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
Oct 19, 2016	2016_189120_0059	010574-16	Follow up

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street St. Catharines ON L2N 4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street St. Catharines ON L2N 4J4

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): September 30, 2016

An inspection (2016-248214-0003) was previously conducted January 28 to February 11, 2016 at which time non-compliance was identified related to clinical bed safety assessments and Order #001 was issued. For this follow-up inspection, the Order has been closed however several non-risk related issues have not been addressed. The remaining non-compliant issues have been identified below and a VPC issued.

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

During the course of the inspection, the inspector toured the home and observed residents in bed, reviewed resident care plans and clinical bed safety assessments, bed safety educational materials and the licensee's 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:

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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_248214_0003	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. 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 who participated in the decision-making, whether bed rails would be indicated or not, alternatives trialled, 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 (Heidehof Bed Rail Risk Assessment) and process was reviewed and it was determined that although the process included most of the required components identified in the Clinical Guidance document identified above, documentation was incomplete due to a poorly developed Bed Rail Risk Assessment tool or questionnaire.

According to the Director of Care (DOC) and staff educator, the Clinical Guidance document was reviewed and questions were incorporated into their existing questionnaire and assessment process that was used to assess residents for bed rail use/safety. However, documentation was missing to determine if all necessary components were implemented. It appeared that not all components were incorporated and several key factors for establishing risk were noted to be missing from the form used. The form used by registered staff and the DOC was comprised of two sections, the “Assessment" (with 4 questions) and the “Conclusion" which identified how many bed rails a resident would be using, if any and why. There was no information on the form related to alternatives trialled before applying a bed rail, whether a sleep observation was conducted, when, for how long and by whom and what if any interventions would be necessary to mitigate any identified risks if bed rails were to be applied, whether by choice of the resident/SDM or for an assessed need.

A) According to the bed rail risk assessment form provided during the inspection, only 4 questions were established to determine the level of risk that a bed rail could pose when used by a resident. The questions related to the resident's cognition, involuntary movements, risk of climbing over bed rails and the capability of getting in and out of bed unsupervised. These all required the assessor to answer with either a "yes" or a "no". Before moving onto the conclusion section, there was no guidance for the assessor as to the significance of answering with a "yes" or a "no" answer and whether the answers placed the resident at any risk, whether low or significant risk. The questions were limited and did not recognize other factors such as falls history, history of bed related injuries, ability to use a call bell, bed mobility, pain, medication use, sleeping habits and patterns, continence and behaviours in relation to bed rail safety.

According to the Director of Care, the process of assessing the residents did include a sleep observation period which occurred during the month of May 2016. Residents were observed by PSWs on different shifts while the resident was in bed, either with or without a bed rail in use to determine if the resident needed one or more bed rails for bed mobility and transfers and to answer the four questions on the bed rail risk assessment form. Newly admitted residents were first assessed without a bed rail. If after a period of time, the resident was assessed as requiring assistance with bed mobility or transfers, one or both bed rails were applied. The information gathered from the sleep observation was transferred by registered staff to the bed rail risk assessment form and the each residents' care plan was amended to include if bed rails were to be applied, the reason, the number of bed rails to be applied and on what side of the bed.

During a tour of the 1st and 2nd floor, ten residents were randomly selected to have their written plan of care reviewed related to their bed rail use and whether bed rail associated risk assessments were conducted and results documented. Eight residents (#001 to #008) who were observed to be in bed and had one or more bed rails in use (guard position) and two residents (#009 and #010) who were not in bed, each had one of their rotating assist bed rails in the guard position. The written plan of care for all ten residents reflected that they each required one or both bed rails for bed mobility (whether for transfers and/or repositioning/turning) but did not indicate when (while in bed or otherwise).

Ten out of ten bed safety assessments were incomplete as the form did not include the necessary questions and components identified in the Clinical Guidance document. Each resident was identified to require one or more bed rails while in bed. Five of those

residents were identified to have cognition issues which warranted a further review to determine level of risk when in bed.

B) Ten out of the ten clinical bed safety assessments did not include what bed rail alternatives were trialled before the bed rails were applied to minimize or eliminate the possible risks associated with strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising. The form did not include a section in which the assessor could document the alternatives trialled before applying a bed rail and whether they were successful or not. According to the home's educational slides titled "Bed Safety and Side Rails" which were used to present to registered and non-registered staff, a range of alternatives were listed in the slides and were noted to the same as the alternatives listed in Clinical Guidance document. For all ten residents reviewed, no alternatives were documented as trialled and according to the staff educator, the alternatives were not documented in any other records. [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 residents are assessed in accordance with prevailing practices where bed rails are used, to be implemented voluntarily.

Issued on this 21st day of October, 2016

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

Original report signed by the inspector.