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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2017	2017_539120_0005	020559-16	Follow up

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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 Follow up inspection.

This inspection was conducted on the following date(s): January 19 and 24, 2017

An inspection (2016-322156-0006) was previously conducted in April 2016 at which time an order were issued related to bed safety. For this follow up visit, the conditions in the order were not complied with and the order is being re-issued.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, registered staff and residents.

During the course of the inspection, the inspector toured several floors, observed resident bed systems, resident clinical records related to bed rail assessments, bed entrapment evaluations and bed safety policies.

The following Inspection Protocols were used during this inspection:
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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the residents were assessed and that resident's beds were evaluated in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted in April 2016 and as a result, non-compliance was identified with this section. An order was issued to redevelop the home's existing clinical assessment form related to bed rails in accordance with prevailing practices, to re-assess all residents using the redeveloped form by an interdisciplinary team, to document the results of the assessment in their written plan of care, to re-evaluate all bed systems using prevailing practices and to educate all staff about bed safety hazards.

Resident Assessments

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidelines includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

Prevailing practices includes using predominant, generally accepted widespread practice

as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this follow up inspection, four residents (#100-103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical Guidance document and if any identified risks were identified and mitigated. All four residents were observed to have one or more rotating assist bed rails applied, either in the “guard” position, the “assist” position or one in both positions. The bed rails were designed to rotate 180 degrees horizontally, or 90 degrees either to the left or to the right from a central point. The terminology for the various bed rail positions was identified in the bed manufacturer’s user guide book. The licensee however identified the bed rails as either being in the “engaged” (guard) position or the “not engaged” (assist) position.

According to the Director of Care and various registered staff, all four residents were

required to be assessed by registered staff and monitored by personal support workers (PSWs) for three days upon admission for sleeping patterns and bed rail use while in bed. PSWs were required to enter their observations into an electronic data base by answering a series of questions. Handwritten forms were completed by registered staff to document any information related to the resident and their bed rails included the "Interdisciplinary Restraint/Personal Assistance Services Devices (PASD) Assessment and Consent" (IRPAC) and "Resident Sleep Patterns – Bed Rail Assessment" (RSPBRA). A total of three different types of forms were reviewed and whether in combination or alone, did not fully capture enough or comprehensive bed safety information identified in the Clinical Guidance document noted above. The forms were geared towards the use of various types of Personal Assistance Services Devices (PASD) and bed rails were included as one type of PASD.

The questions that were answered by the PSWs and who were tasked to observe the resident in bed were designed as "yes" and "no" questions. These included whether or not the resident slept during their shift, if they attempted to self-transfer, required bed rails to reposition themselves, if they settled after being given a snack or after being toileted. Three relevant questions related to sleep behaviour were included which related to restlessness, if the resident slept near the edge of the bed or traveled to the four corners of the bed. The data collected did not include whether other factors related to bed safety as identified in the Clinical Guidance document were considered such as the resident's cognition status, medication use, signs of pain or discomfort, whether the resident fell from bed (during the observation or before coming to the home), acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, had altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, if they were at risk of climbing over the bed rails, their sleeping characteristics (or sleeping disorders) and any other habits and behaviours. automatically applied until a need was established.

The IRPAC form was primarily designed to establish whether the bed rail was a restraint or a PASD, depending on the abilities of the resident to get in and out of bed when applied. It included an "alternatives" section that was to be completed if the bed rail was considered a physical restraint. It included a section which identified the "type of PASD/restraint" used whereby if "bed rails" were selected, the reason for their use was to be identified and if any risks associated with their use was identified, that bed rails were not to be used and "wedges" be used as an alternative. However, the form was not designed to include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was successful or not. The list of alternatives on the form

were extensive and included some related and some unrelated interventions for alternatives to bed rails such as walking program, pain management, nourishment/fluids, OT/PT, modifications to environment, room change, equipment, sensory aids, positioning, diversional activities, scheduled toileting, medication review and responsive behaviour interventions. According to the Clinical Guidance document, the use of "perimeter reminders" or "border definers" such as body pillow, cushions, bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. These particular accessories or modified equipment were not included as options on the form to better guide staff decision making, however some of these options were observed to be in use in the home.

