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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 10, 2018	2018_539120_0047	028742-18	Follow up

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Upper Canada Lodge
272 Wellington Street P.O. Box 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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): October 31, 2018

An inspection (#2018-539120-0018) was previously conducted in April 2018, related to resident assessments where bed rails were used or applied. The inspection resulted in the issuance of a compliance order (CO). The CO included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices. The CO was to be complied with by August 2018. For this follow-up inspection, not all of the requirements in the CO were met.

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

During the course of the inspection, the inspector toured several home areas and observed resident bed systems, reviewed resident clinical records, bed safety policies and procedures and associated forms.

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	Légende 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 failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

An inspection was previously conducted in April 2018, related to resident assessments where bed rails were used or applied. The inspection resulted in the issuance of a compliance order (CO). The CO included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices. The prevailing practice used to determine compliance related to this section included 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)".

In accordance with s.15(1) of O. Reg. 79/10, the licensee was required to ensure that requirements previously laid out in CO #001 from inspection report #2018-539120-0018 was complied with by August 2018. Specifically, the licensee was to comply with the following;

1. Amend the home's existing "Bed Rail Risk Assessment " 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). This document is 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 and after 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 use or if no alternatives were trialled, document why they were not trialled; and
c) include the names of the interdisciplinary team members who participated in assessing the resident.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed rail risk 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 assessing each resident using the amended bed rail risk 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 Rail Risk Assessment (RKM00-025)" policy to include requirement #1 and #2 noted above, the role of the select interdisciplinary members involved in the resident assessments, the available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards.

6. Registered staff who complete the bed rail risk assessments shall have knowledge of the contents of 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 the "Guide for Modifying Bed Systems

and Using Accessories to Reduce the Risk of Entrapment, (U.S. F.D.A, 2006)".

7. All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

The licensee failed to complete 1 a,b, 4, 5 and 6.

A review of the licensee's current bed rail related risk assessment policy and form was conducted with the Clinical Director of Care (CDOC). The CDOC stated that they participated in developing or amending the form and processes related to bed safety which was organized by their corporate office. The CDOC identified that their amended policy for new resident admissions was not to apply bed rails for any resident until they spent several nights in bed under observation.

An assessment form that was used by registered staff to complete resident assessments was entitled "Bed Rail Risk Assessment (BRA) V8" and included five sections for completion upon admission or when a change in condition was noted. Post admission, if a resident used one or more bed rails and no changes were noted, the resident received a quarterly assessment which did not include the completion of all five sections.

A key section of the form entitled “Assessment and Risk” included five relevant questions related to the resident that could potentially increase their risk of a bed rail-related injury. These questions were to be completed before a resident was assessed to require a bed rail. The questions included the resident’s state of mind (whether confused, agitated, distressed, cognitively impaired), whether they had involuntary body movements, altered sensations, were at risk of climbing over the bed rails, and if the resident needed to get out of bed unsupervised. The section also included the outcome of the assessment (once a sleep observation period was conducted) to determine why or why not bed rails would be used, alternatives trialled and their outcome and the resident’s sleep pattern and history.

With respect to requirement 1a of the compliance order, no questions were included on the BRA form or any other document that related to observations of the resident while in bed after bed rails were applied, to establish safety risks. The sleep observation process appears to have been focused on the process prior to the application of bed rails. According to the licensee’s policy, PSWs were tasked to document nightly how the residents were sleeping on a software system called POC (Point of Care). No further details were included in the policy. According to the CDOC, PSWs routinely observed

residents in bed at all times for any number of safety issues, including bed system related hazards. PSWs were to complete on each shift, electronic forms entitled "sleeping" and "PASD" which were filled out on POC. Neither of these forms included any questions related to bed safety with bed rails applied [i.e sleeping with limbs in various zones in and around the bed rail, resident attempted to climb over rails, sleeping up against the bed rail, torso partially off the bed] but focused on whether the resident had a bed rail applied or not, was awake, asleep or awake and out of bed. If other concerns were identified, they were to be brought to the attention of the registered staff who were required to document the concern in the resident's electronic chart. The licensee's BRA and the CDOC stated that the registered staff were to review the POC tasks completed by the PSWs and incorporate the results in section two of the form entitled "Sleep Pattern & History" as part of their decision making to determine the extent of risk associated with bed rail use. The process, as described was not included in the licensee's policies and was not clear on the assessment form.

