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
Sep 1, 2017	2017_539120_0051	007638-17	Follow up

Licensee/Titulaire de permis

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

Ontario

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 25, 2017

An inspection (2017-57610a-0006) was previously conducted March 13-22, 2017, at which time non-compliance was identified related to clinical bed safety assessments of residents who used one or more bed rails. Several of the conditions that were laid out in the order were not complied with and are being re-issued. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nursing Manager and Personal Support Workers.

During the course of the inspection, the inspector toured five out of six home areas, observed resident bed systems, resident clinical records, bed safety assessments, staff training materials and bed safety policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An inspection (2017-57610a-0006) was previously conducted March 13-22, 2017, and non-compliance was identified with this section related to resident clinical assessments where residents used one or more bed rails. An order with multiple conditions was issued on April 12, 2017, for a compliance date of July 15, 2017. The order included requirements to (1) review and revise the home's bed rail assessment form, (2) assess residents as an interdisciplinary team and document the results, (3) update the written plan of care for each resident after a re-assessment was completed (4) obtain or develop an education and information package about bed safety hazards for families, residents and staff (5) ensure all of the bed rail policies and procedures include the information found in the guidance document noted below.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering 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, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as

per manufacturer's directions), pass all zones of entrapment (specific areas that are measured around the bed rail and mattress and the bed rail itself), 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 assessment guideline offers examples of key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, 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, environmental factors and the entrapment status of the resident's bed.

The guidance document 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 (at night only, when requested by resident or with staff assistance), how many bed rails (one, two or four), 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 follow-up inspection, confirmation was made that all residents who used one or more bed rails were re-assessed using the licensee's amended "Bedrail Risk Assessment" (BRA) form. Eight residents (#100-107) were randomly selected to review the results of the assessments. The assessments lacked a conclusive risk over benefit component, the results of a sleep observation period with and without bed rails and adequate documentation related to alternatives trialled. It was difficult to determine at the end of the assessment if the resident was a high or low risk of bed related injury or entrapment based on the selected answers on the form and whether they needed any particular interventions to mitigate possible risks. In some cases, certain sections of the form were blank, and it was not known if the answers did not apply to the resident or the RN forgot to complete the section.

A. The licensee's bed safety related policy RC -05-06-19 titled "Resident Bedrail Risk

Assessment and Use" dated May 1, 2017, did not include any reference to the clinical guidance document for source of information or further reading. The policy did not include the role for the care giver or personal support worker (PSW) in providing essential information to the Registered Nurse (RN) about resident risks of bed rail use, night time habits, behaviours, bed mobility and sleep patterns. No information was included as to how resident safety would be assessed while in bed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time residents would be monitored with or without bed rails, what available alternatives needed to be trialled before deciding that bed rails are an ideal option and for how long, who would monitor residents during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically team members would participate in assisting the RN in making a final decision about the benefits versus the risks of the resident's bed rail.

The Bedrail risk policy directed the RN to use the BRA form which included some relevant questions to assist decision making around the hazards of bed rail use such as use of medications, bed rail injuries (banging into or against the rail), sleeping habits (if the resident was restless, frequently exited the bed, was in pain), bed mobility and transfer abilities, if at risk of climbing over the bed rails, falls from bed, if body parts went through the bed rail, and if the resident was aware of safety issues associated with getting up from bed. It did not include if the resident had involuntary body movements (from seizures, Cerebral Palsy, Parkinson's disease, etc.), communication deficits, understood the purpose of the bed rail or knew how to apply it independently and if the resident knew how to use other bed related accessories or components. Residents with cognition deficits and a health condition with involuntary body movements are at higher risk of bed related injuries and entrapment.

B. The Bedrail policy was confusing regarding how to receive and document consent for bed rail use. The policy included a statement that "if a resident requires more than an assist bed rail, it must be discussed with the Director of Nursing and that consent by a resident or SDM is required". Based on this statement, it would appear that if a resident had only this type of bed rail, and only one bed rail, consent was not required. No information was included if consent was to be in writing, verbal or how it would be documented. The staff training materials (Slides - Safe Use of Bed Rails) provided included the need to obtain consent for all bed rail use. The Nurse Manager reported that consent is obtained in writing and documented in the resident's written plan of care. Residents #100-104 and #107 who were assessed to use one or more bed rails included a consent note in their plan of care.

C. The Bedrail policy did not include how residents and their substitute decision makers would be involved in deciding how or when bed rails would be used, exactly what risks or benefits would be shared about bed rail use and how the information would be provided (verbal or in writing). No written information regarding the hazards of bed rails and the regulations governing their use in Ontario was made available to any family member or resident. According to the Nurse Manager, the information was shared verbally, just prior to getting consent for bed rail use.

