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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2018	2018_539120_0006	018018-17	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Brampton
7891 McLaughlin Road BRAMPTON ON L6Y 5H8

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): February 1, 2018

A follow up inspection (2017-539120-0042) was previously conducted on July 4, 2017, in response to a Compliance Order related to bed safety issued on December 14, 2016. For this follow-up inspection, the requirements in the Compliance Order were not fully met. See below for details.

During the course of the inspection, the inspector(s) spoke with the Clinical Practice Lead, registered staff and personal support workers.

During the course of the inspection, the inspector toured two home areas and randomly selected residents who were assessed as requiring bed rails, reviewed resident clinical records (bed safety assessments), staff participation rates for bed safety training and training materials and bed safety policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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 failed to ensure that, where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

The Director of the Ministry of Health and Long Term Care sent a Memorandum to all long term care home administrators on August 12, 2012, identifying a specific document from Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (2008)". The Ministry expected the administrators to follow the recommendations in the document to reduce or mitigate the risk of bed-related hazards. Included in the Health Canada guidelines, are the titles of two additional documents (companion guides) which further provide specific guidance in assessing residents who use one or more bed rails and how to mitigate bed systems that do not pass entrapment zone specifications. The companion guide for assessing residents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", and provides the necessary guidance in establishing a clinical assessment where bed rails are used by residents. The companion guide for mitigating bed systems is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". The Health Canada Guidelines and the two companion guides are therefore the "prevailing practices" under s. 15(1) and shall be complied with.

Two previous inspections were made, one in November 2016, and the second, a follow-up inspection, on July 4, 2017. The initial visit in November 2016, resulted in the issuance of a Compliance Order (CO) on December 14, 2016, for a compliance date of March 15, 2017. The CO included multiple requirements related to the licensee's bed

safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with prevailing practices.

During the follow up inspection on July 4, 2017, the conditions that were laid out in the CO were not met. Therefore another CO was issued on July 25, 2017, which included similar requirements listed above with additional details, and the compliance date was December 29, 2017. The requirements included; (1) an amendment to the home's existing forms related to resident clinical assessments to include (a) what the risks were to residents while sleeping in bed, with and without bed rails and (b) if a bed rail was determined to be necessary (i.e. to assist with an activity of daily living such as bed mobility or transfers in and out of bed), if alternative solutions were trialled prior to using one or more bed rails, and (c) document whether the alternatives were effective or not during a sleep observation period. The CO also included the requirement for the licensee's bed safety policies to include (2) additional details to guide staff in assessing residents, (3) that registered staff document the rationale for or against the implementation of bed rails as it related to bed safety risks, (4) that the written plan of care for all residents who used one or more bed rails be updated where necessary and (5) that all staff are provided with face to face education related to the amended policies, type of bed safety hazards, available interventions, regulatory requirements and alternatives to bed rail use.

For this follow-up visit, the following conditions were determined to be outstanding:

Condition (1)(c), (2) and (3) related to policies, procedures and forms;

The home's policy, titled "Bedrail Minimization and Risk Reduction"(RC-10-01-10) dated September 2017, included the requirement for registered staff to complete Appendix 3, which was a form titled "Bed Rail and Entrapment Risk Assessment (BRERA)" and to "assess the resident's situation looking for possible risk factors related to the use of bed rails and that "all alternative measures to promote resident safety must be assessed and considered prior to the use of bed rails". However, the alternative measures to be used prior to the use of bed rails to promote resident safety were not identified.

The policy also included reference to an Appendix 2, which was a guide to assist registered staff in speaking with a resident or their substitute decision maker (SDM) about bed rail alternatives or interventions and how to handle objections to trialling alternatives. The direction for those who refused trialling an alternative was to allow the

bed rail to remain on the bed, but did not include any direction with respect to the legal requirements of the licensee or any reference or link to either of the companion guides listed in the Health Canada Guidelines. The Clinical Practice Leader (CPL) who participated in the completion of the assessment forms reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment in accordance with prevailing practices as required by the Regulation.