The RSPBRA form was designed to be used just after admission, after observing the resident in bed for at least one night with the application of bed rails. The form consisted of 11 questions in a "yes" or "no" format that were answered by registered staff. The form was not designed to include the dates that the resident was observed sleeping in bed with and without bed rails applied either in the "guard" or "assist" position. The form included whether or not the resident slept through the night, if they got up through the night and why, if they attempted to climb over the bed rails or head/foot board, if they required bed rails to reposition themselves, if they were at risk of falling out of bed, and whether their bed rail was a restraint or PASD. The data collected did not include whether other factors related to bed safety as identified in the Clinical Guidance document were considered such as the resident's cognition status, medication use, signs of pain or discomfort, sleep characteristics or disorders (restlessness, position on mattress, sleep walking, vivid dreams etc), whether the resident fell from bed (during the observation or before coming to the home), acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, had altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, and any other habits and behaviours. The information from both forms and the electronic data base were collected by registered staff and transferred to the residents' written plan of care.

Resident #100 was observed at the time of inspection, lying in bed with their left bed rail in the "guard" position and their right bed rail in the "assist" position. When tested, the bed rail on the resident's right was very loose and unsafe for use which was reported to registered staff. The resident's written plan of care identified that one bed rail was to be used for bed mobility under the "Activities of Daily Living" focus and under the "PASD"

focus, the resident was to have one half bed rail on the left side engaged and one half bed rail on the right side not engaged. A sleep assessment of the resident was completed in November 2014 which identified that the resident did not use the bed rails. The resident's IRPAC form dated May 2015, and May 2016, identified that the resident used one half bed rail on left engaged and one half bed rail on right not engaged as a positioning device. A new sleep assessment was not completed to monitor the resident while in bed with bed rails for safety issues. No information was listed on the IRPAC form regarding alternatives trialled prior to applying the bed rails and whether they were successful or not.

Resident #101 was observed at the time of inspection, lying on their bed with their right bed rail in the "assist" position and their left bed rail in the "guard" position. The resident stated that they used the bed rails, one to transfer in and out of bed with and the other to reposition with while in bed. The bed rail in the "guard" position was tested and was loose. The resident was admitted to the home in November 2016 and their sleep assessment was completed on the same date, before spending one night in the home. The resident's IRPAC form was blank. The residents written plan of care did not include any information about the use of their bed rails.

Resident #102 was observed at the time of inspection, lying on their bed. Both of their bed rails were in the "guard" position. No sleep assessment form could be located in their chart by the inspector or registered staff. The resident's IRPAC form dated August 2014, September 2015 and November 2016 identified use of both bed rails and the section under "Alternatives" was blank. The resident's written plan of care Identified that both half bed rails were required in the "engaged" position for bed mobility. On both days of the inspection, the resident's left bed rail was observed to be too far from the side of the mattress, creating a very large gap known as entrapment zone 2 and 3 and their right bed rail was very loose, presenting an entrapment risk to the resident.

Resident #103 was observed at the time of inspection, lying on their bed with both bed rails in the "guard" position. The resident was admitted to the home in July 2016, and their sleep assessment was done on the same day, prior to spending one night in bed. According to a registered staff member on the same floor, the sleep assessments were conducted upon admission, without a full night's observation. The resident's IRPAC form completed in July 2016, identified that two half bed rails were to be applied for bed mobility and positioning. A different form was attached to the IRPAC form titled the "Least Restraint Alternatives Assessment Form" which was blank. The resident's written plan of care identified that both half rails were to be applied in the "engaged" position for bed

mobility. No information was listed on the IRPAC form regarding alternatives trialled prior to applying the bed rails and whether they were successful or not.

The licensee did not develop any policies or procedures for the various staff members in the home to follow in conducting clinical bed safety assessments and did not identify what forms were to be used and when. The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

Bed Evaluations

The licensee was required to re-evaluate all of their beds according to the order issued on June 3, 2016. At the time of inspection, the entrapment status of the beds were not specifically known as the beds were last evaluated in October 2013. During this inspection, confirmation was made that all but 31 beds out of 201 beds passed entrapment zones 1-4 in October 2013 and for those that failed, the bed rails were removed from the bed. A total of 37 beds were re-evaluated in 2016. According to the Administrator and the licensee's policy E05-05, re-evaluations of the bed systems in 2016 were limited to those beds where residents received a new or different bed rail or a new mattress and where bed systems were re-assigned to a different resident.

