BRITISH COLUMBIA

Patient Care Quality Review Boards

Annual Report 2014/2015

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Letter to the Minister of Health

> *"I feel that our concerns were finally heard and addressed."*
>
> **COMPLAINANT**

Sept. 25, 2015

The Honourable Terry Lake
Minister of Health
Room 337, Parliament Buildings
Victoria, BC V8V 1X4

Dear Minister,

It is our pleasure to present the Patient Care Quality Review Boards' Annual Report for the period from April 1, 2014 to March 31, 2015. This report has been prepared in accordance with sections 15(1) and 16(1) of the *Patient Care Quality Review Board Act*.

This Patient Care Quality Review Board system provides patients with a confidential means to identify their experience with our health care system and to ensure a fair and independent review of their concern. This is a demanding process that both tries to resolve any patient complaint and also looks to expose and bring to the ministry or the health authority's attention any care quality issues that might in the future be prevented. The review process relies upon the cooperation of the Ministry of Health, the Patient Care Quality Offices in the health authorities and all the front-line staff throughout the province. Above all, this endeavour to constantly improve health care quality is totally dependent upon patients, clients, residents, and their loved ones who bring their personal health care experiences to us.

Finally, as representatives of all six review boards, we take this opportunity to acknowledge the hard work performed by our secretariat staff. Their investigation process is challenging and critical to the overall success of this program.

Respectfully submitted,

Dr. John (Jack) H. Chritchley
chair, Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards

William Norton
chair, Northern Patient Care Quality Review Board

Roger Sharman
chair, Interior Patient Care Quality Review Board

Richard J. Swift, Q.C.
chair, Vancouver Island Patient Care Quality Review Board

Patient Care Quality Office

"A central function of the Patient Care Quality Review Boards is to ensure that patients and the patient experience are able to influence and improve the delivery of high quality care within our health care system."

JOHN (JACK) H. CHRITCHLEY
chair, Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards

Introduction

The Patient Care Quality Review Boards (the boards) are a fundamental part of a program that focuses on individual care quality experiences within our health system and translates those experiences into quality improvements. The program replicates and improves upon international best practices for reviewing patient care quality complaints.

The boards were established by the *Patient Care Quality Review Board Act* in 2008. There are six boards – each aligned with a health authority. The boards are independent from the health authorities and are accountable to the Minister of Health.

The boards assume that most individual complaints received are likely indicative of a concern that others have experienced, but not raised. The boards see each complaint as a potential opportunity to improve some aspect of quality care within the health care system. The boards make recommendations to the individual health authorities or to the Minister of Health to improve health care systems, processes, policies or services for the benefit of all British Columbians.

The health system in British Columbia provides a phenomenal number of health care interventions each year and as with any large and complex system, it is expected to respond to many patient concerns and to some formal complaints. The boards address only those complaints that have not been resolved by the health authority Patient Care Quality Offices. Timely access to effective patient-centred care is the foundational driver in the planning and implementation of all strategic actions in the health system strategy. The boards are well positioned to align with the Ministry of Health's goal to deliver patient-centered health care; a service built around the individual, not the provider and administration.

In order to perform an effective review process, the board members are provided with a complete picture of a patient's care experience from start to finish, and that includes the investigation and proposed resolution already performed by the health authority Patient Care Quality Office. This comprehensive assessment of the care experience enables the boards to identify lapses in communication, care quality and complaint resolution that may not have been evident from other vantage points in the health care system.

The Patient Care Quality Review Boards' annual report provides a unique view of the care quality activities performed by the boards and improvement opportunities in British Columbia.

Executive Summary

In 2014/15, the boards accepted 100 review requests and this represents the second highest annual intake for the boards. The boards completed 98 reviews and made 86 recommendations to the health authorities for care quality improvement. The boards may make multiple recommendations in one case. In 50 cases, the boards did not make recommendations because either the care quality provided was assessed as being appropriate or the circumstances of the complaint did not present an opportunity for care quality improvement. Some of the lessons learned from the boards' recommendations continue to be shared across the health authorities.

Some key themes arising from this year's board recommendations to the health authorities centred on discharge planning, communication and emergency department mental health treatment. The boards also recommended that the Minister of Health review the use of incidental radiology findings.

Since the program's inception in 2008, the boards have completed 458 reviews and made a total of 591 recommendations to the health authorities, those recommendations prompting action on a broad range of care quality issues. The boards have also made 11 recommendations directly to the Minister of Health.

