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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 28, 2016	2016_200148_0021	019842-16, 020227-16 AND 014868-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

CARLINGVIEW MANOR
2330 CARLING AVENUE OTTAWA ON K2B 7H1

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 15, 18, 19 (on site) and July 21, 2016, (off site)

This inspection included three separate complaints with items including ambulation equipment, provision of dietary needs, feeding assistance and use of bed rails.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director (ED), Director of Care (DOC), Assistant Executive Director (AED), Environmental Services Manager (ESM), Clinical Manager, Registered Nurses, Registered Practical Nurses, Registered Dietitian, Dietary Manager, Food Service Supervisor, Health Care Aide/Personal Support Workers, family and residents, in addition to a representative from Ontario Medical Supply.

The Inspector reviewed resident health care records, planned menus and documents related to the bed assessments. The Inspector also observed meal service provision, resident care equipment and provision of resident care and services.

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

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 ensure that where bed rails are used, 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 practice, to minimize the risk to the resident.

Interdisciplinary assessments and plan of care for resident #002 indicates that he/she is palliative and bedridden, dependent on staff for activities of daily living, experiences anxiety and aggressive behaviours, is at medium/high risk of falls, has a history of climbing out of bed and leaning over the bed, a history of hallucinations and the resident uses half bed rails (one on each side).

A complaint was received indicating that resident #002 had sustained an injury due to the use of the bed rails. A review of resident #002's health care record demonstrated that on a specified date, the resident caught his/her left leg in the bed rail causing skin tears. The resident was unable to describe what had occurred due to cognitive impairment. After the incident the resident's bed rails were covered with bumper pads. Inspector #148 observed the rails and bumper pads to be in use during the time of the inspection. As reported by the home's ESM, the bed system for resident #002 was evaluated several months prior to the incident, which included the use of bed rails and had passed the evaluation criteria.

In discussion with the home's DOC and AED, the following were identified as polices related to resident assessment, as it relates to the use of bed rails including: policy #LTC-K-25, #LTC-K-10-ON and #LTC-K-10-05-ON.

Upon inquiry by the Inspector, it was established that the home has based their written policies on the guidance document from Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). Specifically, policy LTC-K-10-ON, references the HC guidance document and resident assessment for associated risk when side rails (bed rails) are in use. All Long-Term Care Homes were directed to use this as a best practices document in 2012 by the Director under the LTCHA 2007. The HC guidance document speaks to the need to assess residents for risk related to bed rail use. As endorsed by the HC guidance document, the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Homes and Home Care settings" (clinical guidance document), 2007, provides for guidance for the assessment of the resident where bed rails are used.

The clinical guidance document describes that the individual resident assessment be a documentation of the risk-benefit assessment and be available within the health care record. The clinical guidance document describes the assessment to include medical diagnosis, sleep habits, medications, ability to toilet self, existence of delirium, cognition, communication, mobility in and out of bed and risk of falls.

Inspector #148 discussed the home's process to assess the resident's risk in relation to the use of bed rails with the home's DOC. She identified the home's use of a Decision Tree (policy #LTC-K-10-05-ON) that assists with defining the use of the bed rails with questions related to the resident's transfer and bed mobility status. She further reported that the home will review the history of the resident's use of bed rails, will speak with the resident and family about the potential use of bed rails and risks associated with the use of bed rails and that the policy for side rails is followed.

In review of the health care record, including plans of care, progress notes and Minimum Data Set (MDS) assessments the resident was assessed for the use of bed rails as it relates to the bed rails as a personal assistance services device. There was no documentation to support that the resident had a risk-benefit assessment, whereby the resident was assessed in accordance with prevailing practices to minimize the risk when bed rails are in use. [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 to ensure that where bed rails are used, the resident is assessed in accordance with evidence-based practices to minimize the risk to the resident, to be implemented voluntarily.

Issued on this 28th day of July, 2016

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

Original report signed by the inspector.