D. The BRA form included an alternatives section for completion by the RN, however the options on the form included interventions such as bed alarm, fall prevention mat, hi low bed, scheduled toileting, increased monitoring and decreased time in bed. The interventions listed are options that can be implemented with or without bed rails in place. No bed rail alternatives were listed such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters. When discussed with the Director of Care and Nurse Manager, about availability in the home of these alternatives, positioning pillows or body pillow and raised perimeter mattresses were used, but wedges or bolsters had not been trialled. Seven of the residents were admitted to the home prior to September 30, 2016, and were re-assessed using the BRA form. All but one resident, who did not use bed rails, had any alternatives offered to replace the bed rails as they all used them in the past and were used to them.

E. The BRA form, which was required to be used upon admission (or with any change in status), was not designed to document what bed related risks were monitored for after admission. The form was not designed to include input from PSWs, who would need to be included in observing the residents while in bed, for a period of time. The form did not include the names of any staff member who participated in the assessment other than the registered staff member. According to the Nurse Manager, who assisted RNs in completing the assessments using the BRA form, an interdisciplinary team approach was taken by including PSWs in providing information about the resident. PSWs provided information about the residents' abilities to reposition themselves in bed and their overall activities of daily living (sleeping, eating, dressing, toileting, pain, falls, communication etc.). If a risk related issue was identified, the RN would be informed and the concern documented in the resident's clinical record. The safety checks were described as being a basic check, to determine if the resident was in bed, sleeping or awake, and not in any distress. Safety checks were described of being a continuous routine of all staff for all residents, however it was not well established if all of the PSWs were aware of specific bed related hazards as they did not have any written references to refer to.

F. During the tour of five out of the six home areas, observations were made that some home areas had more bed rails applied than others when beds were unoccupied. In two specified home areas, a minimum of 12 unoccupied beds were observed with rotating assist bed rails in the guard position or quarter and three quarter length bed rails elevated. One PSW explained that it was a habit, of leaving the bed rails in place while making the beds. The plan of care for some of these residents was reviewed and it was not clear when the bed rails were to be applied, as the plans failed to specify if bed rails were to be used only when in bed, when supervised or with resident discretion. In two cases, residents # 105 and #106 were observed lying in bed, both with a three quarter bed rail applied on one side, but did not have a BRA form or written plan of care requiring them to have any bed rails applied. Therefore, staff did not follow the plan of care for these two residents.

G. Resident BRA assessments #100, 101, 102, 103 and 104 all had incorrect bed rail size selected by the RN. Three had three-quarter length bed rails, but were documented to have either a half bed rail or full length bed rail. Two had quarter length bed rails but were documented to have half bed rails. According to the Nurse Manager, the half bed rails referred to the bed rails that are known as "rotating assist rails" which can be rotated into three different positions. The terminology of the types and sizes of bed rails in the home were not included in any policy or training materials.

H. Residents #100 and #107 were both assessed to require one or more bed rails for mobility/comfort/security. Not enough information was available on the BRA form to determine their bed mobility status or other risk factors. For both residents, the "Functional" section on the BRA was not completed as to their mobility status. Both residents were identified to require extensive assistance by staff for bed mobility on their care plans. Both residents were on medications and resident #100 had a specified medical condition. Neither of these factors were listed on the BRA form. If both residents required extensive assistance with bed mobility, it is unlikely that they would benefit from having a bed rail in place for mobility reasons. It is unknown if either resident required the bed rails for comfort or security, as it was not identified on the BRA form. The reason for applying the bed rails was not specific, but rather several reasons were listed in one commonly used statement. The same conclusion or statement was listed on the plan of care for four other residents.

The conclusions on the BRA forms for six of the above noted residents who were assessed to require one or more bed rails 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".

Issued on this 27th day of September, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0051
Log No. / No de registre :	007638-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 1, 2017
Licensee / Titulaire de permis :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maureen Goodram

To IDLEWYLD MANOR, 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_57610a_0006, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing "Bedrail Risk Assessment" form related to resident clinical assessments and the use of bed rails to include additional relevant questions and guidance related to bed safety hazards related to:

a. the resident while sleeping for a specified period of time in their bed system with one or more bed rails applied, that establishes their ability to understand and independently use their bed rail(s) or any other accessory or bed component that has been deemed necessary; and
b. whether the resident had involuntary body movements, communication deficits, sleep related disorders, or was being managed for pain; and
c. the resident's overall risk for injury, suspension or entrapment; and
d. whether the alternatives and/or interventions that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during a specified observation period.