With respect to requirement 1b of the compliance order, the form included an area under section two for the assessor to complete entitled "Alternatives Trialed and Outcome". A selection of viable alternative options was not listed under section two or in the policy. Alternatives are options that replace bed rail use and interventions include options that are implemented with or without bed rails. The process of what was trialled, when and for how long was not included in the licensee's policies and was not explained on the assessment form.

With respect to requirement #4, the fact sheet that was provided for review entitled "Resident and Family Information" dated July 2018, did not include the regulations and prevailing practices governing adult hospital beds in Ontario, how beds that include a bed rail will be maintained (how tested to ensure that it passes entrapment zone testing) and the role of the SDM with respect to resident assessments. The fact sheet identified that the bed rails would be removed from the bed upon admission, but did not include how the bed system would be evaluated for safety after bed rails are applied and if residents would be assessed after bed rails are applied for safety risks.

With respect to requirement #5, the licensee's most recent policy provided by the CDOC entitled "Bed Rail Risk Assessment" RKM00-025 revised July 2018, did not include requirement #1b, the available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards. The policy did not include any information about how to determine if bed rails were a safety risk for the resident, the types of safety risks, how to mitigate any identified safety risks (and what available

accessories and supplies were available for the various types of risks) and the use of available alternatives.

With respect to requirement #6, related to what guidance was available to the assessors completing the bed rail assessments, a decision tree was provided for review. Based on the flow diagram, a resident or substitute decision maker (SDM) who requested a bed rail would only have the safety risks explained to them. No further direction was given to assess the resident for safety risks. The CDOC confirmed that once a resident or SDM requested a bed rail, no further assessment was conducted.

If neither the resident or SDM requested a bed rail, the resident was assessed to determine whether they could get in and out of bed unsupervised. The direction was further split from this question, if the answer was yes, no risk related concerns were pursued and the resident was provided with a bed rail. If the resident could not get in and out of bed unsupervised, two additional questions were asked; if the resident had involuntary body movements or if the resident got out of bed unsafely. A bed rail therefore would not be implemented. The decision tree nor the policy included any guidance for the assessor to base their decision on the outcomes of a sleep observation period after bed rails were applied and after data was acquired by the interdisciplinary team members. No direction was given to conclude and document the risk versus the benefits of the application of one or more bed rails.

Resident #100, who was previously selected for review and two additional residents (#101, #102) were randomly selected during this inspection to determine if they were assessed for bed rail-related safety risks in accordance with the Clinical Guidance document noted above. All three residents had a current written plan of care identifying that they required two assist rails up at all times while in bed to support bed mobility.

Resident #100 was not observed in bed at the time of inspection, however, their bed system had two bed rails, one on each side of the bed. The resident was identified with several risk factors associated with an increased risk of bed system related injury. Whether the resident was actually able to use the bed rails was not clear in the plan of care.

The resident's BRA was completed in August 2018, due to a change in bed rails. However, it was not identified in the assessment or clinical chart what the change was. The assessor documented that the resident had one risk factor and that the resident's SDM requested the bed rails for bed mobility and two bed rails were provided. No

documentation was made as to whether alternatives were trialled and what the outcome was for any sleep related observations with bed rails applied. Another BRA was completed in September 2018, as a quarterly assessment. The assessor identified that the bed rails were requested/required by the resident and all other sections were blank except for the section related to consents. Due to the fact that the resident had bed rails, another type of assessment entitled "PASD Evaluation" dated August 2018, was completed and included that two bed rails would be used for transfers and mobility. No alternatives were documented as trialled. No progress notes were made in the resident's clinical record as to the risk over benefit analysis. No conclusion could be made about the resident's overall risk associated with bed rail use in reviewing the assessments available.

Resident #101 was observed in bed with two fixed bed rails in place, one on each side of the bed. The resident was identified with several risk factors associated with an increased risk of bed system related injury. Whether the resident was actually able to use the bed rails was not clear in the plan of care.