The policy did not include how personal support workers (PSW) were involved in the resident assessment process. According to the CPL, PSWs were required to answer approximately 10 bed safety related questions while residents were observed in bed, specifically related to sleep titled "72 Hours Sleep Habits" form. The completed form was to be provided to the registered staff. How the information was subsequently analyzed and where the collected information would be documented was not specified in the policy or on the BRERA form. The BRERA form included six sections, A through F. Section A included a list of 20 risk factors to choose from related to a resident’s status such as judgement, cognition, medication use, risk of falling, transfer status, history of bed related injury, communication status, physical size, and night time behaviours. No documentation, link or reference was made to the results of the 72 hour sleep observation. Although the form included a text box under Section A for the assessor to document or summarize the residents individual risk for bed entrapment, it was unclear, based on the responses reviewed for four selected residents, whether the risks outweighed the benefits of bed rail use.

According to the Clinical Practice Leader (CPL), who took the lead in implementing their bed safety program, the process of assessing the residents for bed rail related hazards varied, depending on the resident's admission date. The residents who were admitted to the home prior to July 2017, and who were allocated one or more bed rails, did not receive a formal risk assessment which included documented bed rail risk related information about the resident while asleep. A conclusion by an interdisciplinary team would have been required to determine the benefits over the risks of having one or more bed rails applied (as required by prevailing practices). For these residents, routine monitoring by personal support workers (PSWs) was in place to determine if general safety risks were present for the resident while in bed. General safety risks included but were not limited to residents falling out of bed. Any issues observed were required to be reported to registered staff. The CPL reported that the SDM for many of the residents

admitted prior to July 2017, were not willing to have alternatives to a bed rail trialled and insisted that one or more bed rails remained on the beds, despite the process that was put into place to try alternatives and different approaches to the use of bed rails. Some of these residents were identified to have risk factors for bed rail related injury and no interventions or alternatives documented.

For residents admitted after July 2017, the resident was immediately allocated a bed without bed rails attached, and observed for a period of time. If it was determined that one or more bed rails was necessary, the resident received one or more bed rails. Subsequently, PSWs were therefore tasked to complete a form titled "72 hours Sleep Habits: Assist Rail and Entrapment Risk Assessment Tool". The questions included whether the resident acquired any bruising or an injury from the bed rail, slept close to the edge of the bed, got a body part through the bed rail or between the mattress and bed rail, attempted to climb over the bed rail or fell out of bed and overall bed mobility. If risks were identified, the resident or the resident's SDM were informed. However, if the SDM insisted that the bed rail remain in use by the resident, the CPL reported that the bed rail(s) were left on the bed. The process of trialling other options was not documented and a risk over benefit analysis not completed.

Four residents (#101-104) were randomly selected during this inspection to determine if they were assessed for bed safety risks when bed rails were applied. Four out of the four residents were all admitted to the home prior to 2016, and were assessed for bed rail risks between November 2017 and January 2018, without adequate documentation made by an interdisciplinary team to determine the risks over the benefits, what alternatives were trialled before applying one or more bed rails, the time frames the alternatives were trialled and whether they were successful or not and whether the bed rails used by the residents posed any identified risks and if so, what interventions were implemented to mitigate those risks. No evidence could be provided that registered staff who assessed the residents complied with the policy for residents who were admitted prior to July 2017.

The above noted four residents were confirmed to have been assessed using the BRERA form. The form did not include information about the alternatives trialled but instead a check box was made available which stated "refer to appropriate discipline or team as needed to determine alternatives to bed rails and plan for a safe bed system". Residents #103 and #104 did not have this box checked off when they were identified to have been at risk of entrapment. An additional assessment, identified by the CPL as the "Least Restraint - Personal Assistance Services Device" (PASD) was also completed for

all residents who were assessed to require one or more bed rails. The assessment included why the device would be used, duration of use, and whether the resident had physical or cognitive impairments but did not include whether alternatives to the device or bed rail were trialled.

1.Resident #101, was observed in bed at the time of inspection with a bed rail in an elevated position with an accessory attached to the bed rail. The bed rail provided the resident with the ability to transfer from bed, but did not offer much aid for repositioning while in bed. The resident's written plan of care identified that the resident had multiple bed related risk factors and required assistance of one staff member to a standing position and required a bed rail on one side for repositioning and that it be "secured down". According to the CPL, the term "secured down" meant that the rails were tied down or secured. It did not include the bed rail being in the elevated position.