The licensee's policy E05-05 regarding bed system evaluations included some references similar to those in the HC Guidelines as to when to evaluate the bed systems, such as "when surfaces or a bed rail were changed" and when "issues arise that could affect the condition of bed rails and mattresses". The HC Guidelines identified the need to liaise with both the bed manufacturer and mattress manufacturers (if ordered separately from the bed manufacturer to establish bed system evaluation frequencies. The frequency of evaluating both mattresses and bed frames would depend on multiple factors which are identified by the manufacturers' of the products. The licensee's policy did not include any additional information describing what types of bed rail and mattress conditions would warrant a re-evaluation of the bed system and how the beds would all be monitored for these conditions and other safety issues such as loose bed rails, latch reliability, sharp edges, hydraulic or electrical failure, overheating of motors, mattress type, rail height from the top of the mattress, use of overlays and bed accessories on an on-going basis.

During the inspection, four identified bed systems had loose bed rails for which staff were unaware. The residents assigned to these beds were all confirmed to be using the bed rails. Six beds were not originally evaluated in 2013 as they were equipped with therapeutic air mattresses at the time. During this inspection, none of the six beds were equipped with a therapeutic mattresses and four were not re-evaluated in 2016 after a different mattress was placed on the frame. Confirmation could not be established by the licensee as to whether the bed systems (mattresses, bed rails and bed frame) that were evaluated (measured) in 2013 remained the same during this inspection and that no changes had taken place to alter the original entrapment status of the bed. [s. 15. (1) (a)]

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 March, 2017

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0005
Log No. / Registre no:	020559-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 7, 2017
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	DUNDURN PLACE CARE CENTRE 39 MARY STREET, HAMILTON, ON, L8R-3L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Watson

To RYKKA CARE CENTRES LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2016_322156_0006, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Re-evaluate all of the bed systems in the home in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and document the results. At a minimum, documentation shall include type of mattress and unique mattress identifier, bed rail type, bed frame serial number, date evaluated, name of evaluator, zones tested, issues identified and follow up action taken if necessary.

2. Amend the home's existing forms related to bed rail use and bed safety assessments or create a new form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be

answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time to establish risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

3. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

5. Amend the existing policy E05-05 related to bed systems so that it will guide an assessor in completing resident clinical bed safety assessments in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" and implement the policy.

6. Develop a policy and procedure that will guide an assessor in completing bed system evaluations in accordance with Health Canada Guidelines titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006” and implement the policy.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the residents were assessed and that resident's beds were evaluated in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted in April 2016 and as a result, non-compliance was identified with this section. An order was issued to redevelop

the home's existing clinical assessment form related to bed rails in accordance with prevailing practices, to re-assess all residents using the redeveloped form by an interdisciplinary team, to document the results of the assessment in their written plan of care, to re-evaluate all bed systems using prevailing practices and to educate all staff about bed safety hazards.

Resident Assessments

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidelines includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication

use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this follow up inspection, four residents (#100-103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical Guidance document and if any identified risks were identified and mitigated. All four residents were observed to have one or more rotating assist bed rails applied, either in the "guard" position, the "assist" position or one in both positions. The bed rails were designed to rotate 180 degrees horizontally, or 90 degrees either to the left or to the right from a central point. The terminology for the various bed rail positions was identified in the bed manufacturer's user guide book. The licensee however identified the bed rails as either being in the "engaged" (guard) position or the "not engaged" (assist) position.

According to the Director of Care and various registered staff, all four residents were required to be assessed by registered staff and monitored by personal support workers (PSWs) for three days upon admission for sleeping patterns and bed rail use while in bed. PSWs were required to enter their observations into an electronic data base by answering a series of questions. Handwritten forms were completed by registered staff to document any information related to the resident and their bed rails included the "Interdisciplinary Restraint/Personal Assistance Services Devices (PASD) Assessment and Consent" (IRPAC) and "Resident Sleep Patterns – Bed Rail Assessment" (RSPBRA). A total of three different types of forms were reviewed and whether in combination or alone, did not fully capture enough or comprehensive bed safety information identified in the Clinical Guidance document noted above. The forms were geared towards the use of various types of Personal Assistance Services Devices (PASD) and bed rails were included as one type of PASD.