The resident's last full BRA was completed in November 2017, and a quarterly BRA was completed in September 2018. The reason for the 2017 assessment included the term "other" which was not subsequently identified. Only one risk factor related to an increase in bed system related injury was identified and that bed rails would be used for bed mobility. Yet, under a separate section, the assessor selected that bed rails were not applicable and no bed rails would be used. The section related to the outcome of the resident's assessment (factors for or against use of bed rails and alternatives) were all documented as "N/A". No progress notes were made in the resident's clinical record as to a risk over benefit analysis. No conclusion could be made about the resident's overall risk associated with bed rail use.

According to RPN #003, who completed the quarterly assessment in September 2018, the form was designed so that most of the questions could not be answered expect for the section related to consent. In attempting to establish the level of risk for the resident, RPN #003 was asked about the resident while in bed. They stated that the resident was mobile in bed, capable of getting in and out of bed unassisted but had one identified risk factor that placed them at a greater risk of bed system related injury. When asked if the resident should have bed rails, the RPN stated that they did not believe so. When asked about the resident's sleep pattern and history, or any sleep observation results, the RPN revealed that they were not aware of the process as they had not yet completed a full bed safety assessment for any resident. The RPN was not aware of the policy section

related to sleep observation. When asked if they had received a detailed overview of the bed safety program, RPN #003 confirmed that all registered staff received an email with an attached policy and slides about the program.

Resident #102 was observed in bed with two fixed assist rails in place, one on each side of the bed. The resident was identified with several risk factors associated with an increased risk of bed system related injury. Whether the resident was actually able to use the bed rails was not clear in the plan of care.

The resident's last full BRA was completed in August 2018, and a quarterly BRA was reviewed dated October 2018. The reason for the August 2018, assessment included a change in bed rails. However, it was not identified in the assessment or clinical record what the change was. Only one risk factor was identified and that bed rails would be used for repositioning. The section related to the outcome of the resident's assessment included "N/A', that there were no factors against the use of bed rails. No alternatives were documented as trialled. No progress notes were made in the resident's clinical record as to a risk over benefit analysis. No conclusion could be made about the resident's overall risk associated with bed rail use.

The quarterly BRA dated October 2018, was not completed and had no information about the resident's bed rail use or risk related information.

The October 2018, assessment was reviewed with the assessor, RPN #002. According to the RPN, the resident had limited mobility but was able to grab the bed rail and roll themselves side to side. The RPN believed that bed rails were ideal for the resident and that the benefits outweighed the risks. The RPN did not identify any alternatives that could have been trialled for resident #102 before bed rails were implemented. The RPN was aware of options such as a reaching pole, and raised perimeter mattress but not aware of sturdy side bolsters. The RPN, although knowledgeable about the resident and was aware of the sleep observation process, did not clearly document their clinical decision on the assessment form or clinical record (progress notes).

The conclusions related to these residents and the use of their 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. The licensee therefore failed to assess the residents that used one or more bed rails in accordance with prevailing practices, to minimize risk to the 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 20th day of December, 2018

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

Original report signed by the inspector.

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

Ministère 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2018_539120_0047
Log No. / No de registre :	028742-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 10, 2018
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	Upper Canada Lodge 272 Wellington Street, P.O. Box 1390, NIAGARA-ON-THE-LAKE, ON, L0S-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Margaret Lambert

To The Regional Municipality of Niagara, 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)

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 must be compliant with s. 15(1) of O. Reg. 79/10.

Specifically, the licensee shall complete and implement the following;

1. Revise or amend the current questionnaires on Point of Care related to sleeping tasks to include additional questions relevant to assessing the resident for certain risks associated with bed rail use while in bed. The questions should be related to entrapment, suspension and soft tissue injury in accordance with 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)

2. Review all resident assessments who have been provided with one or more assist rails, to ensure the forms are fully completed with respect to;
a. the alternatives that were trialled prior to using one or more bed rails, and document whether the alternative was effective or not during an observation period. If an alternative was not trialled, document the reasons why it was not trialled; and
b. document if any safety risks were identified during the sleep observation period after a bed rail was applied; and
c. document the rationale for or against the implementation of bed rails as it

relates to the resident's safety risk factors and any actual safety risks identified during their sleep observation period.