2. Update the "Bedrail Risk Assessment" form and written plan of care for all residents who use one or more bed rails and include when bed rail(s) are to be

applied, why, the appropriate size, type, number and side the bed rail(s) are to be applied and if any accessory is to be attached or included with the bed rail(s).

3. 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 facts or myths associated with bed systems and the use of bed rails. The information shall be disseminated to relevant staff, families and residents (if resident is their own POA).

4. Amend the current "Resident Bedrail Risk Assessment and Use" policy 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 at a minimum the policy shall include;

a) details of the process of assessing residents upon admission and when a change in the resident's condition has been identified 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 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 that are available for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
d) how consent from the resident or Substitute Decision Maker (SDM) would be acquired and documented when one or more bed rails have been consented to; and
e) what information will be shared with the SDM or resident prior to the application of the bed rails; and
f) what interventions are available to mitigate any identified bed safety entrapment or injury risks should a resident benefit more from the use of one or more bed rail(s)(i.e. wedges, bolsters, bed rail pads) vs the risk; and
g) the role of the SDM and resident in selecting the appropriate device for bed mobility and transfers; and

h) 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.

Grounds / Motifs :

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.

An inspection (2017-57610a-0006) was previously conducted March 13-22, 2017, and non-compliance was identified with this section related to resident clinical assessments where residents used one or more bed rails. An order with multiple conditions was issued on April 12, 2017, for a compliance date of July 15, 2017. The order included requirements to (1) review and revise the home's bed rail assessment form, (2) assess residents as an interdisciplinary team and document the results, (3) update the written plan of care for each resident after a re-assessment was completed (4) obtain or develop an education and information package about bed safety hazards for families, residents and staff (5) ensure all of the bed rail policies and procedures include the information found in the guidance document noted below.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering 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, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer's directions), pass all zones of entrapment (specific areas that are measured around the bed rail and mattress and the bed rail itself), 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 assessment guideline offers examples of key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, 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, environmental factors and the entrapment status of the resident's bed.

The guidance document 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 (at night only, when requested by resident or with staff assistance), how many bed rails (one, two or four), 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 follow-up inspection, confirmation was made that all residents who used one or more bed rails were re-assessed using the licensee's amended "Bedrail Risk Assessment" (BRA) form. Eight residents (#100-107) were randomly selected to review the results of the assessments. The assessments lacked a conclusive risk over benefit component, the results of a sleep observation period with and without bed rails and adequate documentation related to alternatives trialled. It was difficult to determine at the end of the assessment if the resident was a high or low risk of bed related injury or entrapment based on the selected answers on the form and whether they needed any particular interventions to mitigate possible risks. In some cases, certain sections of the form were blank, and it was not known if the answers did not apply to the resident or the RN forgot to complete the section.

A. The licensee's bed safety related policy RC -05-06-19 titled "Resident Bedrail Risk Assessment and Use" dated May 1, 2017, did not include any reference to the clinical guidance document for source of information or further reading. The policy did not include the role for the care giver or personal support worker (PSW) in providing essential information to the Registered Nurse (RN) about

resident risks of bed rail use, night time habits, behaviours, bed mobility and sleep patterns. No information was included as to how resident safety would be assessed while in bed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time residents would be monitored with or without bed rails, what available alternatives needed to be trialled before deciding that bed rails are an ideal option and for how long, who would monitor residents during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically team members would participate in assisting the RN in making a final decision about the benefits versus the risks of the resident's bed rail.

The Bedrail risk policy directed the RN to use the BRA form which included some relevant questions to assist decision making around the hazards of bed rail use such as use of medications, bed rail injuries (banging into or against the rail), sleeping habits (if the resident was restless, frequently exited the bed, was in pain), bed mobility and transfer abilities, if at risk of climbing over the bed rails, falls from bed, if body parts went through the bed rail, and if the resident was aware of safety issues associated with getting up from bed. It did not include if the resident had involuntary body movements (from seizures, Cerebral Palsy, Parkinson's disease, etc.), communication deficits, understood the purpose of the bed rail or knew how to apply it independently and if the resident knew how to use other bed related accessories or components. Residents with cognition deficits and a health condition with involuntary body movements are at higher risk of bed related injuries and entrapment.

B. The Bedrail policy was confusing regarding how to receive and document consent for bed rail use. The policy included a statement that "if a resident requires more than an assist bed rail, it must be discussed with the Director of Nursing and that consent by a resident or SDM is required". Based on this statement, it would appear that if a resident had only this type of bed rail, and only one bed rail, consent was not required. No information was included if consent was to be in writing, verbal or how it would be documented. The staff training materials (Slides - Safe Use of Bed Rails) provided included the need to obtain consent for all bed rail use. The Nurse Manager reported that consent is obtained in writing and documented in the resident's written plan of care. Residents #100-104 and #107 who were assessed to use one or more bed rails included a consent note in their plan of care.