The resident's BRERA, completed in November 2017, included under "Section A" (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury but did not include two additional risk factors that were identified elsewhere in the resident's plan of care. Under "Section B", the resident was identified to not have a risk for bed entrapment, despite the risk factors noted on other sections of the assessment form. During the inspection, the resident had a bed rail applied in an elevated position. No risk over benefit analysis was included on the form. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, dated November 2017, included that they were able to reposition themselves while in bed, but had a cognition deficit and that that they required a bed rail with an attached accessory for positioning. No alternative to the use of bed rails was documented, and the outcomes and the reason for the bed rail was not given. The conclusion at the end of the assessment was the same as documented under their BRERA form.

2. Resident #102 was not in bed at the time of inspection but both of their bed rails included an attached accessory but were not elevated. The resident's plan of care included the requirement to have an accessory attached to the bed rails but the plan did not specify the exact position that the bed rails were to be in when the resident was in bed. The reason for the bed rails included repositioning and transfers, so that the resident could assist staff with both processes. No information was included as to why the accessories were added to the bed rails. The plan of care included that the resident had a specific medical condition, which was a risk factor for potential bed related injury.

The resident’s BRERA form, completed in January 2018, included under Section A (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury. One specific risk factor identified in the care plan was not selected from the list of possible risk factors. The summary or "risk for bed entrapment" section on the form included a note that stated that the resident was at risk of bed entrapment. The requirement to have an accessory on the bed rail was included but did not provide a reason (and the reason was not in the plan of care). Under Section B, the resident was identified to be at risk for bed entrapment, and yet, bed rails were selected to remain on the bed and in use. The assessor documented that the resident will use bed rails for "safety" reasons, but did not specify what those reasons were. No risk over benefit analysis was included on the form. The resident did not have a 72 hour sleep observation form completed.

The resident’s PASD assessment, completed in January 2018, included that the resident would use bed rails with an attached accessory for turning and repositioning but did not include a reason as to why an accessory was added to the bed rails and alternatives to the use of bed rails was not documented or the outcomes.

3. Resident #103 was observed in bed at the time of inspection with bed rails elevated with attached accessories so that they could be used for turning and repositioning but were in a position that made exiting the bed more difficult. A transfer device was also situated next to the bed on one side. According to the resident's PSW, the resident used the transfer device to exit and enter the bed. The PSW also stated that the resident exhibited symptoms that placed them at higher.

The resident's plan of care included that the resident had various medical conditions, symptoms and behaviours that were considered high risk for a bed rail related injury and required bed rails for safety and turning and repositioning. For transfers, they required the assistance of one person using a specified transfer device. No reason was provided as to why the bed rails were required to be equipped with specific accessories.

The resident's BRERA form, completed in December 2017, included under Section A (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury. Two additional and very specific conditions were not selected from the list of possible risk factors. The summary or "risk for bed entrapment" section on the form did not include the resident's risk of bed related injury but that accessories would be added to the bed rails for "safety reasons" due to a

specific medical condition. The safety reasons were not identified or how bed rails would benefit the resident when symptoms would arise as a result of the medical condition. The risk over the benefit of applying the bed rails was not included. The requirement to have accessories added to the bed rails was included but did not provide a reason. Under Section B, the resident was identified to be at risk for bed entrapment, and yet, bed rails were selected to remain on the bed and in use. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, dated December 2017, included that the resident required the use of bed rails for transferring and positioning and had moderate impairment with decision making and was physically impaired. No documentation was made as to whether alternatives were trialled and the outcomes or why accessories were added to the bed rails. According to the assessor who completed the assessment, the accessories were added to the bed rails to prevent bed rail entrapment.

4. Resident #104 was observed in bed at the time of inspection, with accessories on both bed rails which were elevated. The bed was in a high position with falls intervention devices in place. According to the resident's PSW, the resident's bed mobility was unpredictable and limited. The PSW stated that the resident had the bed rails in place for safety reasons.

The resident's plan of care included the need to have both bed rails "upright" and accessories added for safety, with no specific details about the safety issues. The CPL confirmed that the "upright" position was the "transfer" position. The resident required full staff assistance and a mechanical lift for transfers and 1 to 2 staff assistance for bed mobility. No reason was provided for the accessories on the bed rails and no information was included in the plan about the resident's falls risk with the sole exception that the bed was to be kept in the lowest position. No information was included regarding the resident's specific bed mobility and if they were at any particular risk.

