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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2017	2017_539120_0056	010414-17	Follow up

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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): October 19, 2017

An inspection (2017-574586-0009) was previously conducted between April 26 and May 5, 2017, at which time non-compliance was identified related to the home's bed safety program. Subsequently, an Order was issued. For this follow up visit, not all of the conditions laid out in the Order were complied with and a second Order is being issued.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care, Staff Development Coordinator, Clinical Coordinator, Registered Nurse and maintenance person.

During the course of the inspection, the inspector toured the first and second floor home areas, observed resident bed systems, reviewed the home's bed system entrapment audit results, bed safety policies, procedures and associated forms and resident clinical records.

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)**
- **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 did not ensure that, where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the residents.

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 Guidance Document 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". These are the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006", and are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", includes a uniform set of basic recommendations for caregivers in long term care facilities to use when assessing their residents' need for and possible use of bed rails. Recommendations include but are not limited to the involvement of an interdisciplinary team in the assessment and approval of an individualized care plan for the resident; a risk-benefit assessment that identifies why other care interventions (alternatives to bed rail use) were not appropriate

or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; inspecting, evaluating, maintaining, and upgrading equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factors. In developing "the assessment", consideration to use or not use bed rails should be based on a comprehensive assessment and identification of the resident's needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Therefore, observation of residents in their bed systems, with and without bed rails, over a period of time is essential in being able to answer a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, suffocation, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer's directions), be tested for zones of entrapment (zones one through four which are specific areas around the bed rail and mattress) or have the entrapment zones mitigated, and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The population at risk for entrapment are residents who are elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The assessment guideline offers examples of key assessment questions that guides decision-making such as risk of falling, sleep habits, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns and other factors.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or

on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (when in bed, when in bed with staff assistance, all day), how many bed rails (one, two), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

During this inspection, the licensee's clinical assessments of residents using bed rails was compared to the assessment guidelines and determined to lack several key components as listed below;

A. The licensee’s bed safety related policy titled “Bedrails" (05-06-03B)”, dated May 2017, did not include any references to the above noted assessment guidelines and was missing several key assessment components. The Clinical Coordinator and Staff Development Coordinator, who were tasked at developing the home's clinical bed safety assessment process and subsequent staff education, reported that they used the assessment guidelines as a resource in developing their program along with other resources.

As part of their overall process in assessing the residents, the registered staff were directed by their policy to use a form titled "Bedrail Risk Assessment" (BRA) and the procedures included that all residents would be assessed on admission, quarterly, annually and as needed" and that a "risk assessment would be carried out before bed rails are used". No further direction was included in the policy, however the BRA included that the assessment must be done while the resident is in bed on the evening and night shifts over two consecutive days. It was not clear if this included with or without the bed rails in place as the first few questions on the BRA form included references to bed rails.

The policy did not include who the interdisciplinary team members would be in assessing each resident and what specific roles and responsibilities they had during the assessment. According to the Staff Development Coordinator, both the Physiotherapist and Personal Support Worker (PSW) were involved. The Physiotherapist completed a separate assessment indicating the resident's mobility and transfer status. PSWs were indirectly involved by conducting “safety checks” when residents were in bed. These checks were described as being a continuous routine check for all residents for situations such as a fall from bed, in bed or awake, restless, agitated, behaviours, strange

positioning in bed etc. The PSWs were required to verbally report to the Registered Nurse (RN) if any concerns were noted. The bed system policy did not include specifically what type of bed safety risks or hazards the PSWs should have monitored.

The policy did not include what alternatives were available for trial before deciding that bed rails were the ideal option. The alternatives would need to be tested to determine safety, effectiveness and comfort in addition to how long they would be trialled for, who would monitor the resident, when and how often, what specific safety hazards associated with the alternative would be monitored for and subsequently documented.

