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
Aug 2, 2016	2016_189120_0044	034661-15	Follow up

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8 STONEY CREEK ON L8G 1G6

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

PINE VILLA NURSING HOME
490 HIGHWAY #8 STONEY CREEK ON L8G 1G6

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): July 12, 2016

An inspection (RQI 2015-205129-0019) was previously conducted September 15-30, 2015 at which time several Orders were issued. For this follow-up visit, Order #003 related to resident bed safety assessments was reviewed.

During the course of the inspection, the inspector(s) spoke with the licensee owners, Clinical Lead, Director of Resident and Client Care, Environmental Services Supervisor, residents and non-registered staff.

During the course of the inspection, the inspector toured the home, observed resident bed systems and residents in bed, reviewed bed safety policies and procedures, resident bed safety assessments and their written plan of care, bed entrapment audit results and took illumination levels.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 the resident was assessed in accordance with evidence-based 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 (medical device). 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.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be fully developed in accordance with the Clinical Guidance document identified above. According to the Director of Resident and Client Care and the Clinical Lead, the Clinical Guidance document was reviewed and questions were incorporated into their existing questionnaire or tool titled "Side Rail Use Assessment Tool" which was used to assess residents for bed rail use/safety.

Bed rail safety assessments were reviewed for 4 residents (#001 to #004) who were observed to be in bed and had one or more bed rails in use (elevated) and one resident (#005) who was not observed in bed but had a written plan of care requiring them to have at least one bed rail in use while in bed.

A) The resident assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails immediately after admission. The licensee's policy titled "Bed Entrapment: Use of bed/side rails" (not dated and stamped "Draft") directed registered staff to "assess the resident for bed rail risk on admission and re-admission and that it be completed within 24 hours of admission". The policy further directed registered staff to complete the "Bed Rail Risk Assessment" form. However, the form that was used and which was provided for review was titled "Side Rail

Use Assessment Tool". After re-admission or change in condition, the policy included statements such as "avoid the automatic use of bed rails of any size or shape, residents must be individually assessed", "monitor according to the care plan" and "evaluate to determine if entrapment prevention strategies are effective". There were no details in the procedures as to how the resident would be assessed, by whom and for how long. The Side Rail Use Assessment tool did not include any information regarding how long residents were observed, the dates that they were observed and the specific sleep habits and behaviours that were monitored during a specified observation period.

B) The Side Rail Use Assessment tool did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. Examples on the form included but were not limited to bed exit alarm, call bell within reach, increased monitoring, call bell availability, high impact mat on the floor and hi/low bed. These options are considered interventions for other bed related safety issues (i.e Falls) and are not bed rail alternatives such as a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters or teaching the resident new transfer or re-positioning techniques. The assessment tool did not clearly identify what alternatives were trialled to minimize or eliminate the risks of strangulation, entrapment, entanglement, skin tears or bruising if bed rails were to be applied.

C) The questions included on the assessment tool did not include several key questions related to history of rail injury, entanglement, suspension or entrapment, history of climbing over the rails, any involuntary movements and whether rails were used in the past and why. Relevant questions were noted to include resident overall mobility, medication use, cognition, falls history and communication. When these questions were answered with either a "yes" or a "no", the form did not provide any direction to registered staff who were to decide that the resident was either a "high" or "low" risk for entrapment. No guidance was given as to the exact parameters or factors that constituted a "high" or "low" risk. There was no allocation on the tool to include what sleep patterns and behaviours the resident exhibited after admission and during an established observation period to evaluate the safety risks with and without one or more bed rails applied.

The Clinical Lead who completed all of the resident bed safety assessments reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident

assessment and evaluation in accordance with prevailing practices as required by the Regulation.

D) The assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment tool did not have any names listed. According to the Clinical Lead, registered staff members and personal support workers were involved in providing information about residents' specific needs and behaviours while in bed but were not listed.