The resident's BRERA, completed in January 2018, included under Section A (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury. One particular symptom that was included in the plan of care was not identified as a possible risk factor on the form. The summary or "risk for bed entrapment" section on the form included that the resident was at risk and that the resident would use bed rails for safety reasons. The form also included that accessories were added to the bed rails. No reason was given for the applied accessories. No risk over benefit analysis was included on the form. Under Section B,

the resident was identified to be at risk for bed entrapment, and yet, bed rails were selected to remain on the bed and in use. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, dated January 2018, included that the resident was physically impaired and at risk for falls due to cognitive impairment and impaired judgment, which placed them at risk for rolling out of bed. Two bed rails with attached accessories were selected for use as a positioning device. No documentation was made as to whether alternatives were trialled and the outcomes or why accessories were added to the bed rails. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 13th day of April, 2018

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 :	2018_539120_0006
Log No. / No de registre :	018018-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 5, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Brampton 7891 McLaughlin Road, BRAMPTON, ON, L6Y-5H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hannah Oksemberg

To Extendicare (Canada) Inc., 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: 2017_539120_0042, 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 must be compliant with O. Reg. 79/10, s. 15(1)(a)

The licensee shall complete the following:

1. Re-assess all residents who were admitted prior to July 2017, and who were provided with one or more bed rails, using 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) which is 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 assessment shall, at a minimum, include a process whereby the resident was assessed for;
a. 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
b. safety risks associated with the bed rail, if applied and deemed necessary where an alternative was not successful, while the resident is asleep for a specific period of time.

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and 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) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Amend the current "Bedrail Minimization and Risk Reduction" policy RC-10-01 -10, dated September 2017, to include additional and relevant information noted in the prevailing practices identified as 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) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" related to the identification of risk factors associated with bed rail use. At a minimum the policy shall include;

a) details of the process of assessing residents upon admission, when a change in the resident's condition has been identified and at an established frequency to monitor residents for risks associated with bed rail use on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) alternatives available for the replacement of bed rails; and
d) interventions available for the resident that are used in conjunction with a bed rail; and
e) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
f) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident who uses one or more bed rails, using a resident clinical assessment form and/or process related to safety risks

associated with bed rail use. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards and specify the hazard, the type and size of the bed rail, why it is being used, when it is to be used, how many bed rails are to be applied and on what side of the bed.

Grounds / Motifs :

1. The licensee failed to comply with Compliance Order #001 from inspection #2017-539120-0042 served on July 25, 2016, with a compliance due date of December 29, 2017.

This Compliance 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 (pervasiveness), severity (of the harm or risk of harm) and history of non-compliance. In relation to s. 15(1)(a) of O. Reg. 79/10, the severity of the issue was determined to be a level 2, as the non-compliance had the potential to cause harm to residents. The scope of the issue was determined to be a level 3 (widespread) as four out of four residents were not assessed in accordance with prevailing practices. The home had a level 4 history of on-going non-compliance with this section of the Regulation that included:

* A compliance order (CO) #002 issued on December 14, 2016, with a compliance due date of March 15, 2017 (2016-553536-0021)
* A compliance order (CO) #001 issued on July 25, 2017, with a compliance due date of December 29, 2017 (2017-539120-0042)

The licensee failed to ensure that, where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

The Director of the Ministry of Health and Long Term Care sent a Memorandum to all long term care home administrators on August 12, 2012, identifying a specific document from Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (2008)". The Ministry expected the administrators to follow the recommendations in the document to reduce or mitigate the risk of bed-related hazards. Included in the Health Canada guidelines, are the titles of two additional documents (companion guides) which further provide specific guidance in assessing residents who use one or more bed rails and how to mitigate bed systems that do not pass

entrapment zone specifications. The companion guide for assessing residents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", and provides the necessary guidance in establishing a clinical assessment where bed rails are used by residents. The companion guide for mitigating bed systems is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". The Health Canada Guidelines and the two companion guides are therefore the "prevailing practices" under s. 15(1) and shall be complied with.

Two previous inspections were made, one in November 2016, and the second, a follow-up inspection, on July 4, 2017. The initial visit in November 2016, resulted in the issuance of a Compliance Order (CO) on December 14, 2016, for a compliance date of March 15, 2017. The CO included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with prevailing practices.