As part of their mandate, the health authority Patient Care Quality Offices (PCQOs) collect data regarding the number and type of external complaints, care quality complaints and inquiries such as requests for information. This data is then reported quarterly to the boards. Of the 8,925 complaints and enquiries received by the PCQOs this year, 7,107 of those concerned care quality, a 10 per cent increase from the previous year. Of those more than 7,000 complaints, the boards accepted 100 review requests, which indicates that the PCQOs resolved all but approximately 1.4 per cent of the total care quality complaints they received.

Similarly, the boards track data about the types and number of client exchanges it directly receives. In total, the boards received 693 client enquiries relating to a broad range of care quality issues. This includes all other inquiries (by telephone, fax, email or letter) in addition to the formal review requests.

"As the boards note the growing elderly population and the future of health care, the importance of effective and efficient interactions through the system is of greater consequence. Every individual involved with the system needs to strive for continual improvement in every area for the benefit of all British Columbians."

RICHARD J. SWIFT
chair, Vancouver Island Patient Care Quality Review Board

Care Quality Improvements and Board Achievements

The boards reached a milestone this year, completing their 400th review. While that total proceeded to grow to 458 by the end of the fiscal year, it is further evidence that the boards have provided a valuable avenue for patients, clients, residents and their families to raise complaints about their health care. The medical and health care literature throughout the developed world repeatedly observe that private individuals, despite their best efforts, are generally very ineffective in achieving meaningful change and driving improvement to any health care system. By building upon the patient experience here in British Columbia, the Patient Care Quality Review Boards have contributed to significant positive change and improvement in our health care system. The boards take this opportunity to thank all those who made the effort and took the time to raise their concerns so that improvements could be made.

The boards' recommendations to the health authorities are based on the boards' review of the facts about the case presented to them. Once a recommendation is received, the health authority is required to respond with its plan to address the recommendation or to indicate whether work is already underway to address the recommendation. The health authorities' responses to the boards' recommendations have the potential to lead to better outcomes and care quality improvement in the health care system. A key to a successful review is the intake process.

The boards have now been operating with the new online review request form for one full year. Since the implementation of the form, its benefits to the efficiency of the process have been immediately evident to both board secretariat staff and the patient requesting their review. In the last year, the online review request form has become the most common method for initiating a review, with a total of 42 per cent of all reviews starting in this way. A further 13 per cent of reviews were initiated using the online review request form in conjunction with staff over the phone. Over the same period, the use of the traditional hard-copy form has fallen dramatically: mail-in forms reduced by 63 per cent, faxed forms reduced by 40 per cent, and submissions received by citizens who printed, scanned and emailed their form reduced by 85 per cent.

Additionally, a lengthy project was completed this year to standardize reporting categories in each aspect of the Patient Care Quality program. Representatives from the each health authority Patient Care Quality Office, the secretariat and the ministry collaborated to outline each category of complaint and its definition. This new reporting structure will allow for more accurate, reliable and comparable data across the province. Improvements to data collection and reporting will improve the ability to see trends and identify areas for improvement. This project was a significant undertaking and the boards would like to voice their appreciation to those involved.

The boards would also like to take the opportunity to acknowledge the work of the Patient Care Quality Offices and its officers. The boards have noted that the health authorities' response letters provided to complainants are offering a clear outline of the complaints received and complete responses to each concern. The health authorities resolve over 98 per cent of the complaints they receive each year.

Key Recommendation Themes in 2014/15

Discharge Planning and Process

Over the past two years, the boards have seen an increase in the number of cases where discharge planning, particularly for vulnerable adults, was not handled in a timely or satisfactory manner. The boards made a number of recommendations this year to improve the discharge processes in five of the six health authorities across the province. Recommendations included staff training to improve the communication between staff, patients and their families prior to discharge and clear policy development to guide the discharge process.

Emergency Department Mental Health Treatment

Over the past two years, the boards have reviewed a growing number of complaints from people dissatisfied with the treatment they received in the emergency department for mental health concerns. The boards found that the emergency treatment provided to patients presenting with serious mental health concerns was, at times, lacking timeliness and/or sufficient follow-up. The boards recognize this is a very serious and complex issue that will require further monitoring by the health care system.