Resident #001 was observed in bed with both 1/2 sized bed rails elevated. There was some confusion identified between the various records completed by the Clinical Lead. The resident's most recent written plan of care stated that "one short bedrail (no side identified) up when in bed as PASD (Personal Assistance Services Device) for positioning" and "staff to sign bed rail restraint form with each hourly check". It is not clear why the term "restraint" was included on the written plan of care if the bed rail was identified as a PASD. The Side Rail Use Risk Assessment Tool dated April 2016 identified that the resident was at "high risk" for entrapment, had a history of falls, poor bed mobility and poor mobility and other factors. If these factors were identified, the form directed the assessor to consider alternatives to bed rails. Further within the assessment, it identified that "no side rail was indicated as other interventions were in place to prevent or reduce falls" and that "side rails were indicated and served as an enabler to promote independence" (PASD). A written note was included that stated that "the right side rail be up for positioning in bed". No documentation was available indicating what alternatives to bed rails were trialled prior to application, what interventions were implemented to reduce the safety risks and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use.

Resident #002 was observed in bed with one left 3/4 sized bed rail elevated. According to the resident's Side Rail Use Risk Assessment dated January 2016, the resident did not have a history of falls, was using the side rail for positioning and support and the resident was able to request the side rails while in bed. The resident's PASD assessment dated April 2016 identified that the purpose of the PASD was for comfort and repositioning. The plan of care included that staff "fill out a bed rail restraint form as with hourly checks" and that "left rail be up for positioning as per resident and POA". There was confusion as to whether the bed rail being considered a PASD or a restraint. No documentation was available indicating what alternatives to bed rails were trialled prior to application and whether the resident was observed sleeping in bed to establish sleeping

patterns and habits that could contribute to safety risks associated with bed rail use.

Resident #003 was observed in bed with both 3/4 bed rails elevated. The resident's most recent written plan of care included "2 side rails up when in bed for safety". The resident's Side Rail Use Risk Assessment dated February 2016 included that the resident could use the rails for positioning and support and that they did not express desire to have side rails when sleeping in bed but that the family requested that both bed rails be applied. On the resident's "Initial Restraint Assessment form" dated April 2016, it included that the family requested the bed rails and the goal in applying the restraint was "to ensure safety and prevent resident falls". A hand written note included that "POA had requested that 2 side rails be up" and the reason for applying the bed rails was "fear of falling out of bed and climbing out". The resident already had interventions in place to prevent falls from the bed such as falls mats, bed alarm and bed in lowest position. Bed rails have not been identified as a falls prevention strategy and the "safety" statement was not defined. The licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. No documentation was available indicating what alternatives to bed rails were trialled prior to application and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use.

Resident #004 was observed in bed with one left 1/2 sized rail elevated. The resident's most recent written plan of care dated April 2016 included "no bed rails when in bed". The resident's Side Rail Use Assessment dated March 2016 identified that the resident had a history of falls, poor bed mobility, on medications and cognition issues and that the "resident was using side rail for positioning and support" and that the "resident did not express desire for rails while in bed". The responses were contradictory. The assessor identified the resident to be "high risk" for entrapment. It was not clear why the bed rail was applied and in use at the time of inspection or why the assessment identified that the resident was "currently using the side rail for positioning". No documentation was available indicating what alternatives to bed rails were trialled prior to the application of the one bed rail and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use, especially as the assessor believed them to be "high risk".

Resident #005 was not seen in bed at the time of inspection, however the resident's most recent written plan of care and Side Rail Use Assessment dated January 2016 were

reviewed after discussion regarding the role of the SDM in deciding the application of bed rails (medical device). According to the Clinical Lead, the resident's family insisted that staff apply 2 bed rails when the resident was in bed, even though the resident was assessed as not being able to use them. The resident required two person assistance for transfers and turning. The Side Rail Use Assessment included that the resident did not have a history of falls, poor bed mobility, did not use rails for repositioning, was on medications and was high risk for entrapment. No interventions for the possible entrapment risks were identified on the plan of care or Side Rail Use Assessment form. All falls risk interventions were identified and apparently in place (mat, alarm etc). According to the written plan of care, dated August 2015, under the "Falls Risk" category, a statement was included "put 2 side rails up for safety" which was also noted as a method to "prevent rolling out of bed". The licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. The resident was deemed to be at "high risk" of entrapment when bed rails were applied but did not include what interventions could be applied to mitigate the potential risks. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements as set out in the lighting table were maintained.