B. The BRA form was divided into five sections. The first section included only two risk related questions regarding bed rail use and the RN was to conclude whether a bed rail would be applied. These included if the resident was at risk of climbing over the bed rails or was confused or agitated. The third question was related to the risk of using the bed rails over the risk of falling out of bed. Under section two, the only risk related questions included whether the resident "was likely to roll, slip or slide from bed" and "if the resident understood the purpose of bed rails - consider communication difficulties". Section three had one question related to resident head size and stature and the rest of the questions, including those under section four, were related to bed functionality. These included how the mattress and bed rails fit onto the frame of the bed, any notable gaps and maintenance related issues and were not clinically related to the resident. The bed evaluation component was completed separately by the maintenance person in the home on August 4, 2017. Section five included one question related to whether the RN was making a decision to use bed rails and to explain why or why not. The number of questions on the form were inadequate to determine the risk over the benefits of applying one or more bed rails. Examples of questions to assist decision making around the hazards of bed rail use include but are not limited to sleeping habits (if the resident was restless, frequently exited the bed, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote, the residents' cognition status, involuntary body movements, behaviours that increased risk of falling from bed or a history of bed entrapment, suspension or injury.

The BRA form included one question under section two regarding alternatives, whether an alternative was considered. No documentation space was included to identify when the alternative was trialled, for how long and the outcome. No options were listed as to which alternative would replace the "hard" bed rails. According to the document "A

Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006", examples include perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters. The alternatives would need to be implemented and trialled for a period of time to determine if it met the resident's needs and the outcome documented. The BRA form did not include the option to document outcomes.

C. A random selection of residents were chosen for review, some who were observed in bed at the time of inspection. Although not all of these residents occupied their beds at the time of the observation, the residents either had a sign above their bed or a written plan of care identifying that PSWs were to apply bed rails. To confirm whether residents were assessed in accordance with prevailing practices, the following resident's records were reviewed;

1. Resident #100 was admitted to the home in mid 2015, and observed in bed on October 19, 2017. One quarter length bed rail was elevated on the resident's right side. The resident's written plan of care identified that the resident had impaired skin integrity and needed to be turned and repositioned every two hours, on medication to manage several health conditions, had responsive behaviours, was a high risk of falls and to ensure PASD (1 bed rail door side) was used when in bed to assist with positioning. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. No information was listed about their bed mobility. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff.

The BSA form completed on May 30, 2017, identified that the resident did not understand the use of the bed rails and that their use was not discussed with the Power of Attorney or resident. The assessment did not identify if the resident had any bed mobility issues, any medical conditions or was on any medications that would increase their risk while in bed with bed rails applied.The RN checked off the option "no" when asked if the decision was made to use the bed rails. They further wrote that "Quad rails on headboard are used as grab bars and to hold bed switch monitor". The RN, when interviewed, explained that when assessed, the resident was in a different bed system, with a dark brown frame and that they had half rails near the head board. No re-assessment was completed when the resident received a different bed system in June 2017. No alternatives to bed rail use was documented on the BRA form as there were no options to include this information. It was unclear if the risks identified in the care plan were factored into the RNs assessment of the resident and whether the bed rails were the most appropriate option for the

resident.

A list of residents using bed rails was acquired from the ADOC, dated September 27, 2017. The resident was not on the list.

2. Resident #101 was admitted to the home in early 2016, and a therapeutic mattress was implemented in November 2016, was observed in bed with both quarter length bed rails elevated. The resident's written plan of care identified that the resident had impaired skin integrity and needed staff to turn and reposition them every two hours, an identified physical limitation, required two persons to transfer using a mechanical lift, was a moderate risk of falls, on medications to manage a health condition and to apply two bed rails up for repositioning when in bed. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. No information was available about their bed mobility. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff. The type of bed rail was not specified.

The BRA form completed on May 24, 2017, included that the resident requested the use of two bed rails for turning and repositioning and was not identified to have any cognitive issues. No information was included on the BRA regarding the various conditions listed on the written plan of care linked to an increased risk of bed safety hazards. No alternatives to the bed rails were documented as trialled. It was unclear if the risks identified in the care plan were factored into the RNs assessment of the resident and whether the bed rails were the most appropriate option for the resident. Based on the discussion with the RN, if residents were already using bed rails before the assessment was first implemented, then the bed rails were left on the bed and no alternatives were trialled.

The resident was not listed on the home's list of resident's using a bed rail dated September 27, 2017.

