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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 22, 2016	2016_189120_0014	028506-15	Follow up

Licensee/Titulaire de permis

KING NURSING HOME LIMITED
49 Sterne Street Bolton ON L7E 1B9

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

KING NURSING HOME
49 Sterne Street Bolton ON L7E 1B9

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): March 16, 2016

An inspection (2015-189120-0064) was previously conducted on July 30, 2015 and non-compliance (Order #001) was issued on August 17, 2015 related to bed safety. For this follow-up inspection, the majority of the conditions laid out in the order were complied with. The remaining non compliant issue is administrative in nature and was issued separately in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Administrator, Registered Nurse and RAI/MDS Co-ordinator.

During the course of the inspection, the inspector toured the home and randomly selected residents who were both in and out of bed and had bed rails in apparent use, reviewed the home's bed safety entrapment audit, resident written plans of care and any clinical documentation completed regarding resident bed rail use.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_189120_0064	120

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 resident.

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 evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their SDM (Substitute Decision Maker) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as

identified in the above guideline. According to the Director of Care (DOC), the guideline was not incorporated into the form they had previously used titled "Restraint/PASD Assessment". The reason given was that the assessment (in electronic format and part of a software program) was not originally developed by the home staff and they could not make changes to it. A condition laid out in the previous Order #001 issued on August 17, 2015 required that the clinical bed rail use assessment form be developed using the information identified in the above noted guideline related to bed rail use safety. The only available assessment used by registered staff to conduct the resident bed rail safety assessments was the Restraint/PASD assessment and it did not include any of the questions geared towards assessing safety issues such as potential rail injuries (banging into or against the rail), sleeping habits (if next to a rail and along edge of bed), strangulation, suffocation, accidental suspension off the side of the bed or tendency to climb over the rails. The DOC reported that they were in the process of developing a separate "home specific" questionnaire and had become familiar with the above noted guideline.

According to the DOC, an interdisciplinary team was involved in assessing each resident for rail use and did in fact consider bed rail use safety issues but that those decisions were not documented. The documentation that was kept included the resident's mobility and transfer capabilities and risk factors related to falling from the bed, medication use, balance, involuntary body movements, skin integrity and potential risk of injury to self or others but did not include specific safety risks of rail use.

B) During a tour of the home on all 3 floors, observations were made that approximately 20% of resident beds with attached bed rails to the frame of the bed had at least one bed rail raised (1/4 length rail) or at least one rotating assist rail in the guard position (centre of bed). The residents did not all occupy their beds at the time of the observation. To confirm the need for bed rails to be engaged or "raised" while residents were out of bed, the residents' written plans of care were reviewed.

Residents #001, 004 and 005 were not in bed at time of observation and each had at least one quarter bed rail raised. The resident's written plan of care revealed that both quarter bed rails were to be used while the resident was in bed for repositioning. No information was available regarding the need for the bed rail to remain in the raised position at any other time for any of the residents.

Resident #006 was not in bed at time of observation and had one right rotating assist bed rail in the guard position (centre of bed) and a rail pad was attached. The resident's

written plan of care did not include that the bed rail was padded or the reason and that the right 1/4th rail be applied for transfers and bed mobility. No information was available regarding the need for a bed rail to remain in the raised or guard position at any other time. Discussed with the RAI-MDS co-ordinator, who was involved in updating the resident's plan of care, the use of the word "1/4th" to describe the bed rail. The term could be confused with a 1/4 or quarter rail when the rail type was a rotating assist rail.

Discussion with the DOC revealed that staff were given direction and training to leave the bed rail in the lowered or down position after the resident got out of bed (unless otherwise assessed). The DOC acknowledged that it was a habit that staff were trying to modify during their bed making tasks. [s. 15(1)(a)]

Issued on this 22nd day of March, 2016

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

Original report signed by the inspector.