3. All registered staff who participate in the assessment of residents where bed rails are used shall receive face to face education so that they have an understanding of and are able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and 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) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

4. All personal support workers who will be involved in completing the sleeping tasks on Point of Care shall be made aware of the new questions related to residents while asleep with bed rails applied so that they have an understanding of and are able to complete the questions associated with a resident's bed system and associated hazards and risks.

5. Amend the current "Bed Rail Risk Assessment" policy RKM00-025 revised July 2018, 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 the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" related to the identification of risk factors associated with bed rail use. At a minimum the policy shall include;

a) 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
b) alternatives that are available for the replacement of bed rails; and
c) interventions available for the resident that are used in conjunction with a bed rail if certain risks are identified; and
d) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility or transfers; and

e) the procedure for observing residents when sleeping after bed rails have been applied for safety risks; and
f)) links to references used to develop the policy.

6. Amend the current "Resident and Family Information" sheet dated July 2018, to include the regulations governing adult hospital beds in Ontario, how beds that include a bed rail will be maintained (how tested to ensure that it passes entrapment zone testing), the role of the SDM with respect to resident assessments and when and how often residents would be assessed for bed system related hazards once bed rails were applied if deemed necessary.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

An inspection was previously conducted in April 2018, related to resident assessments where bed rails were used or applied. The inspection resulted in the issuance of a compliance order (CO). The CO included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices. The prevailing practice used to determine compliance related to this section included 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)".

In accordance with s.15(1) of O. Reg. 79/10, the licensee was required to ensure that requirements previously laid out in CO #001 from inspection report #2018-539120-0018 was complied with by August 2018. Specifically, the licensee was to comply with the following;

1. Amend the home's existing "Bed Rail Risk Assessment " 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). This document is 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 and after 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 use or if no alternatives were trialled, document why they were not trialled; and
c) include the names of the interdisciplinary team members who participated in assessing the resident.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed rail risk 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 assessing each resident using the amended bed rail risk 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 Rail Risk Assessment (RKM00-025)" policy to include requirement #1 and #2 noted above, the role of the select interdisciplinary members involved in the resident assessments, the available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards.

6. Registered staff who complete the bed rail risk assessments shall have knowledge of the contents of 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 the "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, (U.S. F.D.A, 2006)".

7. All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

The licensee failed to complete 1 a,b, 4, 5 and 6.

A review of the licensee's current bed rail related risk assessment policy and form was conducted with the Clinical Director of Care (CDOC). The CDOC stated that they participated in developing or amending the form and processes related to bed safety which was organized by their corporate office. The CDOC identified that their amended policy for new resident admissions was not to apply bed rails for any resident until they spent several nights in bed under observation.

An assessment form that was used by registered staff to complete resident assessments was entitled "Bed Rail Risk Assessment (BRA) V8" and included five sections for completion upon admission or when a change in condition was noted. Post admission, if a resident used one or more bed rails and no changes were noted, the resident received a quarterly assessment which did not include the completion of all five sections.

A key section of the form entitled "Assessment and Risk" included five relevant questions related to the resident that could potentially increase their risk of a bed rail-related injury. These questions were to be completed before a resident was assessed to require a bed rail. The questions included the resident's state of mind (whether confused, agitated, distressed, cognitively impaired), whether they had involuntary body movements, altered sensations, were at risk of climbing over the bed rails, and if the resident needed to get out of bed unsupervised. The section also included the outcome of the assessment (once a sleep observation period was conducted) to determine why or why not bed

rails would be used, alternatives trialled and their outcome and the resident's sleep pattern and history.