3. Resident #103 was admitted to the home in mid 2016, and was observed in bed on October 19, 2017, with both quarter length bed rails elevated. The resident's written plan of care identified that the resident was a moderate risk of falls, had skin integrity issues and required repositioning every two hours to relieve pressure and reduce risk for skin breakdown and to remind/assist resident to turn and reposition when in bed, that a PASD (1 bed rail) was to be used when in bed to assist with positioning, and that the resident could self transfer and to leave one bed rail up at all times. No information was available

regarding the resident's bed mobility. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff. The type of bed rail or the side for placement was not specified.

The BRA form completed on May 23, 2017, included the answer "no" when asked if the decision was made to use the bed rails, "no" to the question if the resident understood the purpose of the bed rails and "no" to the question if the decision to use the bed rails was discussed with the Power of Attorney. The RN further documented that "half rails on headboard are used as grab bars for getting up, turning and positioning during care, to hold bed switch monitor". The RN, when interviewed, explained that when assessed, the resident was in a different bed system, with a dark brown frame and that they had half rails near the head board. No re-assessment was completed when the resident received a different bed system in June 2017. No alternatives to bed rail use was documented on the BRA form as there were no options to include this information. It was unclear if the risks identified in the care plan were factored into the RNs assessment of the resident and whether the bed rails were the most appropriate option for the resident.

The resident was listed on the home's list of resident's using a bed rail dated September 27, 2017, however the resident was listed as requiring one bed rail, not two as was observed.

4. Resident #104 was admitted to the home in early 2014, and was not in bed on October 19, 2017. One quarter length bed rail was elevated on the left side of the bed. The resident's written plan of care identified that the resident was a moderate risk of falls, had skin integrity issues, was on medications with mind altering side effects, had a history that included involuntary body movements, communication difficulties, cognitive deficits, required two staff to transfer them with a mechanical lift, required repositioning every two hours and required two bed rails up at all times when in bed to assist with positioning. No information was available regarding resident's bed mobility. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff. The type of bed rail was not specified.

The BRA form completed on May 25, 2017, identified that the resident did not understand the use of the bed rails and that their use was not discussed with the Power of Attorney or resident. The RN checked off the option "no" when asked if the decision was made to use the bed rails. They further documented that "Half rails on headboard

positioning during care and to store bed switch monitor". The RN explained that when assessed, the resident was in a different bed system, with a dark brown frame and that they had half rails near the head board. The assessment did not identify if the resident had any bed mobility issues, any medical conditions or was on any medications that would increase their risk while in bed with bed rails applied. No re-assessment was completed when the resident received a different bed system in June 2017. No alternatives to bed rail use was documented on the BRA form as there were no options to include this information.

5. Resident #106 was admitted to the home in late 2016, and was observed in bed on October 19, 2017, with both quarter length bed rails elevated. The resident's written plan of care identified that the resident was a high risk of falls, was on medications for several health conditions, confused with declining cognitive status, required to be repositioned every two hours and that one bed rail was used when in bed to assist with positioning. No information was available regarding the resident's bed mobility. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. The type of bed rail and the side for placement was not specified.

The BRA form completed on May 23, 2017, identified that the resident did not understand the use of the bed rails and the RN checked off the option "no" when asked if the decision was made to use the bed rails and documented that the resident did not use bed rails.

The resident was listed on the home's list of resident's using a bed rail dated September 27, 2017, and was documented as requiring one bed rail.

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. [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 10th day of November, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0056
Log No. / No de registre :	010414-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 6, 2017
Licensee / Titulaire de permis :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rosemary Okimi

To HERITAGE GREEN NURSING HOME, 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_574586_0009, CO #002;

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. Amend the home's existing "Bed Risk Assessment" form and process related to resident clinical assessments and the use of bed rails to include additional 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. The amended form and or process shall, at a minimum, include questions related to the following;

a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility status, medical condition, medication use, behaviours and other relevant risk factors prior to the application of any bed rail or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards); and
b. the observation of the resident while sleeping for a specific period of time, to establish any safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and

c. the alternative or alternatives that were trialled prior to applying one or more bed rails and document whether the alternative was effective or not during a specified 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. 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. The written plan of care shall include at a minimum information about the resident's ability to independently use the bed rail(s) or whether staff supervision is required, why bed rails are being used or applied, how many, on what side of the bed, bed rail type or size and when they are to be applied (when in bed, at all times, when care provided etc).

4. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the SDM and licensee with respect to resident assessments and any other relevant information regarding bed safety. The information shall be disseminated to relevant staff, families and residents and/or SDM.

5. Amend the policy titled "Bed Rails" 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 "A Guide for Modifying Bed Systems and Using Accessories to Reduce Entrapment, (U.S. F.D.A, June 2006)". At a minimum the policy shall include links to the above noted guidelines and;

a) additional details of the process of assessing residents upon admission, after

admission and when a change in the resident's condition has been identified and when a change to the bed system has been made to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories 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 interdisciplinary 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) what specific options are available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks; and
d) the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs; and
e) who the interdisciplinary team members are in assessing each resident and their specific roles and responsibilities with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote control) and associated safety hazards, and;
f) what alternatives are available for trial before deciding that bed rails are the ideal option, how they will be tested to determine safety, effectiveness and comfort in addition to; how long they would be trialled for, who would monitor the resident, when and how often and what specific safety hazards associated with the alternative would be monitored for; and
g) links to references used to develop the policy

6. Provide face to face training to all relevant staff (PSWs, registered staff, OT/PT) who are affiliated with residents and/or their bed systems with respect to the home's amended bed safety assessment policies and procedures and associated forms.

Grounds / Motifs :

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

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

Guidance Document 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". These are the “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and “A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006”, and are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003”, includes a uniform set of basic recommendations for caregivers in long term care facilities to use when assessing their residents’ need for and possible use of bed rails. Recommendations include but are not limited to the involvement of an interdisciplinary team in the assessment and approval of an individualized care plan for the resident; a risk-benefit assessment that identifies why other care interventions (alternatives to bed rail use) were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; inspecting, evaluating, maintaining, and upgrading equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factors. In developing “the assessment”, consideration to use or not use bed rails should be based on a comprehensive assessment and identification of the resident’s needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Therefore, observation of residents in their bed systems, with and without bed rails, over a period of time is essential in being able to answer a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, suffocation, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer’s directions), be tested for zones of entrapment (zones one through four which are specific areas around the bed rail and mattress) or have the entrapment zones mitigated, and the resident must be clinically assessed to

determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The population at risk for entrapment are residents who are elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The assessment guideline offers examples of key assessment questions that guides decision-making such as risk of falling, sleep habits, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns and other factors.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (when in bed, when in bed with staff assistance, all day), how many bed rails (one, two), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

During this inspection, the licensee's clinical assessments of residents using bed rails was compared to the assessment guidelines and determined to lack several key components as listed below;

A. The licensee's bed safety related policy titled "Bedrails" (05-06-03B)", dated May 2017, did not include any references to the above noted assessment guidelines and was missing several key assessment components. The Clinical Coordinator and Staff Development Coordinator, who were tasked at developing the home's clinical bed safety assessment process and subsequent staff

education, reported that they used the assessment guidelines as a resource in developing their program along with other resources.

As part of their overall process in assessing the residents, the registered staff were directed by their policy to use a form titled "Bedrail Risk Assessment" (BRA) and the procedures included that all residents would be assessed on admission, quarterly, annually and as needed" and that a "risk assessment would be carried out before bed rails are used". No further direction was included in the policy, however the BRA included that the assessment must be done while the resident is in bed on the evening and night shifts over two consecutive days. It was not clear if this included with or without the bed rails in place as the first few questions on the BRA form included references to bed rails.

The policy did not include who the interdisciplinary team members would be in assessing each resident and what specific roles and responsibilities they had during the assessment. According to the Staff Development Coordinator, both the Physiotherapist and Personal Support Worker (PSW) were involved. The Physiotherapist completed a separate assessment indicating the resident's mobility and transfer status. PSWs were indirectly involved by conducting "safety checks" when residents were in bed. These checks were described as being a continuous routine check for all residents for situations such as a fall from bed, in bed or awake, restless, agitated, behaviours, strange positioning in bed etc. The PSWs were required to verbally report to the Registered Nurse (RN) if any concerns were noted. The bed system policy did not include specifically what type of bed safety risks or hazards the PSWs should have monitored.

The policy did not include what alternatives were available for trial before deciding that bed rails were the ideal option. The alternatives would need to be tested to determine safety, effectiveness and comfort in addition to how long they would be trialled for, who would monitor the resident, when and how often, what specific safety hazards associated with the alternative would be monitored for and subsequently documented.