Communication

Communication is a consistent theme throughout the majority of the complaints brought to the boards every year. The boards acknowledge that the primary role of health care professionals is to provide high quality patient care. However, it is also understood that the mechanics of providing health care are often very complex and involve concepts that the general public is not always familiar with. In many cases where patients suffer a negative outcome, the cause is outside of the health care professionals' scope of control. It is these cases that require the most empathetic and thorough explanation to patients, residents, clients or their families to ensure their understanding.

The whole of the Patient Care Quality program is an avenue for communication with patients, clients, residents and their families. However, the boards recognize that once a complaint is brought forward for review, the issues have been firmly established and entrenched. Empathetic interpersonal communication and proactive de-escalation at the point of service is essential to increase the level of understanding for patients and their loved ones and their experience through the health care system.

Where communication issues are noted to be the root of a complaint, the boards recommended in-person meetings between everyone involved to explain, in plain language, the reasons for the outcomes and care that was received.

"By being anchored in the regions they serve, the boards are well-positioned to observe unique factors affecting the different areas of the province."

WILLIAM NORTON
chair, Northern Patient Care Quality Review Board

About the Patient Care Quality Review Boards

"The Patient Care Quality Review Boards view complaints as a vital form of patient feedback and accept that each complaint can provide unique and valuable information that helps us make recommendations for quality improvement."

ROGER SHARMAN
chair, Interior Patient Care Quality Review Board

Mandate

The *Patient Care Quality Review Board Act* and External Complaint Regulation govern how the boards review complaints and what can and cannot be reviewed.

The boards may review any care quality complaint regarding services funded or provided by a health authority, either directly or through a contracted agency. The boards may also review complaints regarding services expected, but not delivered, by a health authority (e.g., a complaint regarding a cancelled surgery).

The boards may only review complaints that have first been addressed by a health authority's Patient Care Quality Office, unless otherwise directed by the minister.

If the boards receive a complaint that cannot be reviewed, the complainant is redirected to the most appropriate body for their concerns.

As a result of a review, the boards can make recommendations to a health authority or to the minister to improve the way complaints are handled, to improve the quality of patient care, or to resolve a specific care quality complaint.

Finally, the boards monitor, track, and report on care quality complaints in British Columbia.

The Review Process

Patients and their loved ones may request a review by submitting a review request form (by mail, email, online, or fax), or by calling 1 866 952-2448. If the board can review the complaint, the health authority's Patient Care Quality Office will be notified and asked to provide a copy of any information relating to the complaint.

The board will review the facts and other background information, seeking expert advice and/or clarification from the health authority, the complainant, and/or other experts, as required.

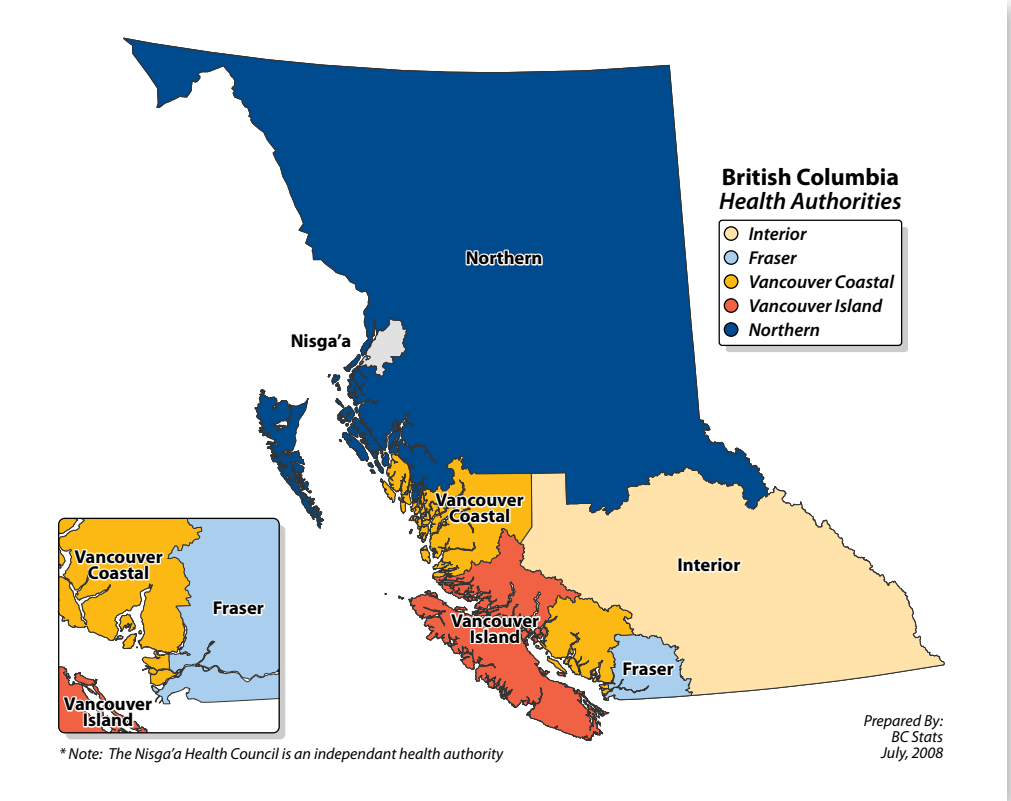
Once the review is complete, the board will send the complainant and the health authority a final decision letter, indicating whether any recommendations have been made. The board explains its findings and the reasoning for decisions in the letter. A copy of the letter is also sent to the Minister of Health so the ministry can follow up with the health authority on the implementation of recommendations.

