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
Jul 4, 2016	2016_189120_0038	025799-15	Follow up

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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): June 15, 2016

An inspection (2015-267528-0016) was previously conducted June 23-July 7, 2015 at which time Order(#001) was issued related to the absence of a formal resident assessment process for residents who used bed rails. For this follow-up visit, the specific conditions included in the Order were met and an assessment process developed and implemented. However, non compliance was identified with respect to the developed resident assessment and documentation process for residents who use one or more bed rails.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Clinical Nurse Specialist, Registered Nurse and Maintenance Manager.

During the course of the inspection, the inspector toured the 2nd floor of the home, observed resident bed systems and various residents in bed, reviewed the licensee's bed system audit results, resident clinical records (plan of care, Bed Rail Risk Assessment) and bed safety policies and procedures.

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)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_267528_0016	120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted, widespread practice as the basis for clinical decisions.

According to one of the FDA companion documents tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", all residents who use one or more bed rails are to 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 completed to determine whether the bed rail(s) are a safe device for residents while 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, that options are discussed with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks. 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 (if next to a rail and along edge of bed) 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 that it was not developed fully in accordance with the FDA Clinical Guidance document.

According to the Director of Care, the questionnaire used by herself and her registered staff included a form titled "Nurse-Bed Rail Risk Assessment - V5" which was completed electronically (Point Click Care) for each resident. During the inspection, the assessment form was reviewed and noted to have been completed for 6 randomly selected residents, however the questions and processes identified in the prevailing practices identified above were not fully incorporated into the assessment form and process.

1. The bed rail risk assessment did not include 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. The licensee's policy titled "Bed Entrapment" directed registered staff to complete the assessment upon admission for new residents and did not direct staff to observe the residents while in bed for any particular period of time to determine sleep patterns, habits and behaviours before completing any questions.

According to the licensee's clinical nursing specialist, registered staff were provided with direction that no bed rails were to be applied upon admission and that the bed be automatically lowered to the lowest position for the first night to determine falls risk. The application of bed rails would be applied at a later date, depending on need for assistance (Personal Assistance Services Device - PASD). However this information was

not in the licensee's bed entrapment policy.

2. The assessment form did not include an area to document what alternatives were trialled prior to applying the bed rails for any resident who had a medical symptom or condition warranting their application. After completing the observation period and determining that the resident would benefit from a device to assist with bed mobility or transfer to and from bed, the licensee's assessment form did not include an area to document what options to reduce the risk of bed rail use were discussed with the resident/SDM and whether they were trialled. The licensee's companion procedure titled "Requirements for the Use of Bed Rails" identified that the only situation that would require registered staff to trial and document an alternative to the use of bed rails was when two 3/4 length bed rails were being considered for bed mobility or repositioning (PASD). Many beds within the home were observed to have quarter and 3/4 sized bed rails. Bed rails of all sizes may present entanglement, suspension or entrapment hazards.

According to a Registered staff member who completed many of the resident assessments, beds did not have the bed rails attached to the frame of their beds when a new resident was admitted. The bed rail risk assessment forms were completed quickly just after admission, were based on the answers provided by the SDM (if available) and resident (if capable) and that the few questions available on the form could not be accurately answered without getting to know the resident better.

3. The bed rail risk assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment forms reviewed included the name of the registered staff member only.

4. The bed rail risk assessment form was designed so that at the start of the form, under the title "Considerations", there were 6 questions related to the residents' cognition, unique clinical conditions and bed use habits. If any of the questions were answered with a "yes", bed rails were not recommended for use. The bed rail risk assessment form did not include questions related to a resident's overall mobility (if able to get into and out of bed safely with or without bed rails), falls history, past injuries related to bed rail use, past entanglement or entrapment, medication use, specific behaviours, toileting habits or sleeping patterns. Although some of the information was gathered under other assessments, the information was not included in the bed rail risk assessment form to aid the assessor in making a comprehensive decision about bed rail use and the safety risks associated with their use for each resident.

At the end of the bed rail risk assessment form, a section titled "Outcomes" included the reason for the application of bed rails. The reasons were limited to three options: 1) to support bed mobility, 2) resident request, 3) SDM request. The section was completed regardless if the "Considerations" section identified that bed rails were not recommended for the resident.

According to the assessments under the title labeled "Considerations" dated November 26/27, 2015 for residents #101, #108 and #109, the bed rails were "not recommended" due to cognition issues and would therefore pose a potential risk for injury/entrapment. Despite this fact, under "Outcomes", each resident was identified to require at least one bed rail to "support bed mobility". A tour of the 3 identified resident rooms was conducted on June 15, 2016 revealed that all 3 resident beds had one 3/4 bed rail raised. According to the written plan of care for residents #101 and #109, both had written direction for staff to apply a 3/4 bed rail for "safety when in use". No direction regarding the use of a bed rail was identified in the written plan of care for resident #108.

According to the bed rail risk assessment for resident #105, who was identified to have cognition issues and bed rail application was not recommended, the "Outcome" section identified that the bed rails would be applied based on the request of the SDM. A tour of the identified resident room was conducted on June 15, 2016 revealed that one 3/4 bed rail was raised. According to the written plan of care for resident #105, no written direction regarding the use of a bed rail was identified.

According to the Director of Care and registered staff member, the application of bed rails would in some cases be applied because they felt pressured by the SDMs who insisted that a bed rail be applied on the first night, regardless of the risks associated with bed rails explained to them. The bed rails were subsequently attached and applied without an independent evaluation period. 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 and as required by the Regulation.

The severity of harm for this non-compliance is #2 (potential for actual harm), the scope is #2 (pattern) and there is compliance history as an Order was previously issued on July 23, 2015 related to the absence of a formal assessment and documentation process for residents who use one or more bed rails. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 11th day of July, 2016

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

Original report signed by the inspector.