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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 19, 2016	2016_195166_0028	013490-16	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

HIGHLAND WOOD
7199 Gelert Road P.O. Box 115 HALIBURTON ON K0M 1S0

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

CAROLINE TOMPKINS (166), LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 3, 4, 5, 6, 7, 2016

Complaint log # 028782-16, related to resident care was inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, Residents' Council, Family Council, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Resident Assessment Instrument (RAI)Coordinator, Director of Care/Administrator(DOC/ADM) and Activation Aide.
During the course of this inspection, the inspectors observed staff to resident interactions, resident to resident interactions, toured residents' rooms and common areas, observed infection control practices, medication administration, reviewed clinical records and the licensee's policies VII-F-10.08, Restraint Implementation and VII-G-10.34, Bed Rail and Pad Use.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the use of a physical device was applied in accordance with the manufacturer's instructions(if any).

During this inspection, resident # 002, #004, #010 were observed at various times . Observations indicated the use of 2 quarter rails in the up position placed in the middle of the bed frame. There was also the use of a full length bed pad in place on the right side (the side the resident would exit the bed). The bed pad on each end of the bed rail had no barrier to prevent the resident from falling.

Review of the plan of care for all three residents and interview of staff indicated the bed rails and bed pads were used as a restraint for safety and to prevent falls.

Review of the home's policy "Bed Rail and Pad Use" (VII-G-10.34) revised November 2015 indicated:

-bed rails will not be used for restrain of a resident
-assess the resident's need for the use of bed rail and bed rail pads. Indications for use may be to protect a restless resident from injury while in bed or to facilitate proper body alignment preventing a resident from placing limbs through or between bed rails.

Interview of the Administrator/DOC indicated no manufacturer's instructions were available to provide direction whether the full length bed pads were to be used for quarter rails placed in the middle of the bed frame. The Administrator/DOC also indicated no assessments were completed related to the use of the quarter bed rails that were placed in the middle of the bed frames and use of full length bed pads. [s. 110. (1) 1.]

2. The licensee failed to ensure the following requirements were met where a resident is being restrained by a physical device under section 31 of the Act.
That staff applied the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Observation of resident # 002 at various times indicated the use of 2 quarter bed rails (in the up position placed in the middle of the bed frame) with the use of a full length bed pad in place on the right side (the side the resident would exit the bed).

Interview of the RAI-Coordinator indicated the quarter bed rails used in combination with the bed rail pad was used as a restraint to prevent residents from falling out of bed.

Interview with PSW#103, RPN #105 & #106 (on the same dates) indicated the use of quarter bed rails with a full bed pad daily whenever resident #002 was put into bed.

Review of the physician's order for resident #002 indicated the use of bed rails with a bed pad but only as needed (PRN). (111) [s. 110. (2) 2.]

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and without limiting the generality of this requirement, the licensee shall ensure that the following are documented: what alternatives were considered, why those alternatives were inappropriate and all assessments, reassessments and monitoring, including the resident’s response.

Resident #002, who is not mobile, was observed seated in a positional chair, with fall prevention devices in place. Observation of the resident's room indicated two quarter rails, when in the up position were placed in the middle of the bed frame and the use of a

full length bed pad on right side (where resident would exit) were also in place when the resident was in bed. A high-low bed and mat were also in place.

Resident #010 , who is cognitively impaired, was also observed seated in a positional chair, with fall prevention devices in place. Observation of the resident's room indicated two quarter rails, when in the up position were placed in the middle of the bed frame and the use of a full length bed pad on right side (where resident would exit) were in place when the resident was in bed. A high-low bed and mat were also in place.

Interview with PSW#103, RPN #105 & #106 indicated both residents use a positional chair and falls prevention devices during the day. The PSW and RPNs also confirmed the use of the quarter side rails with a full bed pad, were put in place whenever the residents were put into bed.
The RPNs indicated all the restraints were put in place after both of the residents had sustained a fall and had been deemed high risk for falls.

Interview of the RAI Coordinator indicated resident #010 has fall prevention devices in place, at the request of resident #010's Power of Attorney.
The RAI Coordinator also indicated the bed rails used in combination with the rail pad were used as a restraint to prevent the resident from falling out of bed.

Review of health care records for resident #002, indicated on a specific date, the resident fell, sustained an injury and was deemed a high risk for falls. The positional chair and the falls prevention devices were put into place at the time of the fall. The use bed rails and bed pad were put in place on a later date .The resident has not incurred any further falls.

Review of the health care record for resident #010 indicated on a specific date, the resident sustained a fall with an injury and was deemed a high risk for falls. The positional chair and the falls prevention devices were put in place at the time of fall. The use bed rails and bed pad were put in place on a later date. The resident has not incurred any further falls.

Interview of the Administrator/DOC indicated the registered nursing staff are to document the alternatives tried in the progress notes and reassessments are to be documented under the restraint assessments. The Admin/DOC was unable to recall when the full length bed pads were put in place.
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There is no documented evidence of alternatives considered prior to the application of

the restraints or a reassessment of residents #002 and resident #010 related to the use of the restraints.(111) [s. 110. (7) 6.]

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 when bed rail pads and bed rails are used as a method of fall intervention, the equipment is applied as per manufacturers' instructions. Bed assessments are completed related to the use of the quarter bed rails that are placed in the middle of the bed frames and use of full length bed pads.
All resident assessments, reassessments and monitoring, including residents' responses related to the use of the restraints are completed and that staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class, to be implemented voluntarily.

Issued on this 19th day of October, 2016

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

Original report signed by the inspector.