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

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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
Feb 22, 2017	2017_539120_0010	034122-16, 034124-16, 034125-16	Follow up

Licensee/Titulaire de permis

NIAGARA HEALTH SYSTEM
63 THIRD STREET WELLAND HOSPITAL SITE WELLAND ON L3B 4W6

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

NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT
155 Ontario Street St. Catharines ON L2R 5K3

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8 & 9, 2017

An inspection (RQI 2014-191107-0009) was previously conducted between April 8 and 24, 2014 at which time an order was issued related to bed safety evaluations. On a subsequent visit, the order remained outstanding in June 2015 and an additional order was added to address the lack of resident assessments related to bed rail use and safety risks. A follow up inspection was conducted on June 29, 2016 and both orders remained outstanding. For this follow-up visit, the conditions in both orders were met, however non compliance was identified. See below for details.

An order related to the home's preventive maintenance program (schedules and procedures) was issued during an inspection conducted on January 20, 2015. During two subsequent inspections, one conducted between May 25 and June 11, 2015 and the other conducted on June 29, 2016, the order remained outstanding. The order was re-issued on August 10, 2016. For this follow up inspection, the conditions in the order were met.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care.

During the course of the inspection, the inspector toured the home which included random resident rooms, observed resident bed systems and residents in bed, reviewed the home's maintenance audit check lists, completed resident room audits for January 2017, written maintenance policy and procedures, bed safety policy, bed system evaluation (entrapment zones) results, clinical resident assessments for bed rail safety, staff training and education materials for bed safety and the written plan of care for randomly selected residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

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

- **2 WN(s)**
- **2 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	2016_189120_0042	120
O.Reg 79/10 s. 15. (1)	CO #002	2016_189120_0042	120
O.Reg 79/10 s. 90. (1)	CO #003	2016_189120_0042	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, the residents were assessed in accordance with prevailing practices to minimize risk to the resident.

Six residents (#100-105) were selected for review to determine whether they were assessed for bed rail safety in accordance with prevailing practices. Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. According to Health Canada, a document developed by the U.S. Food and Drug Administration titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" provides the necessary guidance in establishing a clinical assessment where bed rails are used. Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident.

According to the Director of Care, all residents in the home were clinically assessed by registered staff between September 12 and October 16, 2016 following the guidelines in the above noted clinical guidance document. The process included monitoring residents

while in bed by personal support workers (PSWs) for one night without bed rails and three nights with bed rails. The forms used to document information related to the resident and their bed rail use, risk factors and sleeping habits and patterns were titled “Bed Rail Use - Safety Assessment - Observation Period without Bed Rails" and "Bed Rail use - Safety Assessment -Observation Period with Bed Rails". However in reviewing the forms, they 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.

On October 28 and on November 29, 2016, a total of 37 new bed systems were delivered to the home and provided to residents. The new beds were equipped with two fixed pivoting assist side rails made of molded hard plastic approximately 35 centimeters wide and 40 centimeters high. The side rails were located near the bed's half way point where the resident would enter and exit the bed. The side rails had a release mechanism on the bed rail post that could be pressed to remove the side rail, but otherwise the side rails were "fixed" to the bed frame without being able to push them down or rotate them down and below the level of the mattress. The original bed systems were equipped with either 3/4 length bed rails or split 1/4 length bed rails that could be easily raised or lowered according to need. When lowered, the bed rail was "not in use". However, with the new bed systems, the assist side rails could not be easily manipulated in the same way, and as such, the bed rails were considered to be "in use" at all times by the resident and therefore would require the licensee to determine possible safety risks associated with their use. Discussion was held with the Director of Care that bed rails that were fixed in place anywhere along the side of the bed could present a number of risks including a suspension risk that could lead to death. Some of the 37 residents who did not use a bed rail with their original bed and who had a different type of bed rail were therefore provided with two side rails without first conducting a clinical assessment to determine what if any safety risks were associated with the bed system and that could pose harm to the resident.