The questions that were answered by the PSWs and who were tasked to observe the resident in bed were designed as "yes" and "no" questions. These

included whether or not the resident slept during their shift, if they attempted to self-transfer, required bed rails to reposition themselves, if they settled after being given a snack or after being toileted. Three relevant questions related to sleep behaviour were included which related to restlessness, if the resident slept near the edge of the bed or traveled to the four corners of the bed. The data collected did not include whether other factors related to bed safety as identified in the Clinical Guidance document were considered such as the resident's cognition status, medication use, signs of pain or discomfort, whether the resident fell from bed (during the observation or before coming to the home), acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, had altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, if they were at risk of climbing over the bed rails, their sleeping characteristics (or sleeping disorders) and any other habits and behaviours. automatically applied until a need was established.

The IRPAC form was primarily designed to establish whether the bed rail was a restraint or a PASD, depending on the abilities of the resident to get in and out of bed when applied. It included an "alternatives" section that was to be completed if the bed rail was considered a physical restraint. It included a section which identified the "type of PASD/restraint" used whereby if "bed rails" were selected, the reason for their use was to be identified and if any risks associated with their use was identified, that bed rails were not to be used and "wedges" be used as an alternative. However, the form was not designed to include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was successful or not. The list of alternatives on the form were extensive and included some related and some unrelated interventions for alternatives to bed rails such as walking program, pain management, nourishment/fluids, OT/PT, modifications to environment, room change, equipment, sensory aids, positioning, diversional activities, scheduled toileting, medication review and responsive behaviour interventions. According to the Clinical Guidance document, the use of "perimeter reminders" or "border definers" such as body pillow, cushions, bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. These particular accessories or modified equipment were not included as options on the form to better guide staff decision making, however some of these options were observed to be in use in the home.

The RSPBRA form was designed to be used just after admission, after observing the resident in bed for at least one night with the application of bed rails. The form consisted of 11 questions in a "yes" or "no" format that were answered by registered staff. The form was not designed to include the dates that the resident was observed sleeping in bed with and without bed rails applied either in the "guard" or "assist" position. The form included whether or not the resident slept through the night, if they got up through the night and why, if they attempted to climb over the bed rails or head/foot board, if they required bed rails to reposition themselves, if they were at risk of falling out of bed, and whether their bed rail was a restraint or PASD. The data collected did not include whether other factors related to bed safety as identified in the Clinical Guidance document were considered such as the resident's cognition status, medication use, signs of pain or discomfort, sleep characteristics or disorders (restlessness, position on mattress, sleep walking, vivid dreams etc), whether the resident fell from bed (during the observation or before coming to the home), acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, had altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, and any other habits and behaviours. The information from both forms and the electronic data base were collected by registered staff and transferred to the residents' written plan of care.

Resident #100 was observed at the time of inspection, lying in bed with their left bed rail in the "guard" position and their right bed rail in the "assist" position. When tested, the bed rail on the resident's right was very loose and unsafe for use which was reported to registered staff. The resident's written plan of care identified that one bed rail was to be used for bed mobility under the "Activities of Daily Living" focus and under the "PASD" focus, the resident was to have one half bed rail on the left side engaged and one half bed rail on the right side not engaged. A sleep assessment of the resident was completed in November 2014 which identified that the resident did not use the bed rails. The resident's IRPAC form dated May 2015, and May 2016, identified that the resident used one half bed rail on left engaged and one half bed rail on right not engaged as a positioning device. A new sleep assessment was not completed to monitor the resident while in bed with bed rails for safety issues. No information was listed on the IRPAC form regarding alternatives trialled prior to applying the bed rails and whether they were successful or not.

