Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_539120_0080	018783-16	Follow up

Licensee/Titulaire de permis

PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE
72 Town Centre Drive Townsend ON N0A 1S0

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

GARDENVIEW LONG TERM CARE HOME
72 Town Centre Drive Townsend ON N0A 1S0

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 19, 2016

An inspection (2015-344586-0013) was previously conducted in July 2015 and an Order issued related to the home's bed safety program. A follow-up visit conducted in May 2016 revealed that the Order was not complied with and another Order issued. For this follow-up visit, the majority of the conditions laid out in the Order were addressed and the Order was closed. The remaining compliance issues are identified below.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RAI-MDS Co-ordinator, registered and non-registered staff.

During the course of the inspection, the inspector toured both floors of the home, observed resident bed systems and reviewed residents' clinical records related to bed safety assessments and bed rail use.

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	2016_189120_0036	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 :

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

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

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative

interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this follow up inspection, five residents (#101-105) were selected for review to determine whether they were adequately assessed for bed rail safety. All five residents had a written plan of care requiring that they have one or more bed rails in a particular position (available for use) or were observed in bed with one or more bed rails in use. For this report, the term "in use" includes bed rails that were either in the "guard" position or in the "assist" or "transfer" position. All five residents were assessed by registered staff and monitored by personal support workers over a 7 day period for use of their bed rails using the "Bed Rail Risk Assessment" form. When the form was reviewed, it was noted to have been modified for residents admitted after November 1, 2016, and both the modified version and the original version were missing information identified in the Clinical Guidance document noted above. Discussions were held with the Director of Care (DOC) and registered staff who completed the resident assessments and confirmation was made that many residents, after assessed, no longer required bed rails and the licensee was in the process of removing them. The licensee however was still actively streamlining their assessment process and identified that non-registered staff were not following the written plan of care for residents on the 2nd floor and continued to apply bed rails where not required. The licensee had not developed any policies or procedures for the various staff members in the home to follow in conducting the bed safety assessments and the role of the various interdisciplinary team members was not defined.

A) The licensee's "Bed Rail Risk Assessment" form related to bed rails, included a

number of relevant questions related to the resident's cognition status and some bed related risk factors such as whether the resident fell from bed (over last 6 months), had altered sensations, involuntary movements, communication abilities, if the resident would be getting out of bed unsupervised (future tense), whether they were able to operate the bed rails safely, if the resident used the bed rails for turning and repositioning in bed, overall bed mobility and if they were at risk of climbing over the bed rails. Questions that were missing included those related to toileting habits, signs of pain or discomfort, sleep patterns (or sleeping disorders), habits and behaviours to establish the various risks associated with having a bed rail in place such as but not limited to whether the resident tried to get their arms and legs through the openings in the bed rail, banged body parts against the bed rail, slept on the edge of the bed, had excessive movement in bed and/or did not have the ability to move out of a particular position or were confused despite being cognitively aware when awake. For all five residents, there was no indication of how the resident slept over the 7 day observation period and what potential risks were observed. The form was not designed to include documentation related to a sleep observation period and progress notes reviewed did not include any details either.

B) The "Bed Safety Assessment" form included a section related to what alternatives were trialled, but the form was not designed to include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was successful or not. The list of alternatives on the form did not include all possible alternatives to using a "hard bed rail". The options listed on the form included interventions to prevent injury from falls from bed (mat on floor and bed in lowest position), reminder to use the call bell, restorative care and more frequent staff monitoring (no specifics given). According to the Clinical Guidance document, other options include the use of “perimeter reminders” or “border definers” such as body pillow/cushions/bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort). The alternatives would need to be trialled before a hard bed rail was applied. For four out of the five resident assessments reviewed, bed rails were already in use by the residents prior to the assessment. The assessment therefore was based on confirmation that the resident was still using the hard bed rail(s) and the alternatives listed for all four residents included "bed in the lowest position". For resident #104, the assessment was completed 3 days after admission and did not include whether alternatives were trialled before applying the hard bed rail, when, for how long and whether the alternative trialled was successful or not.

C) The "Bed Safety Assessment" form did not include any names of the persons who

completed the assessment to ensure an interdisciplinary team was involved in assessing the resident. According to the DOC, the registered staff who completed the assessments liaised with the PSWs and the Physiotherapist for input. However, this was not obvious on any of the documentation provided.

Several assessments were confusing and lacked comprehensive conclusions. One question in particular on the assessment form which was answered for residents #101 and #105, identified that they could not use their bed rails safely, however no details were provided as to why they could not. The question, which is considered appropriate, was subsequently removed from the form after October 31, 2016. Based on other questions on both assessments, an assumption was made that neither resident could use their bed rails safely because they were both identified to have moderate to severe cognitive impairment.

Resident #105 was identified on their assessment as having severe cognitive impairment, that they did not request that bed rails be applied, did not have a history of falls out of bed, had altered sensations (no specifics given), did not use their bed rails for bed mobility and required total assistance with bed mobility by staff. During the inspection, the resident was observed to be in bed (in the lowest position with mat on the floor), had padded bed rails and had both bed rails applied in the "guard" position. Under the section identified as "Clinical Decision Making", a note was made by an unnamed assessor that the resident required bed rails because they had dementia, stirred in bed and was therefore at risk of falls. Another question was checked off that the SDM requested the bed rails. The resident's written plan of care identified that the resident required two bed rails in the guard position but did not address the reason why the resident required the bed rails to be in the "guard" position and did not identify why the bed rails required padding. According to various bed manufacturer instructions, falls prevention best practices and the Clinical Guidance document, the use of bed rails is not the best solution for falls prevention and should not be automatically applied if a resident has been assessed at risk of falling out of bed. The medical diagnosis of having dementia is not a reason to apply bed rails and residents with cognitive impairment along with other factors are at higher risk of bed related injuries. However, for resident #105, the assessor documented that the recommendations for applying two bed rails for the resident was due to "the following medical condition/symptoms - dementia, risk for falls".

Resident #101 was identified to require extensive assistance with bed mobility (therefore required staff assistance to turn and reposition), could not use the bed rails safely, did

not request to use the bed rails, had not fallen out of bed in the last 6 months, had moderate cognitive impairment and needed supervision to get out of bed. The clinical decision made by an unnamed assessor was that the resident "required extensive assistance with transferring out of bed, was a medium risk of falls and used the bed rails for turning and repositioning in bed". The written plan of care identified that the resident required two bed rails in the guard position for bed mobility. The conclusion on the assessment form did not identify what was unsafe about the bed rails for this resident, did not clearly identify how the resident used the rails if they required extensive assistance with bed mobility and how the risk outweighed the benefit of applying the bed rails.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and 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 patient.
[s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.