Resident #100 was assessed prior to October 28, 2016 and determined not to be able to use the bed rails due to cognition issues and lack of bed mobility. The resident received a "new" bed system on or after October 28, 2016 with two pivoting assist rails attached and was not re-assessed to determine if the bed rails would present any particular safety risks for the resident or if any alternatives to bed rails were trialled before implementing them.

Resident #101 was observed to be occupying their "new" bed system, with both pivoting

assist rail in place. The resident's written plan of care identified that the resident would use one bed rail on their left side for turning. Their bed assessment without bed rails identified the same and did not include any information about alternatives trialled. However, the assessment was done prior to the resident receiving the "new" bed system. No re-assessment was completed to determine if the two pivoting assist rails presented any safety risks for the resident or if any alternatives to bed rails were trialled before implementing them.

Resident #102 was observed to be occupying an original bed system with both quarter length bed rails in the elevated position. The resident's assessment without bed rails identified that they did not require the use of bed rails. The resident's written plan of care identified that the resident was independent for bed mobility (therefore did not use bed rails). The staff therefore did not follow the written plan of care to ensure that the resident's bed rails remained down and not in use in order to ensure that the bed rails did not present any unidentified safety risks to the resident.

Resident #103 was originally assessed without bed rails in early October 2016 and determined not to require bed rails. The resident received a "new" bed system with two pivoting assist rails on or after October 28, 2016. The resident's written plan of care dated after they received the new bed system identified that the resident required two bed rails to assist with bed mobility. No assessment was conducted with bed rails to determine if the two pivoting assist rails presented any safety risks or if any alternatives to bed rails were trialled before implementing them.

Resident #104 was equipped with a bed system consisting of two quarter length bed rails in the elevated position and a therapeutic mattress. Their bed assessment without bed rails was dated mid September 2016. An interdisciplinary team identified that the resident required two bed rails for repositioning as the "alternative" on the assessment form. The alternatives to bed rails included on the form were "bolsters, raised edges on mattress, transfer pole etc". The interdisciplinary team did not document what if any alternatives were trialled before applying the two quarter length bed rails.

Resident #105 was equipped with a bed system consisting of two quarter length bed rails in the elevated position. The "conclusion" section of the resident's assessment without bed rails dated late September 2016 was blank, indicating that the process was not attempted or the form was not completed. The assessment without bed rails included information that the resident exited the bed more than once independently and did not need assistance to reposition or transfer out of the bed. No information was available to

determine why bed rails were or were not indicated for the resident. On the third night of sleep observation, the resident's assessment with bed rails indicated that the resident required assistance to self- transfer in and out of bed, that they attempted to climb out of bed when the bed rails were applied, and used the bed rails to reposition themselves. The resident's "Quarterly Bed Rail Risk Assessment" completed in late October 2016 was incomplete for questions related to whether the resident could independently turn side to side or if they could get out of bed safely without human assistance or an assistive device. The status of the resident's need for bed rails was confusing and no alternatives were documented as trialled before applying the bed rails. The assessments in general did not provide a comprehensive evaluation of whether or not the resident was at risk for any safety related issues related to bed rail use. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, that residents are assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the furnishings were maintained in a good state of repair.

The doors on the floor to ceiling wooden wardrobes located in 31 resident rooms were observed to be in poor condition. The doors on the units where handles were located to open the wardrobes, were rough with exposed wood. Some were beginning to splinter. It was obvious that the varnish had worn away. According to the Administrator, housekeeping staff used sodium hypochlorite on the surfaces to kill germs during infectious outbreaks which wore away the protective finish.

The rooms were audited by an employee on October 6, 2016 and the condition of the wardrobes documented and submitted to the maintenance department. The Administrator reported that the maintenance department had made changes to their maintenance reporting system in the fall of 2016 and the request was lost. No action plans to address the issue were available at the time of inspection. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that furnishings are maintained in a good state of repair, to be implemented voluntarily.

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.