Resident #101 was observed at the time of inspection, lying on their bed with their right bed rail in the "assist" position and their left bed rail in the "guard" position. The resident stated that they used the bed rails, one to transfer in and out of bed with and the other to reposition with while in bed. The bed rail in the "guard" position was tested and was loose. The resident was admitted to the home in November 2016 and their sleep assessment was completed on the same date, before spending one night in the home. The resident's IRPAC form was blank. The residents written plan of care did not include any information about the use of their bed rails.

Resident #102 was observed at the time of inspection, lying on their bed. Both of their bed rails were in the "guard" position. No sleep assessment form could be located in their chart by the inspector or registered staff. The resident's IRPAC form dated August 2014, September 2015 and November 2016 identified use of both bed rails and the section under "Alternatives" was blank. The resident's written plan of care Identified that both half bed rails were required in the "engaged" position for bed mobility. On both days of the inspection, the resident's left bed rail was observed to be too far from the side of the mattress, creating a very large gap known as entrapment zone 2 and 3 and their right bed rail was very loose, presenting an entrapment risk to the resident.

Resident #103 was observed at the time of inspection, lying on their bed with both bed rails in the "guard" position. The resident was admitted to the home in July 2016, and their sleep assessment was done on the same day, prior to spending one night in bed. According to a registered staff member on the same floor, the sleep assessments were conducted upon admission, without a full night's observation. The resident's IRPAC form completed in July 2016, identified that two half bed rails were to be applied for bed mobility and positioning. A different form was attached to the IRPAC form titled the "Least Restraint Alternatives Assessment Form" which was blank. The resident's written plan of care identified that both half rails were to be applied in the "engaged" position for bed mobility. No information was listed on the IRPAC form regarding alternatives trialled prior to applying the bed rails and whether they were successful or not.

The licensee did not develop any policies or procedures for the various staff members in the home to follow in conducting clinical bed safety assessments and did not identify what forms were to be used and when. The conclusions related to these residents and the use of their bed rails was not comprehensive,

was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

Bed Evaluations

The licensee was required to re-evaluate all of their beds according to the order issued on June 3, 2016. At the time of inspection, the entrapment status of the beds were not specifically known as the beds were last evaluated in October 2013. During this inspection, confirmation was made that all but 31 beds out of 201 beds passed entrapment zones 1-4 in October 2013 and for those that failed, the bed rails were removed from the bed. A total of 37 beds were re-evaluated in 2016. According to the Administrator and the licensee's policy E05-05, re-evaluations of the bed systems in 2016 were limited to those beds where residents received a new or different bed rail or a new mattress and where bed systems were re-assigned to a different resident.

The licensee's policy E05-05 regarding bed system evaluations included some references similar to those in the HC Guidelines as to when to evaluate the bed systems, such as "when surfaces or a bed rail were changed" and when "issues arise that could affect the condition of bed rails and mattresses". The HC Guidelines identified the need to liaise with both the bed manufacturer and mattress manufacturers (if ordered separately from the bed manufacturer to establish bed system evaluation frequencies. The frequency of evaluating both mattresses and bed frames would depend on multiple factors which are identified by the manufacturers' of the products. The licensee's policy did not include any additional information describing what types of bed rail and mattress conditions would warrant a re-evaluation of the bed system and how the beds would all be monitored for these conditions and other safety issues such as loose bed rails, latch reliability, sharp edges, hydraulic or electrical failure, overheating of motors, mattress type, rail height from the top of the mattress, use of overlays and bed accessories on an on-going basis.

During the inspection, four identified bed systems had loose bed rails for which staff were unaware. The residents assigned to these beds were all confirmed to be using the bed rails. Six beds were not originally evaluated in 2013 as they were equipped with therapeutic air mattresses at the time. During this

inspection, none of the six beds were equipped with a therapeutic mattresses and four were not re-evaluated in 2016 after a different mattress was placed on the frame. Confirmation could not be established by the licensee as to whether the bed systems (mattresses, bed rails and bed frame) that were evaluated (measured) in 2013 remained the same during this inspection and that no changes had taken place to alter the original entrapment status of the bed.

This Order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of O. Regulation 79/10, the scope of the non-compliance is widespread, as none of the residents who used one or more bed rails were assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and the history of non compliance is on-going. An order was previously issued on June 3, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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