With respect to requirement 1a of the compliance order, no questions were included on the BRA form or any other document that related to observations of the resident while in bed after bed rails were applied, to establish safety risks. The sleep observation process appears to have been focused on the process prior to the application of bed rails. According to the licensee's policy, PSWs were tasked to document nightly how the residents were sleeping on a software system called POC (Point of Care). No further details were included in the policy. According to the CDOC, PSWs routinely observed residents in bed at all times for any number of safety issues, including bed system related hazards. PSWs were to complete on each shift, electronic forms entitled "sleeping" and "PASD" which were filled out on POC. Neither of these forms included any questions related to bed safety with bed rails applied [i.e sleeping with limbs in various zones in and around the bed rail, resident attempted to climb over rails, sleeping up against the bed rail, torso partially off the bed] but focused on whether the resident had a bed rail applied or not, was awake, asleep or awake and out of bed. If other concerns were identified, they were to be brought to the attention of the registered staff who were required to document the concern in the resident's electronic chart. The licensee's BRA and the CDOC stated that the registered staff were to review the POC tasks completed by the PSWs and incorporate the results in section two of the form entitled "Sleep Pattern & History" as part of their decision making to determine the extent of risk associated with bed rail use. The process, as described was not included in the licensee's policies and was not clear on the assessment form.

With respect to requirement 1b of the compliance order, the form included an area under section two for the assessor to complete entitled "Alternatives Trialed and Outcome". A selection of viable alternative options was not listed under section two or in the policy. Alternatives are options that replace bed rail use and interventions include options that are implemented with or without bed rails. The process of what was trialled, when and for how long was not included in the licensee's policies and was not explained on the assessment form.

With respect to requirement #4, the fact sheet that was provided for review entitled "Resident and Family Information" dated July 2018, did not include the

regulations and prevailing practices governing adult hospital beds in Ontario, how beds that include a bed rail will be maintained (how tested to ensure that it passes entrapment zone testing) and the role of the SDM with respect to resident assessments. The fact sheet identified that the bed rails would be removed from the bed upon admission, but did not include how the bed system would be evaluated for safety after bed rails are applied and if residents would be assessed after bed rails are applied for safety risks.

With respect to requirement #5, the licensee's most recent policy provided by the CDOC entitled "Bed Rail Risk Assessment" RKM00-025 revised July 2018, did not include requirement #1b, the available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards. The policy did not include any information about how to determine if bed rails were a safety risk for the resident, the types of safety risks, how to mitigate any identified safety risks (and what available accessories and supplies were available for the various types of risks) and the use of available alternatives.

With respect to requirement #6, related to what guidance was available to the assessors completing the bed rail assessments, a decision tree was provided for review. Based on the flow diagram, a resident or substitute decision maker (SDM) who requested a bed rail would only have the safety risks explained to them. No further direction was given to assess the resident for safety risks. The CDOC confirmed that once a resident or SDM requested a bed rail, no further assessment was conducted.

If neither the resident or SDM requested a bed rail, the resident was assessed to determine whether they could get in and out of bed unsupervised. The direction was further split from this question, if the answer was yes, no risk related concerns were pursued and the resident was provided with a bed rail. If the resident could not get in and out of bed unsupervised, two additional questions were asked; if the resident had involuntary body movements or if the resident got out of bed unsafely. A bed rail therefore would not be implemented. The decision tree nor the policy included any guidance for the assessor to base their decision on the outcomes of a sleep observation period after bed rails were applied and after data was acquired by the interdisciplinary team members. No direction was given to conclude and document the risk versus the benefits of the application of one or more bed rails.

Resident #100, who was previously selected for review and two additional residents (#101, #102) were randomly selected during this inspection to determine if they were assessed for bed rail-related safety risks in accordance with the Clinical Guidance document noted above. All three residents had a current written plan of care identifying that they required two assist rails up at all times while in bed to support bed mobility.

Resident #100 was not observed in bed at the time of inspection, however, their bed system had two bed rails, one on each side of the bed. The resident was identified with several risk factors associated with an increased risk of bed system related injury. Whether the resident was actually able to use the bed rails was not clear in the plan of care.