C. The Bedrail policy did not include how residents and their substitute decision makers would be involved in deciding how or when bed rails would be used, exactly what risks or benefits would be shared about bed rail use and how the information would be provided (verbal or in writing). No written information regarding the hazards of bed rails and the regulations governing their use in Ontario was made available to any family member or resident. According to the Nurse Manager, the information was shared verbally, just prior to getting consent for bed rail use.

D. The BRA form included an alternatives section for completion by the RN, however the options on the form included interventions such as bed alarm, fall prevention mat, hi low bed, scheduled toileting, increased monitoring and decreased time in bed. The interventions listed are options that can be implemented with or without bed rails in place. No bed rail alternatives were listed such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters. When discussed with the Director of Care and Nurse Manager, about availability in the home of these alternatives, positioning pillows or body pillow and raised perimeter mattresses were used, but wedges or bolsters had not been trialled. Seven of the residents were admitted to the home prior to September 30, 2016, and were re-assessed using the BRA form. All but one resident, who did not use bed rails, had any alternatives offered to replace the bed rails as they all used them in the past and were used to them.

E. The BRA form, which was required to be used upon admission (or with any change in status), was not designed to document what bed related risks were monitored for after admission. The form was not designed to include input from PSWs, who would need to be included in observing the residents while in bed, for a period of time. The form did not include the names of any staff member who participated in the assessment other than the registered staff member. According to the Nurse Manager, who assisted RNs in completing the assessments using the BRA form, an interdisciplinary team approach was taken by including PSWs in providing information about the resident. PSWs provided information about the residents' abilities to reposition themselves in bed and their overall activities of daily living (sleeping, eating, dressing, toileting, pain, falls, communication etc.). If a risk related issue was identified, the RN would be informed and the concern documented in the resident's clinical record. The safety checks were described as being a basic check, to determine if the resident was in bed, sleeping or awake, and not in any distress. Safety checks

were described of being a continuous routine of all staff for all residents, however it was not well established if all of the PSWs were aware of specific bed related hazards as they did not have any written references to refer to.

F. During the tour of five out of the six home areas, observations were made that some home areas had more bed rails applied than others when beds were unoccupied. In two specified home areas, a minimum of 12 unoccupied beds were observed with rotating assist bed rails in the guard position or quarter and three quarter length bed rails elevated. One PSW explained that it was a habit, of leaving the bed rails in place while making the beds. The plan of care for some of these residents was reviewed and it was not clear when the bed rails were to be applied, as the plans failed to specify if bed rails were to be used only when in bed, when supervised or with resident discretion. In two cases, residents # 105 and #106 were observed lying in bed, both with a three quarter bed rail applied on one side, but did not have a BRA form or written plan of care requiring them to have any bed rails applied. Therefore, staff did not follow the plan of care for these two residents.

G. Resident BRA assessments #100, 101, 102, 103 and 104 all had incorrect bed rail size selected by the RN. Three had three-quarter length bed rails, but were documented to have either a half bed rail or full length bed rail. Two had quarter length bed rails but were documented to have half bed rails. According to the Nurse Manager, the half bed rails referred to the bed rails that are known as "rotating assist rails" which can be rotated into three different positions. The terminology of the types and sizes of bed rails in the home were not included in any policy or training materials.

H. Residents #100 and #107 were both assessed to require one or more bed rails for mobility/comfort/security. Not enough information was available on the BRA form to determine their bed mobility status or other risk factors. For both residents, the "Functional" section on the BRA was not completed as to their mobility status. Both residents were identified to require extensive assistance by staff for bed mobility on their care plans. Both residents were on medications and resident #100 had a specified medical condition. Neither of these factors were listed on the BRA form. If both residents required extensive assistance with bed mobility, it is unlikely that they would benefit from having a bed rail in place for mobility reasons. It is unknown if either resident required the bed rails for comfort or security, as it was not identified on the BRA form. The reason for applying the bed rails was not specific, but rather several reasons were listed in

one commonly used statement. The same conclusion or statement was listed on the plan of care for four other residents.

The conclusions on the BRA forms for six of the above noted residents who were assessed to require one or more bed rails 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. The severity is 2 (potential for actual harm/risk), the scope is 3 (the number of residents who have not been adequately assessed is widespread) and the compliance history is 4 (on-going non-compliance with a previous compliance order issued April 12, 2017). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, 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 1st day of September, 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