B. The BRA form was divided into five sections. The first section included only two risk related questions regarding bed rail use and the RN was to conclude whether a bed rail would be applied. These included if the resident was at risk of climbing over the bed rails or was confused or agitated. The third question

was related to the risk of using the bed rails over the risk of falling out of bed. Under section two, the only risk related questions included whether the resident "was likely to roll, slip or slide from bed" and "if the resident understood the purpose of bed rails - consider communication difficulties". Section three had one question related to resident head size and stature and the rest of the questions, including those under section four, were related to bed functionality. These included how the mattress and bed rails fit onto the frame of the bed, any notable gaps and maintenance related issues and were not clinically related to the resident. The bed evaluation component was completed separately by the maintenance person in the home on August 4, 2017. Section five included one question related to whether the RN was making a decision to use bed rails and to explain why or why not. The number of questions on the form were inadequate to determine the risk over the benefits of applying one or more bed rails. Examples of questions to assist decision making around the hazards of bed rail use include but are not limited to sleeping habits (if the resident was restless, frequently exited the bed, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote, the residents' cognition status, involuntary body movements, behaviours that increased risk of falling from bed or a history of bed entrapment, suspension or injury.

The BRA form included one question under section two regarding alternatives, whether an alternative was considered. No documentation space was included to identify when the alternative was trialled, for how long and the outcome. No options were listed as to which alternative would replace the "hard" bed rails. According to the document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006", examples include perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters. The alternatives would need to be implemented and trialled for a period of time to determine if it met the resident's needs and the outcome documented. The BRA form did not include the option to document outcomes.

C. A random selection of residents were chosen for review, some who were observed in bed at the time of inspection. Although not all of these residents occupied their beds at the time of the observation, the residents either had a sign above their bed or a written plan of care identifying that PSWs were to

apply bed rails. To confirm whether residents were assessed in accordance with prevailing practices, the following resident's records were reviewed;

1. Resident #100 was admitted to the home in mid 2015, and observed in bed on October 19, 2017. One quarter length bed rail was elevated on the resident's right side. The resident's written plan of care identified that the resident had impaired skin integrity and needed to be turned and repositioned every two hours, on medication to manage several health conditions, had responsive behaviours, was a high risk of falls and to ensure PASD (1 bed rail door side) was used when in bed to assist with positioning. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. No information was listed about their bed mobility. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff.

The BSA form completed on May 30, 2017, identified that the resident did not understand the use of the bed rails and that their use was not discussed with the Power of Attorney or resident. The assessment did not identify if the resident had any bed mobility issues, any medical conditions or was on any medications that would increase their risk while in bed with bed rails applied.The RN checked off the option "no" when asked if the decision was made to use the bed rails. They further wrote that "Quad rails on headboard are used as grab bars and to hold bed switch monitor". The RN, when interviewed, explained that when assessed, the resident was in a different bed system, with a dark brown frame and that they had half rails near the head board. No re-assessment was completed when the resident received a different bed system in June 2017. No alternatives to bed rail use was documented on the BRA form as there were no options to include this information. It was unclear if the risks identified in the care plan were factored into the RNs assessment of the resident and whether the bed rails were the most appropriate option for the resident.

A list of residents using bed rails was acquired from the ADOC, dated September 27, 2017. The resident was not on the list.

2. Resident #101 was admitted to the home in early 2016, and a therapeutic mattress was implemented in November 2016, was observed in bed with both quarter length bed rails elevated. The resident's written plan of care identified that the resident had impaired skin integrity and needed staff to turn and reposition them every two hours, an identified physical limitation, required two

persons to transfer using a mechanical lift, was a moderate risk of falls, on medications to manage a health condition and to apply two bed rails up for repositioning when in bed. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. No information was available about their bed mobility. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff. The type of bed rail was not specified.

The BRA form completed on May 24, 2017, included that the resident requested the use of two bed rails for turning and repositioning and was not identified to have any cognitive issues. No information was included on the BRA regarding the various conditions listed on the written plan of care linked to an increased risk of bed safety hazards. No alternatives to the bed rails were documented as trialled. It was unclear if the risks identified in the care plan were factored into the RNs assessment of the resident and whether the bed rails were the most appropriate option for the resident. Based on the discussion with the RN, if residents were already using bed rails before the assessment was first implemented, then the bed rails were left on the bed and no alternatives were trialled.