During the follow up inspection on July 4, 2017, the conditions that were laid out in the CO were not met. Therefore another CO was issued on July 25, 2017, which included similar requirements listed above with additional details, with a compliance date of December 29, 2017. The licensee was required to complete the following:

1. Amend the home's existing forms related to resident clinical assessments and their bed systems 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) which is 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 resident while sleeping for a specific period of time, to establish safety risks to the resident after a bed rail has been applied and deemed necessary

where an alternative was not successful; and
c. 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.

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and 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) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Amend the current "Bedrail Minimization and Risk Reduction" policy (RC-10-01-10) to include additional and relevant information noted in the prevailing practices identified as 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) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" related to the identification of risk factors associated with bed rail use. At a minimum the policy shall include;

a) details of the process of assessing residents upon admission, when a change in the resident's condition has been identified and at an established frequency to monitor residents for risks associated with bed rail use on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) alternatives available for the replacement of bed rails; and
d) interventions available to mitigate any identified bed safety risks (i.e. wedges,bolsters, bed rail pads); and
f) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
g) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

4. All direct care staff are to be informed about the amended bed rail entrapment zones, minimization policy and be provided with face to face education about bed entrapment zones, the current laws related to bed systems in Ontario, resident risk factors that are considered high risk for bed system injury or entrapment, the available accessories and options used to mitigate bed system injuries and entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use and how to identify bed rails or other bed system components that are not in good working order and the process of reporting and mitigating any malfunctions.

5. Update the written plan of care for those residents where changes were identified after re-assessing each resident who uses one or more bed rails, using the amended resident clinical assessment form and/or process related to bed systems. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards, the type and size of the bed rail, why it is being used, when it is to be used, how many bed rails are to be applied and on what side of the bed.

For this follow-up visit, the licensee failed to complete items #(1)(c), (2) and (3) (a-g).

The home's policy, titled "Bedrail Minimization and Risk Reduction"(RC-10-01-10) dated September 2017, included the requirement for registered staff to complete Appendix 3, which was a form titled "Bed Rail and Entrapment Risk Assessment (BRERA)" and to "assess the resident's situation looking for possible risk factors related to the use of bed rails and that "all alternative measures to promote resident safety must be assessed and considered prior to the use of bed rails". However, the alternative measures to be used prior to the use of bed rails to promote resident safety were not identified.

The policy also included reference to an Appendix 2, which was a guide to assist registered staff in speaking with a resident or their substitute decision maker (SDM) about bed rail alternatives or interventions and how to handle objections to trialling alternatives. The direction for those who refused trialling an alternative was to allow the bed rail to remain on the bed, but did not include any direction with respect to the legal requirements of the licensee or any reference or link to either of the companion guides listed in the Health Canada Guidelines. The Clinical Practice Leader (CPL) who participated in the completion of the

assessment forms reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment in accordance with prevailing practices as required by the Regulation.

The policy did not include how personal support workers (PSW) were involved in the resident assessment process. According to the CPL, PSWs were required to answer approximately 10 bed safety related questions while residents were observed in bed, specifically related to sleep titled "72 Hours Sleep Habits" form. The completed form was to be provided to the registered staff. How the information was subsequently analyzed and where the collected information would be documented was not specified in the policy or on the BRERA form. The BRERA form included six sections, A through F. Section A included a list of 20 risk factors to choose from related to a resident's status such as judgement, cognition, medication use, risk of falling, transfer status, history of bed related injury, communication status, physical size, and night time behaviours. No documentation, link or reference was made to the results of the 72 hour sleep observation. Although the form included a text box under Section A for the assessor to document or summarize the residents individual risk for bed entrapment, it was unclear, based on the responses reviewed for four selected residents, whether the risks outweighed the benefits of bed rail use.

