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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Nov 6, 2015	2015_346133_0041	O-002591-15	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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): October 8th, 9th, 14th, 15th (on-site)

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager for Personal Care, the Hospitality Manager, the Recreation Assistant, the Senior Environmental Services Attendant, registered and non registered nursing staff, the Recreation Coordinator, and a resident's visiting family member.

Over the course of the inspection, the inspection reviewed a critical incident report, reviewed components of the health care record of the resident involved in the critical incident, reviewed documentation related to the activities of the home's "Restraints and Bed Rails working group", reviewed documentation related to the testing of potential entrapment zones on beds with bed rails in use, reviewed selected residents' risk assessment for bed entrapment and associated plans of care. In the company of the Senior Environmental Services Attendant, the inspector observed selected resident beds with bed rails in use.

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)**
- **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. 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 has failed to comply with O. Reg. 79/10, s. 15 (1) (a) in that, where bed rails are used, the process to assess residents and evaluate their bed systems, to minimize the risk to the resident, had not been completed at the time of the inspection as follow up actions had not been taken.

In August 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

On October 8th, 2015, inspector #133 began a critical incident system inspection related to the entrapment and injury of resident #001's leg in between his/her mattress and a bed rail. The inspector met with the home's Hospitality Manager (HM) to discuss the entrapment event. The inspector was made aware that resident #001's bed had been tested in accordance with the HC guidance document, in March 2015, and it had passed the dimensional limit testing for Zones 1-4.

The HM explained to the inspector that all beds with bed rails in place are tested at least annually in accordance with the HC guidance document. The HM explained that this testing was done by the home's senior environmental services attendant (SESA), throughout March 2015. Registered nursing staff were then informed, via email from the SESA, about which beds had failed the entrapment zone testing on their units. The HM explained that the home's Rehabilitation Assistant (RA) had a key role in supporting registered nursing staff on the matter of follow up action required when a bed failed the entrapment zone testing.

The HM provided the inspector with the SESA's "2015 bed entrapment binder", which contained the results for all beds assessed in 2015. The binder also included copies of emails sent to registered nursing staff on each unit. The emails directed the registered nursing staff to refer to an attached process map, and to contact the RA for further support if assistance was needed in terms of required follow up actions.

On October 9th, 2015, Inspector #133 met with the home's RA. The RA provided the inspector with a copy of the process map that was attached to the emails mentioned above. It directs registered nursing staff that if a resident is assessed at moderate to high risk of bed entrapment, and the resident's bed did not pass the safety testing, they are to contact the RA to "assist in evaluating options, (removal of rails, wedges etc).." The RA also showed the inspector a copy of the "bed entrapment cheat sheet" she had created for registered nursing staff in May 2015, which summarized all potential scenarios. The RA explained that it had not been clear to registered nursing staff what the process map was directing them to do, and that in May 2015 she had gone to every unit, looked at the results of every bed test and the assessment of risk for bed entrapment for every resident. The RA explained she then provided a summary of what action was required for every resident. The RA explained that she did not follow up with the registered nursing staff to verify that follow up action had been taken, as this was not her role. The "bed entrapment cheat sheet" includes the following direction: if resident is at moderate or high risk of entrapment and the bed is unsafe, refer to the rehab assistant, "we have to change something to the bed". The RA explained that the home did not currently have processes in place for the use of accessories to mitigate the risk associated with entrapment zones that had failed the testing process. The RA explained that removal of the bed rails was to be the primary intervention, with the implementation of safety measures such as lowering the bed to the floor, use of fall mats and the use of bumper pads/wedges, as per assessed need. The RA and the inspector also looked at the "bed entrapment communication form", which the RA explained is also filled out and

given to registered nursing staff when a bed fails the entrapment zone testing. The communication form outlines the measures described above, and directs registered nursing staff to refer to the RA .

Focusing on the results of the bed testing process conducted in March 2015, Inspector #133 worked with the home's SESA, who had done the testing, to determine if there had been any changes to select beds that had failed and to confirm if the potential entrapment zone would still fail. These observations were made on October 9th and 14th, 2015. In all beds selected for further inquiry, there were quarter (1/4) rails in place that had failed the zone 4 test, at one or both ends of each rail. In collaboration with the SESA, it was confirmed that no changes had been made to ten residents' beds (resident #001, #002, #004, #005, #006, #007, #008, #009, #012 and #016).

The most recent "resident risk for bed entrapment assessment" document for resident # 001, #002, #004, #005, #006, #007, #008, #009, #012 and #016 was reviewed on October 8th and again on October 14th, 2015. All residents were assessed to be at moderate to high risk of entrapment.

Zone 4 is defined by Health Canada as "under the rails at the ends of the rail". This space is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. The space poses a risk of life threatening entrapment of the neck.

On October 14th, 2015, the inspector spoke with registered nursing staff #S104 and #S105. Both indicated that following review of the resident's risk for entrapment and bed testing results, they would now be filling out referral forms for the RA (Staff #S104 for resident #001, Staff #S105 for residents #002,#004, #005, #006, #007, #008, #009). Staff #S105 explained that she didn't feel she had all of the information necessary to know what needed to happen when a bed failed the testing process. She said it had been difficult to receive the information, as she had no knowledge about the potential entrapment zones.

On October 15th, 2015, the inspector spoke with registered nursing staff #S106, who indicated that following review of resident #012's risk for entrapment assessment and bed testing results, she would now be filling out referral forms for the RA. Staff #S106 explained that she had not been clear on what next steps were required when the information about the bed failures had first been provided. Staff #S106 said she did not understand what the bed failures meant, did not understand what the potential

entrapment zones were, and did not understand how to quantify the risks.

On October 15th, 2015, the inspector spoke with registered nursing staff #S107, related to resident #016. Staff #S107 explained that when she received information about the resident's bed failure, she understood that a care plan was required, and that no further actions were to taken.

On October 15th, 2015, the Hospitality Manager (HM) explained that there were thirteen sets of quarter (1/4) rails in storage that were expected to pass entrapment zone testing. The HM explained they had intended to start by replacing nine sets, and this was a work in progress, related to the activities of the home's "Restraints and Bed Rails" working group, that is working towards reducing the use of bed rails and restraints through education and training of staff, residents and families. The HM indicated that the replacement process would begin the week of October 19th, 2015. A spreadsheet that included all of the bed testing information and the residents risk assessment scores was reviewed. As indicated on the spreadsheet, the HM confirmed that of the ten residents that inspector #133 had selected for further inquiry during the inspection, seven (resident #002, #004, #005, #006, #008, #012, and #016) were expected to get new rails.

As per the spreadsheet provided to the inspector by the HM, there were a total of twenty residents at moderate to high risk of entrapment, in beds with quarter rails that had failed zone 4 entrapment testing. [s. 15. (1) (a)]

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 where bed rails are used, the resident is assessed and his or her bed system is evaluated, in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to residents, to be implemented voluntarily.

Issued on this 6th day of November, 2015

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

Original report signed by the inspector.