Non-compliance was previously issued on July 2015 with respect to inadequate lighting levels in the home.

The home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "All other homes". A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in several bedrooms and several resident ensuite washrooms, tub/shower room and dining room. The meter was held a standard 30 inches

above and parallel to the floor as per the Illuminating Engineering Society of North America. Window coverings were drawn in the resident bedrooms tested. The lighting levels achieved in the dining room were in areas away from windows. Lights were verified to have been on for more than 5 minutes prior to measuring. Outdoor conditions were bright during the measuring procedure and natural light could not be fully excluded.

1. Resident bedrooms were all equipped with the same entry light, over bed lights and a general room light in the centre of each room. Some of the larger rooms (#3, 4, 5, 6, 12) were equipped with 2 - 4 foot fluorescent fixtures on the ceiling with two bulbs and a clear lens. The private and semi-private rooms (#2, 7, 8, 9, 18, 19) were equipped with one ceiling light. During the measuring process, all of the lights in bedroom #6 were turned on and allowed to warm up. One light was 290 lux and the other was 220 lux directly underneath which dropped to 50 lux in front of the closets and 150 lux between the beds. Where there was one ceiling light, the lux was 175 lux under the ceiling light and less every where else except for at the head of the bed.

The entry light was recently replaced in each bedroom with a new fixture that was semi flush and equipped with a compact fluorescent bulb encased in a clear lens. The light turned on with a motion sensor instead of a switch. When measured directly under the light, it was 100 lux. Discussed previously with the Environmental Services Supervisor the necessity to ensure that each resident room had individual control for lighting preference.

Lighting requirements did not meet a minimum of 215.28 lux in areas at the entry, route to the bed from the entry, areas in and around the bed and in areas near a closet or wardrobe.

2. Resident ensuite washrooms were configured in 2 different ways (room #4 vs room #19) but were all equipped with the same light fixtures over the vanity. The light fixture was designed to accept 4 light bulbs, but in many washrooms, only 2 incandescent bulbs were functional. When all of the bulbs were present and functional, the lux was over 215.28 at the vanity, however in some of the larger washrooms, the lux was not more than 175 at the toilet. Resident washroom #7 had 195 lux at the vanity and 100 lux at the toilet. Resident washroom #3 had 100 lux at the vanity and at the toilet.

3. The tub/shower room was equipped with various types of fixtures. The areas that did not meet the minimum requirement of 215.28 lux was at the entrance into the room and towards the sink (25 lux), around the tub (150 lux), within both shower areas (35 lux), at

the toilet (175 lux) and at the sink (110 lux).

4. Light bulbs were burnt out or flickering in many areas throughout the home causing inadequate illumination such as in the main lounge, in the dining room near the servery and over the servery area, front area of home (near piano), main hall in front of the nurse's station and in the activity room. Some bulbs appeared white, yellow or blue. The age of the bulb, colour, clarity and type of lens, type of fixture and the condition of the ballasts are contributing factors to poor illumination levels in the home. According to the Environmental Services Supervisor, no illumination assessment was completed by him self or any person with training and experience in the field of lighting. This was identified as a necessary step in an inspection report dated July 27, 2015. He reported that ballasts were being replaced when lights burnt out, which was part of their remedial program, however no preventive component was included to assess and replace defective ballasts. An independent assessment of all resident accessible areas during darker outdoor conditions would be necessary to obtain more accurate values and a broader scope of the issues.

This VPC is based upon 3 factors, severity, scope and history of non-compliance in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity was 2 (potential for harm/risk), the scope was 3 (widespread - low lighting levels throughout the home) and the compliance history was 3 (previously issued in the same area). A written notification was previously issued related to this section on July 27, 2015 . [s. 18.]

