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

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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
Jan 9, 2017	2016_539120_0077	018618-16, 018624-16	Follow up

Licensee/Titulaire de permis

PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

PARK LANE TERRACE
295 GRAND RIVER STREET NORTH PARIS ON N3L 2N9

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): December 12, 2016

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, registered staff, personal support workers (PSWs) and residents.

During the course of the inspection, the inspector toured 3 home areas, observed resident bed systems and incontinent product supplies, reviewed resident clinical records, staff participation rates for training related to the licensee's bed safety and bowel and bladder programs, reviewed incontinent product procedures, bed system entrapment audit results and bed safety clinical assessments.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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_343585_0007	120
O.Reg 79/10 s. 51. (2)	CO #004	2016_343585_0007	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.

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".

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". 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. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed 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.

For this follow up inspection to an Order issued in April 2016 for bed safety, a marked reduction was observed in the number of residents who were using bed rails or who were required to use one or more bed rails while in bed. Three residents (#102, #103 and #104) were selected for review to determine whether they were adequately assessed for bed rail safety. All three residents had a written plan of care regarding whether bed rails were to be applied (raised) while the resident was in bed. According to the registered nurse, who assessed all three residents with the assistance of the occupational therapist, all three residents were assessed using their "Bed Safety Assessment" form. Based on the information provided and based on the information documented on the form, the assessment process was not fully completed in accordance with the identified Clinical Guidance document noted above.

A) The licensee's "Bed Safety Assessment" form related to bed rails, included a number of relevant questions related to the resident's cognition status and some bed related risk factors such as whether the resident ever rolled out of bed, was at risk of climbing over the bed rails, had seizure disorder or involuntary movements, was restless, if the resident required bed rails for positioning and transfers, body size, and overall bed mobility (rolling, able to get in and out bed unsupervised). The Clinical Guide identifies additional questions to establish habits and behaviours that could impact bed safety such as toileting habits, environmental factors, medication use, communication issues and signs

of pain or discomfort. Specific risks associated with bed rails in particular include but are not limited to whether the resident tried to get their arms and legs through the openings in the bed rail, banged body parts against the bed rail, slept on the edge of the bed and/or did not have the ability to move out of a particular position or were confused despite being cognitively aware when awake. For all three residents who were selected for review, their bed assessment forms did not include any information regarding a sleep observation period and what was monitored during that time period. According to the registered nurse, in order to complete the form, she liaised with PSWs who monitored residents on the night shift for "safety" issues, but those issues were not all necessarily related to bed safety. No formal check list or a guide was developed for staff with respect to specific bed safety risks that should have been monitored for and documented while the resident was in bed and had one or more bed rails in use.

B) The "Bed Safety Assessment" form included a section related to what alternatives were trialled, but the bed assessments for the three residents reviewed did not include when the alternative was trialled, for how long and whether the alternative(s) was successful or not. All three residents were assessed after bed rails were already in use for each resident for over three years. The list of alternatives on the form did not include all possible alternatives to using a "hard bed rail". The options listed on the form included some relevant interventions such as bed in the lowest position, mat on the floor beside the bed, bed alarm, body pillow or bolster, beveled edged mattress and other. According to the Clinical Guidance document, other options include the use of perimeter reminders or border definers such as body pillow/cushions/bolsters(soft rails), hand grips and various monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort). The alternatives would need to be trialled and results documented before a hard bed rail was applied.

C) Although there was some guidance on the bed safety assessment form to direct the assessor to consider alternatives because of a likelihood of entrapment issues if hard bed rails were applied, the assessment results for resident #102 were not well established. For resident #102, four questions were answered that indicated that hard bed rails would be considered an entrapment risk for the resident and that alternatives should be used. Alternatives included bed in the lowest position, a bolster or body pillow and floor mats. Yet the assessor identified at the end of the assessment, under "Assessment Results", that both bed rails would be in use "as per family request". When the assessment was discussed with the registered nurse who completed the form, they stated that they felt that the resident was not at risk if both of their quarter sized bed rails were applied. This information was quite contradictory to what was identified on the bed

safety assessment. The bed safety assessment forms were not fully comprehensive in establishing 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:

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.

Issued on this 10th day of January, 2017

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

Original report signed by the inspector.