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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 14, 2014	2014_304133_0005	O-000811-13	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

JESSICA LAPENSEE (133)

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): February 25-28, 2014

During the course of the inspection, the inspector(s) spoke with the Chief of Resident Care, the Director of Nursing Practice, a Director of Resident Care, a Manager of Resident Care, the Assistant Manager of Support Services, the Plant Services Supervisor, the Special Approach Worker, a Rehabilitation Assistant, unit clerks and registered and non registered nursing staff members.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report (CIR), reviewed the health care record of two residents, reviewed the functioning of locked and alarmed stairway doors, viewed video camera footage related to the CIR, reviewed "Monthly Unit Inspection" checklists in use at the time of the CIR and at the time of the inspection, reviewed documentation related to the discipline of a staff member in relation to the CIR, reviewed minutes from the home's Emergency Measures Committee meetings

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

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, c.8, s.5, in that the licensee failed to ensure that the home was a safe and secure environment for resident #001.

On a day in August, 2013, resident #001 eloped from a secured unit. As reported to the Ministry of Health and Long Term Care, in a Critical Incident Report (CIR), the resident went out an identified stairway door. This door is locked, and in order to open it, one must enter an access code into a keypad on the wall to the right of the door. An alarm sounds when the door opens, which is cancelled by entering the access code into the keypad again, or by pressing a button on the other side of the door, within the stairwell. As per the CIR, once in the identified stairway vestibule, Resident #001 was able to exit through the exterior fire door. While the exterior fire door is locked, if the handle on the door is held for 15 seconds, the door unlocks. There is signage on the door to this effect, as required by fire safety requirements. As per the CIR, resident #001 was found walking along a busy road, about 20 minutes after their elopement, by staff on their way in to work, who were able to convince the resident to get into their car and return to the home. The resident was returned to the home unharmed, approximately 35 minutes after eloping.

As was seen on video footage from the unit hallway, viewed by the inspector on February 26, 2014, three minutes after Resident #001's elopement, nursing staff member #S101 returned to the care unit after a break, and heard the stairway alarm sounding. Staff member # S101 explained to the inspector that when they understood the source of the alarm to be the stairway door, and not a call for assistance from a resident, they opened the stairway door by using the access code and noted the exterior fire door was also alarming and a red light was flashing on the handle. Staff member #S101 told the inspector that they assumed the alarm had been caused by a staff member who had gone up the stairs and had forgotten to disengage the alarm from within the stairwell, as if often the case. Staff member #S101 explained to the inspector that they did not look outside of the exterior fire door, and did not know how to turn the alarm off. Seven minutes after Resident #001's elopement, a maintenance worker was present in the area, looked around the outside of the fire door, did not see the resident, and reset the door alarm.

Staff member #S101 was disciplined following the event described above, with a focus on their failure to report the exterior fire door alarm to their supervisor, to allow for immediate follow up.

As per resident #001's health care record, they require a secured unit due to the effects of dementia. Resident #001's care plan identifies "exit seeking" as an area of focus. The inspector reviewed various notes within resident's health care record, and spoke with the "Special Approach" worker, # S102, and a Personal Support Worker (PSW), #S103, both of whom indicated that knew resident #001 very well, in order to get a better understanding of the resident's identified behaviour of exit seeking. It was explained to the inspector that it is normal for resident #001 to walk around the care unit, pushing on all of all the doors to make sure they are secured, as this was something they would have done while working at their previous place of employment.

As well, it is normal for resident #001 to be pushing on the doors in an attempt to exit, as in those instances the resident believes it is time for them to go home from their day of work. Staff # S102 and #S103 agreed that resident #001 no longer has the capacity to know or remember an access code for the stairway door, nor would they know what the keypad on the wall to the right of the door was for. The home's investigating manager, Director of Resident Care (DRC) #S104, verbally reported to Long Term Care Home Inspector #117, on August 26, 2013, that following the elopement, they verified and assessed that resident #001 did not know the code to exterior doors. This was confirmed to the inspector, by DRC #S104, during the inspection. As per video footage of the identified hallway area, on the day of resident #001's elopement, it was noted that there was another resident, #002, in the area of the stairway door at the time of the elopement. The video camera does not capture the stairway door, it only captures the area directly leading to the stairway. The inspector spoke with staff member #S102 about resident #002, including review and discussion of resident #002's health care record. Resident #002 is identified as having severe cognitive impairment due to dementia, and is not an exit seeker. In addition to staff member #S102, the inspector spoke with two other nursing staff members, #S103 and #S105, all of whom indicated they knew resident #002 very well, about the possibility of resident #002 knowing the access code for a door. It was agreed by all that this resident could not remember an access code.