According to the Clinical Practice Leader (CPL), who took the lead in implementing their bed safety program, the process of assessing the residents for bed rail related hazards varied, depending on the resident's admission date. The residents who were admitted to the home prior to July 2017, and who were allocated one or more bed rails, did not receive a formal risk assessment which included documented bed rail risk related information about the resident while asleep. A conclusion by an interdisciplinary team would have been required to determine the benefits over the risks of having one or more bed rails applied (as required by prevailing practices). For these residents, routine monitoring by personal support workers (PSWs) was in place to determine if general safety risks were present for the resident while in bed. General safety risks included but were not limited to residents falling out of bed. Any issues observed were required to be reported to registered staff. The CPL reported that the SDM for many of the residents admitted prior to July 2017, were not willing to have alternatives to a bed rail trialled and insisted that one or more bed rails remained

on the beds, despite the process that was put into place to try alternatives and different approaches to the use of bed rails. Some of these residents were identified to have risk factors for bed rail related injury and no interventions or alternatives documented.

For residents admitted after July 2017, the resident was immediately allocated a bed without bed rails attached, and observed for a period of time. If it was determined that one or more bed rails was necessary, the resident received one or more bed rails. Subsequently, PSWs were therefore tasked to complete a form titled "72 hours Sleep Habits: Assist Rail and Entrapment Risk Assessment Tool". The questions included whether the resident acquired any bruising or an injury from the bed rail, slept close to the edge of the bed, got a body part through the bed rail or between the mattress and bed rail, attempted to climb over the bed rail or fell out of bed and overall bed mobility. If risks were identified, the resident or the resident's SDM were informed. However, if the SDM insisted that the bed rail remain in use by the resident, the CPL reported that the bed rail(s) were left on the bed. The process of trialling other options was not documented and a risk over benefit analysis not completed.

Four residents (#101-104) were randomly selected during this inspection to determine if they were assessed for bed safety risks when bed rails were applied. Four out of the four residents were all admitted to the home prior to 2016, and were assessed for bed rail risks between November 2017 and January 2018, without adequate documentation made by an interdisciplinary team to determine the risks over the benefits, what alternatives were trialled before applying one or more bed rails, the time frames the alternatives were trialled and whether they were successful or not and whether the bed rails used by the residents posed any identified risks and if so, what interventions were implemented to mitigate those risks. No evidence could be provided that registered staff who assessed the residents complied with the policy for residents who were admitted prior to July 2017.

The above noted four residents were confirmed to have been assessed using the BRERA form. The form did not include information about the alternatives trialled but instead a check box was made available which stated "refer to appropriate discipline or team as needed to determine alternatives to bed rails and plan for a safe bed system". Residents #103 and #104 did not have this box checked off when they were identified to have been at risk of entrapment. An additional assessment, identified by the CPL as the "Least Restraint - Personal

Assistance Services Device" (PASD) was also completed for all residents who were assessed to require one or more bed rails. The assessment included why the device would be used, duration of use, and whether the resident had physical or cognitive impairments but did not include whether alternatives to the device or bed rail were trialled.

1.Resident #101, was observed in bed at the time of inspection with a bed rail in an elevated position with an accessory attached to the bed rail. The bed rail provided the resident with the ability to transfer from bed, but did not offer much aid for repositioning while in bed. The resident's written plan of care identified that the resident had multiple bed related risk factors and required assistance of one staff member to a standing position and required a bed rail on one side for repositioning and that it be "secured down". According to the CPL, the term "secured down" meant that the rails were tied down or secured. It did not include the bed rail being in the elevated position.

The resident's BRERA, completed in November 2017, included under "Section A" (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury but did not include two additional risk factors that were identified elsewhere in the resident's plan of care. Under "Section B", the resident was identified to not have a risk for bed entrapment, despite the risk factors noted on other sections of the assessment form. During the inspection, the resident had a bed rail applied in an elevated position. No risk over benefit analysis was included on the form. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, dated November 2017, included that they were able to reposition themselves while in bed, but had a cognition deficit and that that they required a bed rail with an attached accessory for positioning. No alternative to the use of bed rails was documented, and the outcomes and the reason for the bed rail was not given. The conclusion at the end of the assessment was the same as documented under their BRERA form.

2. Resident #102 was not in bed at the time of inspection but both of their bed rails included an attached accessory but were not elevated. The resident's plan of care included the requirement to have an accessory attached to the bed rails but the plan did not specify the exact position that the bed rails were to be in when the resident was in bed. The reason for the bed rails included repositioning and transfers, so that the resident could assist staff with both

processes. No information was included as to why the accessories were added to the bed rails. The plan of care included that the resident had a specific medical condition, which was a risk factor for potential bed related injury.

