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

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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347 Preston St Suite 420
OTTAWA ON K1S 3J4
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2018	2018_621547_0021	011088-18	Critical Incident System

Licensee/Titulaire de permis

The Perley and Rideau Veterans' Health Centre
1750 Russell Road OTTAWA ON K1G 5Z6

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

The Perley and Rideau Veterans' Health Centre
1750 Russell Road OTTAWA ON K1G 5Z6

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 31, 2018

Critical incident log #011088-18 regarding a resident who fell from a lift sling that resulted in injury.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers(PSWs), a PSW with the education team, a PSW supervisor, an Administrative Assistant, a Manager of Resident Care and the Administrator.

In addition, over the course of the inspection, the inspector reviewed residents' health care records, staff work routines, observed resident rooms, resident common areas, lift and transfer equipment, documents related to the home's investigations into this critical incident and the manufacturers instructions related to the a specified sling. The inspector observed the delivery of resident care and services and staff to resident interactions during lifts and transfers using a specified sling and manual lift.

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

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 has failed to ensure that staff used sling equipment and positioning aids in accordance with manufacturers' instructions.

Resident #001's plan of care identified that the resident required a specified lift for all

transfers. On a specified date, resident #001 fell from a sling utilized for a lift transfer while being transferred from a specified type of wheelchair to a bed. There were two PSW staff members present at the time of the lift transfer.

PSW #100 indicated to Inspector #547 that they positioned the specified sling to the carry bar hooks of the lift as per their usual practice. PSW #100 indicated that the loops on the sling straps must have moved when the resident was elevated and suspended in the sling when the loop fell off the carry bar hook. PSW #100 bent down to grab the resident's feet and lower legs once the resident was suspended in the sling to help position the resident towards the resident's bed. PSW #101 manoeuvred the resident up to the highest level above the resident's wheelchair when PSW #101 noticed a movement of the front left sling loop and asked PSW #101 to stop the transfer. PSW #100 and #101 indicated the resident began to move at this point and PSW #101 indicated that the resident rolled out of the sling falling to the floor between the wheelchair and the resident's bed. Resident #001 sustained a specified wound that required a specified medical intervention.

PSW #101 indicated to Inspector #547 that it all happened so quickly, that the specified straps of the sling fell off the carry bar hook and the resident slipped to the floor. PSW #101 indicated that both PSW's thought the loop straps were in place in the lift carry bar hooks before raising the resident, however the loop straps were not verified again once the resident was elevated from the wheelchair and suspended by the sling as per the home's procedures.

Inspector #547 observed the specified sling and lift used during this transfer and noted the spreader bar hooks had a spring loaded metal safety clasp that closed after the sling loops were placed into the spreader bar hooks and could not be removed without pushing this spring loaded clasp out of the way to lift the loop in an outward motion to be released from the hook.

Inspector #547 interviewed PSW Supervisor #103 who indicated that the day following this incident, the sling and lift used during this incident were tested and indicated that if the sling loops were verified as required to be situated inside the spreader hooks and clasp, that they could not have migrated off the spreader as the resident's weight would have kept the loops engaged inside the hooks. The PSW supervisor indicated that PSW's are educated to double check that sling loops are properly fastened inside the spreader bar hooks, and that this was not completed as required.

The manufacturers' instructions were provided to Inspector #547 by the Manager of Resident Care #104 that indicated the specified sling used throughout the home was not a new piece of equipment. This Manager of Resident Care further indicated that the nursing staff, including PSW #100 and #101 were provided training annually as per the Licensee's education documentation. The specified sling identified in the instructions that when transferring a resident from a seated position, to ensure the loops of the sling are securely fastened to the spreader bar and fully inside the safety latches. The instructions further indicated when lifting the resident to a level to not quite clear the wheelchair, to verify the loops and sling positioning are securely fastened to the spreader bar.

PSW #100 and #101 did not follow the manufacturers' instructions identified in the specified sling instructions to verify the straps of the sling once the carry bar of the lift is raised just enough to provide tension by the resident's weight. This verification of the straps is required to prevent this incident whereby the mid and lower loop straps migrated off the carry bar and resident #001 fell from the suspended sling to the floor and resident #001 was injured and was required to be sent to hospital. [s. 23.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 7th day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2018_621547_0021
Log No. / No de registre :	011088-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 29, 2018
Licensee / Titulaire de permis :	The Perley and Rideau Veterans' Health Centre 1750 Russell Road, OTTAWA, ON, K1G-5Z6
LTC Home / Foyer de SLD :	The Perley and Rideau Veterans' Health Centre 1750 Russell Road, OTTAWA, ON, K1G-5Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Akos Hoffer

To The Perley and Rideau Veterans' Health Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s. 23.