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 the lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

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

Issued on this 4th day of August, 2016

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 :	2016_189120_0044
Log No. / Registre no:	034661-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 2, 2016
Licensee / Titulaire de permis :	THE THOMAS HEALTH CARE CORPORATION 490 Highway #8, STONEY CREEK, ON, L8G-1G6
LTC Home / Foyer de SLD :	PINE VILLA NURSING HOME 490 HIGHWAY #8, STONEY CREEK, ON, L8G-1G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula White

To THE THOMAS HEALTH CARE CORPORATION, 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: 2015_205129_0019, CO #003;

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 "Side Rail Use Assessment Tool" form to include all 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) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include:

a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and

b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of time; and

c) include the names of the interdisciplinary team members who participated in evaluating the resident; and

d) provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are a safe alternative for the resident being assessed.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.

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. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards.

4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Bed Entrapment: Use of bed/side rails" policy and associated procedures to include all of the above noted requirements.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that the resident was assessed in accordance with evidence-based 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".

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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 (medical device). 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.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be fully developed in accordance with the Clinical Guidance document identified above. According to the Director of Resident and

Client Care and the Clinical Lead, the Clinical Guidance document was reviewed and questions were incorporated into their existing questionnaire or tool titled "Side Rail Use Assessment Tool" which was used to assess residents for bed rail use/safety.

Bed rail safety assessments were reviewed for 4 residents (#001 to #004) who were observed to be in bed and had one or more bed rails in use (elevated) and one resident (#005) who was not observed in bed but had a written plan of care requiring them to have at least one bed rail in use while in bed.

A) The resident assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails immediately after admission. The licensee's policy titled "Bed Entrapment: Use of bed/side rails" (not dated and stamped "Draft") directed registered staff to "assess the resident for bed rail risk on admission and re-admission and that it be completed within 24 hours of admission". The policy further directed registered staff to complete the "Bed Rail Risk Assessment" form. However, the form that was used and which was provided for review was titled "Side Rail Use Assessment Tool". After re-admission or change in condition, the policy included statements such as "avoid the automatic use of bed rails of any size or shape, residents must be individually assessed", "monitor according to the care plan" and "evaluate to determine if entrapment prevention strategies are effective". There were no details in the procedures as to how the resident would be assessed, by whom and for how long. The Side Rail Use Assessment tool did not include any information regarding how long residents were observed, the dates that they were observed and the specific sleep habits and behaviours that were monitored during a specified observation period.

B) The Side Rail Use Assessment tool did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. Examples on the form included but were not limited to bed exit alarm, call bell within reach, increased monitoring, call bell availability, high impact mat on the floor and hi/low bed. These options are considered interventions for other bed related safety issues (i.e Falls) and are not bed rail alternatives such as a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters or teaching the resident new transfer or re-positioning techniques. The assessment tool did not clearly identify what

alternatives were trialled to minimize or eliminate the risks of strangulation, entrapment, entanglement, skin tears or bruising if bed rails were to be applied.

C) The questions included on the assessment tool did not include several key questions related to history of rail injury, entanglement, suspension or entrapment, history of climbing over the rails, any involuntary movements and whether rails were used in the past and why. Relevant questions were noted to include resident overall mobility, medication use, cognition, falls history and communication. When these questions were answered with either a "yes" or a "no", the form did not provide any direction to registered staff who were to decide that the resident was either a "high" or "low" risk for entrapment. No guidance was given as to the exact parameters or factors that constituted a "high" or "low" risk. There was no allocation on the tool to include what sleep patterns and behaviours the resident exhibited after admission and during an established observation period to evaluate the safety risks with and without one or more bed rails applied.

The Clinical Lead who completed all of the resident bed safety assessments reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

D) The assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment tool did not have any names listed. According to the Clinical Lead, registered staff members and personal support workers were involved in providing information about residents' specific needs and behaviours while in bed but were not listed.

Resident #001 was observed in bed with both 1/2 sized bed rails elevated. There was some confusion identified between the various records completed by the Clinical Lead. The resident's most recent written plan of care stated that "one short bedrail (no side identified) up when in bed as PASD (Personal Assistance Services Device) for positioning" and "staff to sign bed rail restraint form with each hourly check". It is not clear why the term "restraint" was included on the written plan of care if the bed rail was identified as a PASD. The Side Rail Use Risk Assessment Tool dated April 2016 identified that the resident

was at "high risk" for entrapment, had a history of falls, poor bed mobility and poor mobility and other factors. If these factors were identified, the form directed the assessor to consider alternatives to bed rails. Further within the assessment, it identified that "no side rail was indicated as other interventions were in place to prevent or reduce falls" and that "side rails were indicated and served as an enabler to promote independence" (PASD). A written note was included that stated that "the right side rail be up for positioning in bed". No documentation was available indicating what alternatives to bed rails were trialled prior to application, what interventions were implemented to reduce the safety risks and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use.

