the room. Sara was complaining of being dizzy. She had a nasty goose egg forming on her head where it had connected with the dresser and the shooting pain in her back made it difficult to get up off the floor. The RCC thought it best to send her to the local emergency room. Mary was safely transported (a little bit late) to the dining room for breakfast.

This was the first time that the RCC had needed to do an incident investigation since the announcement of the new investigation requirements at the management meeting last month. She knew that the OHC co-chair had taken OHC Level II training. She was pretty sure that was about investigations so she asked him if he had some time the following week to help her with the investigation and show her what she was supposed to do. He agreed to help but reminded her that it should be started immediately and not left until after the weekend.

SASWH Facilitator's notes:

** PARTICIPANTS MAY SUBSTITUTE/SUPPLEMENT WITH FACILITY SPECIFIC INFORMATION FROM THEIR OWN FACILITY AS THIS IS ABOUT LEARNING HOW TO EFFECTIVELY USE THE PROCESS, DETERMINE CAUSES AND MAKE APPROPRIATE RECOMMENDATIONS **

This is some additional information that participants should be encouraged to think about on their own, wonder about, ask questions and pay attention to in their investigation. Findings should be based on the facts of this scenario. Where facts are not given participants should use the policies, processes, procedures, rule and practices in place in their work area as well as their general knowledge of the topic and their experience and training.

Some things to note:

- There was no posted checklist for the maintenance of the lift.
- Melissa, the more experienced worker, was using common practice instead of best practice. She did not check the sling or the lift prior to use; she did not communicate and ensure that each sling strap was attached to the lift in equal proportion. Determining how the sling was used should be part of the interview process.
- Melissa said she had never received training.
- Sara was wearing sandals as she didn't yet have the time to buy appropriate work shoes.
- The employer's training records indicated Melissa had received training but had not attended refresher sessions for over 10 years.
- The RCC (supervisor) did not make a practice of watching staff members performing routine tasks. *I have used to term "watch" to indicate that the RCC does not really understand the observation/mentoring/correcting role of the supervisor and simply looks upon that task as watching.*

Physical and Documentary Evidence	**Information Provided**
Wrong sling was identified for the task being performed.	Review of the manufacturer's lift equipment manual indicated certain slings were available for various tasks that would be performed.
Room was cluttered. Scatter mat was at bedside.	Pictures of the scene indicated that the room was full of personal items and a loose mat was on the floor by the bed.
Workers were rushing so they could get their work done on time.	Schedule showed the workers had several residents that day.
Worker was wearing inappropriate footwear.	The worker was observed wearing sandals. Worker was aware of policy on footwear as she had initialed the employment orientation form indicating this was reviewed with her.
Injured worker, Sara, was appropriately trained.	Employer training records indicated this worker had attended TLR the previous week
Melissa, the experienced worker, was previously trained.	Employer training records indicated this worker was initially trained 15 years ago and received a refresher 10 years ago.
Sleeping Inn Care Home had recently purchased some new lifts. This was one of those lifts.	Employer records indicated that Melissa was not trained on the proper use of this current equipment used in this home.
Workers were inadequately supervised during high-risk activities.	The supervisor admitted to not supervising routine tasks.

Document Review
Allow participants the time to determine what documents they will be reviewing and what they hope to find by looking at those documents. Then give them the following in formation

Review of the Safety Management System (SMS) documents revealed:

- Some training records were present, but training was not always current.
- A documented training plan could not be found.
- Policies and procedures are in place, but no documentation was found to show that they were being enforced.
- The TLR policy included the requirement to use the correct sling for the task being done.
- No process was found for creating a safe work environment (e.g., removing a scatter rug prior to completing the task).
- Much of The Sleeping Inn Care Home SMS was given to them by a neighbouring facility who assured them that is follows best practice and meets legislative requirements.
- Except for a few policies used in orientation there were no records to show that the SMS contents were being reviewed with the staff.
- After searching a TLR Resource manual was found in the back of a cupboard
- No current copies of the Saskatchewan Occupational and Safety Act and Regulations were found on the wing.
- The preventative maintenance program has not been fully implemented and not many records were available.

Interview Results
Allow participants the time to determine who they will interview, in what order and what questions they will ask. Then pass out and discuss as appropriate the page of interview results, as below.

What did you learn from Sara (injured worker)?

- She thought her orientation was going well but there was a lot to remember.
- She had been trained in TLR.
- She did not have time to buy appropriate footwear.
- She had reviewed policies and procedures for the job during her orientation.
- She was rushing to get all her residents to the dining room on time.
- When the client started to slip out of the sling, Sara reacted immediately by reaching forward in an attempt to catch the client. The scatter mat that Sara was standing on slid away from the bedside, causing Sara to lose her balance, her footing and sandals.
- She felt a sharp twinge in her back.
- She realized there was no way to stop her fall, when suddenly her head hit the dresser that was behind her.

What did you learn from Melissa (experienced worker)?

- She was rushing to get all her residents to the dining room on time.
- She indicated she had received TLR training.
- The sling in the resident's room was the only sling she ever used (except when she couldn't find it).
- The rug beside the bed was one that the resident had made herself and always had been beside her bed in her own home. The resident and the family requested that it be in the same place in her room at the care home.

What was the supervisor's position?

- She had received her work assignment and was responsible to determine the order of tasks as well as the tasks that required supervision. This was normal practice.
- She was aware that Sara would not have appropriate footwear for the first few days. She wasn't aware that she had the authority to direct Sara to get appropriate footwear immediately or to reassign Sara to a safer task.
- She was an experienced nurse but had never received any special supervisors training.
- She had never seen the job description for a supervisor.
- Her understanding of her role and responsibilities, including authority, were unclear.
- She was trained in TLR about 4 years ago.

What did you learn from the client?

- She indicated she felt herself slipping.
- She reached out to hang onto something but nothing was available.
- Next thing she knew she was on the bed.