DRC #S104 informed the inspector that on the day of Resident #001's elopement, a possible malfunction with the identified stairway door locking mechanism was identified by staff member #S106. Staff member #S106 explained to the inspector that they always ensure that a secured door locks behind them when they have gone through it, and provided the following details. On August 21st, 2014, as per their normal routine, staff member #S106 went down the stairs, from 2nd to 1st floor, a few minutes after 10am. After they passed through the identified stairway door, into the unit hallway, they noted that the door had not locked once it closed on its own, as it normally does. Staff member #S106 explained they opened and closed the door again, but for a second time the door did not lock automatically once it was closed, as it normally does. It was only after pulling the door very hard that staff member #S106 heard the locking mechanism "click" in to place, as they normally hear it do after the door closes on its own.

This information outlined above was not provided to supervisory staff on the care unit and/or to the maintenance department to allow for immediate follow up. It is most likely, given resident #001's health condition, and this report of a lock malfunction, that resident #001 was able to exit the identified stairway door because it was not properly locked at the time.

DRC #S104 confirmed to the inspector that there had not been a procedure in place to audit the functioning of door locks and alarms on secured stairway and exit doors at the time of Resident #001's elopement. Following the elopement, DRC #S104 explained that registered nursing staff were assigned the monthly responsibility to check that all unit coded doors, as a component of the "Monthly Unit Inspection". With regards to locked doors, the Monthly Unit Inspection form in use at the time of the elopement required staff to check "doors locked (soiled, conference, dictation, med rms)". Following the elopement, a new category was added, "coded doors: locked and keypad functioning". Beginning in the month of February, 2014, unit clerks were given the responsibility to oversee the completion of these "Monthly Unit Inspections". In discussion with 3 unit clerks, #S107, #S108 and #S109, on February 27, 2014, the inspector confirmed that when given this responsibility, there was no clarification provided to the effect of what checking a door is to entail. Staff member #S107 explained that to them, it meant verifying that the keypad is functional and the alarm sounds as expected. Staff member #S108 explained that to them, it meant verifying that the door is in fact locked by pushing on it, then verifying that the keypad is functional and the alarm sounds as expected. In addition, staff member #S108 indicated they would not check the stairway door at the end of the hallway, beyond the nurse station, as they did not believe it was a part of the care unit, and they assumed that maintenance staff checked it. Staff member #S109 explained that to them, checking a door meant verifying that the door is locked, by pushing on it, and does not involve testing the keypad or alarm. At the onset of the inspection, DRC #S104 informed the inspector that in addition to the "Monthly Unit Inspection" process, maintenance staff were checking all secured doors once a month as well. In follow up conversation with the Supervisor of Plant Services, it was ascertained that this was not the case. It was clarified that maintenance staff do monthly preventative maintenance checks on outer fire doors, but there is no schedules and procedures in place for preventive maintenance with regards to locked and alarmed stairway and exit doors in the building. O. Reg. 79/10, s. 90 (1) b. requires the licensee to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance. It should be noted that this does not require that it be maintenance staff who follow the established schedules and procedures.

On February 28, 2014, following discussion with the inspector about discussions had with staff member #S107-#S109, as described above, DRC #S104 held a meeting with all unit clerks, in order to clarify the process that should be followed when checking coded doors, and to clarify which doors are to be included in this process.

Following the elopement, in August, 2013, the home's Emergency Measures Committee (EMC) met and discussed, in part, the conditions surrounding resident #001's elopement. The meeting minutes highlight, in part, the need to consider a new procedure for when the external fire doors alarm. DRC #S104 advised the inspector that a new procedure, whereby the home's perimeter is searched by unit staff when an external fire door alarm sounds, was introduced to Registered nursing staff and to the Commissionaires, sometime in late September or early October 2013.

Failure of a staff member to appropriately report a malfunction in the identified stairway door locking mechanism, failure of a staff member to immediately report a fire door alarm to unit supervisory staff, lack of a procedure for routinely inspecting secured stairway doors, and lack of an effective process to respond to fire door alarms in the event of a possible resident elopement, are all contributing factors to the elopement of resident #001 on August 21, 2013.

The licensee failed to ensure that the home was a safe and secure environment for resident #001. The licensee has a history of non-compliance with the LTCHA, 2007, c.8, s.5. On February 21st, 2014, the licensee was issued a Compliance Order (CO) pursuant to this section, as a result of Follow-Up inspection #2014_304133_0004, related to risk to residents due to non-compliance with door security requirements, as is prescribed by O. Reg. 79/10, s,9 (1) 1. The CO was complied by inspector #133 on March 3, 2014, as the licensee had implemented safety measures, as was directed by the CO, by February 25th 2014, to mitigate the risk to residents, until such time that the door security requirements can be fully addressed. [s. 5.]

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 with the requirement that the home is a safe and secure environment for its residents, specifically with regards to immediate actions to be taken when staff hear a fire door alarm and the overall follow up that is to occur as a result, immediate reporting of possible door security malfunctions, and routine monitoring of secured doors to ensure they are locked and alarmed as expected, for the safety of the residents,, to be implemented voluntarily.

Issued on this 14th day of March, 2014

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