Specifically, the Licensee shall:

1. Re-instruct PSW #100 and PSW #101 regarding the proper use of the specified sling when transferring residents for mechanical lift transfers in accordance with the manufacturers' instructions, and

2. Ensure that nursing supervisors that are responsible to supervise PSW's visually conduct a minimum of three random return demonstrations weekly in each building of the home to monitor the adherence of the established mechanical lift and transfer procedures by PSW's, and

3. Take immediate corrective actions if the observed practices were not in accordance of the manufacturers' instructions, and

4. Maintain documented records to support each step taken to achieve compliance with this order

Grounds / Motifs :

1. The licensee has failed to ensure that staff used sling equipment and positioning aids in accordance with manufacturers' instructions.

Resident #001's plan of care identified that the resident required a specified lift for all transfers. On a specified date, resident #001 fell from a sling utilized for a lift transfer while being transferred from a specified type of wheelchair to a bed. There were two PSW staff members present at the time of the lift transfer.

PSW #100 indicated to Inspector #547 that they positioned the specified sling to the carry bar hooks of the lift as per their usual practice. PSW #100 indicated that the loops on the sling straps must have moved when the resident was elevated and suspended in the sling when the loop fell off the carry bar hook. PSW #100 bent down to grab the resident's feet and lower legs once the resident was suspended in the sling to help position the resident towards the resident's bed. PSW #101 manoeuvred the resident up to the highest level above the resident's wheelchair when PSW #101 noticed a movement of the front left sling loop and asked PSW #101 to stop the transfer. PSW #100 and #101 indicated the resident began to move at this point and PSW #101 indicated that the resident rolled out of the sling falling to the floor between the wheelchair and the resident's bed. Resident #001 sustained a specified wound that required a specified medical intervention.

PSW #101 indicated to Inspector #547 that it all happened so quickly, that the specified straps of the sling fell off the carry bar hook and the resident slipped to the floor. PSW #101 indicated that both PSW's thought the loop straps were in place in the lift carry bar hooks before raising the resident, however the loop straps were not verified again once the resident was elevated from the wheelchair and suspended by the sling as per the home's procedures.

Inspector #547 observed the specified sling and lift used during this transfer and noted the spreader bar hooks had a spring loaded metal safety clasp that closed after the sling loops were placed into the spreader bar hooks and could not be removed without pushing this spring loaded clasp out of the way to lift the loop in an outward motion to be released from the hook.

Inspector #547 interviewed PSW Supervisor #103 who indicated that the day following this incident, the sling and lift used during this incident were tested and indicated that if the sling loops were verified as required to be situated inside the spreader hooks and clasp, that they could not have migrated off the spreader as the resident's weight would have kept the loops engaged inside the hooks. The PSW supervisor indicated that PSW's are educated to double check that sling loops are properly fastened inside the spreader bar hooks, and that this was not completed as required.

The manufacturers' instructions were provided to Inspector #547 by the Manager of Resident Care #104 that indicated the specified sling used

throughout the home was not a new piece of equipment. This Manager of Resident Care further indicated that the nursing staff, including PSW #100 and #101 were provided training annually as per the Licensee's education documentation. The specified sling identified in the instructions that when transferring a resident from a seated position, to ensure the loops of the sling are securely fastened to the spreader bar and fully inside the safety latches. The instructions further indicated when lifting the resident to a level to not quite clear the wheelchair, to verify the loops and sling positioning are securely fastened to the spreader bar.

PSW #100 and #101 did not follow the manufacturers' instructions identified in the specified sling instructions to verify the straps of the sling once the carry bar of the lift is raised just enough to provide tension by the resident's weight. This verification of the straps is required to prevent this incident whereby the mid and lower loop straps migrated off the carry bar and resident #001 fell from the suspended sling to the floor and resident #001 was injured and was required to be sent to hospital. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

Service Area Office /
Bureau régional de services : Ottawa Service Area Office