Resident #002 was observed in bed with one left 3/4 sized bed rail elevated. According to the resident's Side Rail Use Risk Assessment dated January 2016, the resident did not have a history of falls, was using the side rail for positioning and support and the resident was able to request the side rails while in bed. The resident's PASD assessment dated April 2016 identified that the purpose of the PASD was for comfort and repositioning. The plan of care included that staff "fill out a bed rail restraint form as with hourly checks" and that "left rail be up for positioning as per resident and POA". There was confusion as to whether the bed rail being considered a PASD or a restraint. No documentation was available indicating what alternatives to bed rails were trialled prior to application and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use.

Resident #003 was observed in bed with both 3/4 bed rails elevated. The resident's most recent written plan of care included "2 side rails up when in bed for safety". The resident's Side Rail Use Risk Assessment dated February 2016 included that the resident could use the rails for positioning and support and that they did not express desire to have side rails when sleeping in bed but that the family requested that both bed rails be applied. On the resident's "Initial Restraint Assessment form" dated April 2016, it included that the family requested the bed rails and the goal in applying the restraint was "to ensure safety and prevent resident falls". A hand written note included that "POA had requested that 2 side rails be up" and the reason for applying the bed rails was "fear of falling out of bed and climbing out". The resident already had interventions in place to prevent falls from the bed such as falls mats, bed alarm

and bed in lowest position. Bed rails have not been identified as a falls prevention strategy and the "safety" statement was not defined. The licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. No documentation was available indicating what alternatives to bed rails were trialled prior to application and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use.

Resident #004 was observed in bed with one left 1/2 sized rail elevated. The resident's most recent written plan of care dated April 2016 included "no bed rails when in bed". The resident's Side Rail Use Assessment dated March 2016 identified that the resident had a history of falls, poor bed mobility, on medications and cognition issues and that the "resident was using side rail for positioning and support" and that the "resident did not express desire for rails while in bed". The responses were contradictory. The assessor identified the resident to be "high risk" for entrapment. It was not clear why the bed rail was applied and in use at the time of inspection or why the assessment identified that the resident was "currently using the side rail for positioning". No documentation was available indicating what alternatives to bed rails were trialled prior to the application of the one bed rail and whether the resident was observed sleeping in bed to establish sleeping patterns and habits that could contribute to safety risks associated with bed rail use, especially as the assessor believed them to be "high risk".

Resident #005 was not seen in bed at the time of inspection, however the resident's most recent written plan of care and Side Rail Use Assessment dated January 2016 were reviewed after discussion regarding the role of the SDM in deciding the application of bed rails (medical device). According to the Clinical Lead, the resident's family insisted that staff apply 2 bed rails when the resident was in bed, even though the resident was assessed as not being able to use them. The resident required two person assistance for transfers and turning. The Side Rail Use Assessment included that the resident did not have a history of falls, poor bed mobility, did not use rails for repositioning, was on medications and was high risk for entrapment. No interventions for the possible entrapment risks were identified on the plan of care or Side Rail Use Assessment form. All falls risk interventions were identified and apparently in place (mat, alarm etc).

According to the written plan of care, dated August 2015, under the "Falls Risk" category, a statement was included "put 2 side rails up for safety" which was also noted as a method to "prevent rolling out of bed". The licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. The resident was deemed to be at "high risk" of entrapment when bed rails were applied but did not include what interventions could be applied to mitigate the potential risks.

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 harm), the scope is 2 (pattern - more than one resident has not been assessed in accordance with prevailing practices) and the compliance history is 4 (ongoing non-compliance with a Compliance Order). Non-compliance was previously issued on November 2, 2015. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

Service Area Office /
Bureau régional de services : Hamilton Service Area Office