The resident was not listed on the home's list of resident's using a bed rail dated September 27, 2017.

3. Resident #103 was admitted to the home in mid 2016, and was observed in bed on October 19, 2017, with both quarter length bed rails elevated. The resident's written plan of care identified that the resident was a moderate risk of falls, had skin integrity issues and required repositioning every two hours to relieve pressure and reduce risk for skin breakdown and to remind/assist resident to turn and reposition when in bed, that a PASD (1 bed rail) was to be used when in bed to assist with positioning, and that the resident could self transfer and to leave one bed rail up at all times. No information was available regarding the resident's bed mobility. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff. The type of bed rail or the side for placement was not specified.

The BRA form completed on May 23, 2017, included the answer "no" when asked if the decision was made to use the bed rails, "no" to the question if the

resident understood the purpose of the bed rails and "no" to the question if the decision to use the bed rails was discussed with the Power of Attorney. The RN further documented that "half rails on headboard are used as grab bars for getting up, turning and positioning during care, to hold bed switch monitor". The RN, when interviewed, explained that when assessed, the resident was in a different bed system, with a dark brown frame and that they had half rails near the head board. No re-assessment was completed when the resident received a different bed system in June 2017. No alternatives to bed rail use was documented on the BRA form as there were no options to include this information. It was unclear if the risks identified in the care plan were factored into the RNs assessment of the resident and whether the bed rails were the most appropriate option for the resident.

The resident was listed on the home's list of resident's using a bed rail dated September 27, 2017, however the resident was listed as requiring one bed rail, not two as was observed.

4. Resident #104 was admitted to the home in early 2014, and was not in bed on October 19, 2017. One quarter length bed rail was elevated on the left side of the bed. The resident's written plan of care identified that the resident was a moderate risk of falls, had skin integrity issues, was on medications with mind altering side effects, had a history that included involuntary body movements, communication difficulties, cognitive deficits, required two staff to transfer them with a mechanical lift, required repositioning every two hours and required two bed rails up at all times when in bed to assist with positioning. No information was available regarding resident's bed mobility. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. Based on the information regarding skin integrity, it appeared that the resident was being repositioned by staff. The type of bed rail was not specified.

The BRA form completed on May 25, 2017, identified that the resident did not understand the use of the bed rails and that their use was not discussed with the Power of Attorney or resident. The RN checked off the option "no" when asked if the decision was made to use the bed rails. They further documented that "Half rails on headboard are used for positioning during care and to store bed switch monitor". The RN explained that when assessed, the resident was in a different bed system, with a dark brown frame and that they had half rails near the head board. The assessment did not identify if the resident had any bed mobility issues, any medical conditions or was on any medications that would increase

their risk while in bed with bed rails applied. No re-assessment was completed when the resident received a different bed system in June 2017. No alternatives to bed rail use was documented on the BRA form as there were no options to include this information.

5. Resident #106 was admitted to the home in late 2016, and was observed in bed on October 19, 2017, with both quarter length bed rails elevated. The resident's written plan of care identified that the resident was a high risk of falls, was on medications for several health conditions, confused with declining cognitive status, required to be repositioned every two hours and that one bed rail was used when in bed to assist with positioning. No information was available regarding the resident's bed mobility. It was unclear if the resident was independent to use the bed rails themselves, or needed assistance with their use. The type of bed rail and the side for placement was not specified.

The BRA form completed on May 23, 2017, identified that the resident did not understand the use of the bed rails and the RN checked off the option "no" when asked if the decision was made to use the bed rails and documented that the resident did not use bed rails.

The resident was listed on the home's list of resident's using a bed rail dated September 27, 2017, and was documented as requiring one bed rail.

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.

This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. In respect to severity, there is potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is widespread (3) and previous non-compliance related to bed rail use was issued under the same section (4) on May 30, 2017 (CO), January 28, 2016 (CO) and October 1, 2014 (VPC).

(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 6th day of November, 2017

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 : Hamilton Service Area Office