The resident's BRA was completed in August 2018, due to a change in bed rails. However, it was not identified in the assessment or clinical chart what the change was. The assessor documented that the resident had one risk factor and that the resident's SDM requested the bed rails for bed mobility and two bed rails were provided. No documentation was made as to whether alternatives were trialled and what the outcome was for any sleep related observations with bed rails applied. Another BRA was completed in September 2018, as a quarterly assessment. The assessor identified that the bed rails were requested/required by the resident and all other sections were blank except for the section related to consents. Due to the fact that the resident had bed rails, another type of assessment entitled "PASD Evaluation" dated August 2018, was completed and included that two bed rails would be used for transfers and mobility. No alternatives were documented as trialled. No progress notes were made in the resident's clinical record as to the risk over benefit analysis. No conclusion could be made about the resident's overall risk associated with bed rail use in reviewing the assessments available.

Resident #101 was observed in bed with two fixed bed rails in place, one on each side of the bed. The resident was identified with several risk factors associated with an increased risk of bed system related injury. Whether the resident was actually able to use the bed rails was not clear in the plan of care.

The resident's last full BRA was completed in November 2017, and a quarterly

BRA was completed in September 2018. The reason for the 2017 assessment included the term "other" which was not subsequently identified. Only one risk factor related to an increase in bed system related injury was identified and that bed rails would be used for bed mobility. Yet, under a separate section, the assessor selected that bed rails were not applicable and no bed rails would be used. The section related to the outcome of the resident's assessment (factors for or against use of bed rails and alternatives) were all documented as "N/A". No progress notes were made in the resident's clinical record as to a risk over benefit analysis. No conclusion could be made about the resident's overall risk associated with bed rail use.

According to RPN #003, who completed the quarterly assessment in September 2018, the form was designed so that most of the questions could not be answered expect for the section related to consent. In attempting to establish the level of risk for the resident, RPN #003 was asked about the resident while in bed. They stated that the resident was mobile in bed, capable of getting in and out of bed unassisted but had one identified risk factor that placed them at a greater risk of bed system related injury. When asked if the resident should have bed rails, the RPN stated that they did not believe so. When asked about the resident's sleep pattern and history, or any sleep observation results, the RPN revealed that they were not aware of the process as they had not yet completed a full bed safety assessment for any resident. The RPN was not aware of the policy section related to sleep observation. When asked if they had received a detailed overview of the bed safety program, RPN #003 confirmed that all registered staff received an email with an attached policy and slides about the program.

Resident #102 was observed in bed with two fixed assist rails in place, one on each side of the bed. The resident was identified with several risk factors associated with an increased risk of bed system related injury. Whether the resident was actually able to use the bed rails was not clear in the plan of care.

The resident's last full BRA was completed in August 2018, and a quarterly BRA was reviewed dated October 2018. The reason for the August 2018, assessment included a change in bed rails. However, it was not identified in the assessment or clinical record what the change was. Only one risk factor was identified and that bed rails would be used for repositioning. The section related

to the outcome of the resident's assessment included "N/A', that there were no factors against the use of bed rails. No alternatives were documented as trialled. No progress notes were made in the resident's clinical record as to a risk over benefit analysis. No conclusion could be made about the resident's overall risk associated with bed rail use.

The quarterly BRA dated October 2018, was not completed and had no information about the resident's bed rail use or risk related information.

The October 2018, assessment was reviewed with the assessor, RPN #002. According to the RPN, the resident had limited mobility but was able to grab the bed rail and roll themselves side to side. The RPN believed that bed rails were ideal for the resident and that the benefits outweighed the risks. The RPN did not identify any alternatives that could have been trialled for resident #102 before bed rails were implemented. The RPN was aware of options such as a reaching pole, and raised perimeter mattress but not aware of sturdy side bolsters. The RPN, although knowledgeable about the resident and was aware of the sleep observation process, did not clearly document their clinical decision on the assessment form or clinical record (progress notes).

The conclusions related to these residents and the use of their 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. The licensee therefore failed to assess the residents that used one or more bed rails in accordance with prevailing practices, to minimize risk to the resident.

This compliance order (CO) is being made 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. In respect to severity, there is potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is widespread (3). The home had a level 4 history as they had on-going non-compliance with s. 15(1) of O. Reg. 79/10 that included:
• compliance order (CO) #001 issued June 4, 2018 with a compliance due date of August 15, 2018 (2018-539120-0018)
(120)

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

Ministère 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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 10th day of December, 2018

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