The resident's BRERA form, completed in January 2018, included under Section A (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury. One specific risk factor identified in the care plan was not selected from the list of possible risk factors. The summary or "risk for bed entrapment" section on the form included a note that stated that the resident was at risk of bed entrapment. The requirement to have an accessory on the bed rail was included but did not provide a reason (and the reason was not in the plan of care). Under Section B, the resident was identified to be at risk for bed entrapment, and yet, bed rails were selected to remain on the bed and in use. The assessor documented that the resident will use bed rails for "safety" reasons, but did not specify what those reasons were. No risk over benefit analysis was included on the form. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, completed in January 2018, included that the resident would use bed rails with an attached accessory for turning and repositioning but did not include a reason as to why an accessory was added to the bed rails and alternatives to the use of bed rails was not documented or the outcomes.

3. Resident #103 was observed in bed at the time of inspection with bed rails elevated with attached accessories so that they could be used for turning and repositioning but were in a position that made exiting the bed more difficult. A transfer device was also situated next to the bed on one side. According to the resident's PSW, the resident used the transfer device to exit and enter the bed. The PSW also stated that the resident exhibited symptoms that placed them at higher.

The resident's plan of care included that the resident had various medical conditions, symptoms and behaviours that were considered high risk for a bed rail related injury and required bed rails for safety and turning and repositioning. For transfers, they required the assistance of one person using a specified transfer device. No reason was provided as to why the bed rails were required to be equipped with specific accessories.

The resident's BRERA form, completed in December 2017, included under Section A (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury. Two additional and very specific conditions were not selected from the list of possible risk factors. The summary or "risk for bed entrapment" section on the form did not include the resident's risk of bed related injury but that accessories would be added to the bed rails for "safety reasons" due to a specific medical condition. The safety reasons were not identified or how bed rails would benefit the resident when symptoms would arise as a result of the medical condition. The risk over the benefit of applying the bed rails was not included. The requirement to have accessories added to the bed rails was included but did not provide a reason. Under Section B, the resident was identified to be at risk for bed entrapment, and yet, bed rails were selected to remain on the bed and in use. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, dated December 2017, included that the resident required the use of bed rails for transferring and positioning and had moderate impairment with decision making and was physically impaired. No documentation was made as to whether alternatives were trialled and the outcomes or why accessories were added to the bed rails. According to the assessor who completed the assessment, the accessories were added to the bed rails to prevent bed rail entrapment.

4. Resident #104 was observed in bed at the time of inspection, with accessories on both bed rails which were elevated. The bed was in a high position with falls intervention devices in place. According to the resident's PSW, the resident's bed mobility was unpredictable and limited. The PSW stated that the resident had the bed rails in place for safety reasons.

The resident's plan of care included the need to have both bed rails "upright" and accessories added for safety, with no specific details about the safety issues. The CPL confirmed that the "upright" position was the "transfer" position. The resident required full staff assistance and a mechanical lift for transfers and 1 to 2 staff assistance for bed mobility. No reason was provided for the accessories on the bed rails and no information was included in the plan about the resident's falls risk with the sole exception that the bed was to be kept in the lowest position. No information was included regarding the resident's specific bed mobility and if they were at any particular risk.

The resident's BRERA, completed in January 2018, included under Section A (related to risk factors for bed entrapment), that the resident had several risk factors that placed them at higher risk of bed related injury. One particular symptom that was included in the plan of care was not identified as a possible risk factor on the form. The summary or "risk for bed entrapment" section on the form included that the resident was at risk and that the resident would use bed rails for safety reasons. The form also included that accessories were added to the bed rails. No reason was given for the applied accessories. No risk over benefit analysis was included on the form. Under Section B, the resident was identified to be at risk for bed entrapment, and yet, bed rails were selected to remain on the bed and in use. The resident did not have a 72 hour sleep observation form completed.

The resident's PASD assessment, dated January 2018, included that the resident was physically impaired and at risk for falls due to cognitive impairment and impaired judgment, which placed them at risk for rolling out of bed. Two bed rails with attached accessories were selected for use as a positioning device. No documentation was made as to whether alternatives were trialled and the outcomes or why accessories were added to the bed rails. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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

Service Area Office / Bureau régional de services : Central West Service Area Office