When a board makes recommendations, the health authority will contact the complainant to discuss the outcome and any actions that may be taken to address the care quality issues highlighted by the board's review.

About the Boards | *Current Members*

Board members are appointed by the Minister of Health based on their expertise and experience. Members are eligible to serve one, two or three year terms, and may be reappointed to consecutive terms at the discretion of the minister. Current employees of the health authority, including board members and contractors, are not eligible to serve on the boards.

This year, we would like to acknowledge the contributions of original board member Sandra Wilking, departing from the Fraser/Vancouver Coastal/Provincial Health Services Review Boards after six years of service.



> *"I am particularly grateful to you and your board for the thorough review."*
>
> **COMPLAINANT**

Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Board

Dr. Jack Chritchley, chair
Dr. John H. V. Gilbert, C.M.
Robert D. Holmes, Q.C.
Dr. Naznin Virji-Babul
Janis A. Volker
R. Hoops Harrison

Interior Patient Care Quality Review Board

Roger Sharman, chair
Dr. Randall Fairey
Donna Horning
Thomas Humphries
Gloria Morgan
Dr. Robert Ross

Northern Patient Care Quality Review Board

William Norton, chair
Dr. Jack Chritchley
Lorna Dittmar
Elizabeth MacRitchie
Allison Read

Vancouver Island Patient Care Quality Review Board

Richard J. Swift, Q.C., chair
Ann Beamish
Michael F. Patterson
Dr. Linda J.A. Thomson
G. Henry Ellis

Statistical Overview | *Patient Care Quality Offices*

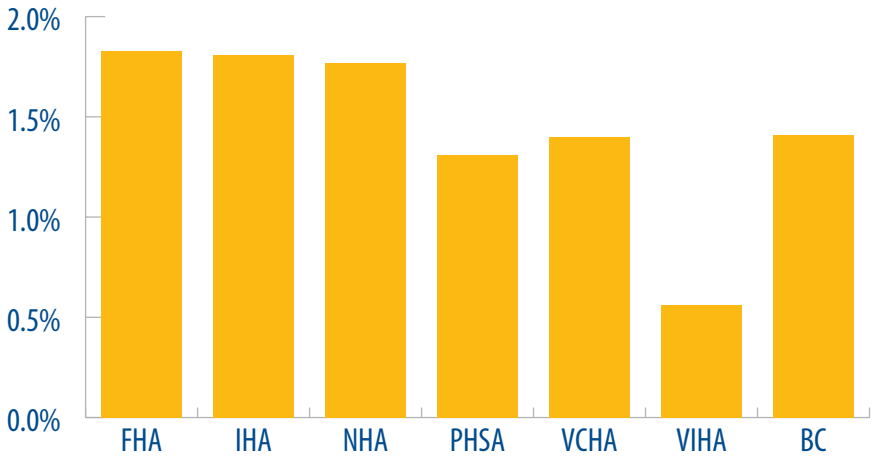
The boards collect data from the health authority Patient Care Quality Offices (PCQOs) regarding the number and type of complaints received by the PCQOs in each quarter throughout the fiscal year. In 2014/15, there were 7,107 care quality complaints (an increase of 634, or 10 per cent, from the 6,473 complaints[1] received in 2013/14), 171 external complaints and 1,647 inquiries in British Columbia (see Appendix A for details). The table below presents the volume of care quality complaints received by each PCQO between April 1, 2014 and March 31, 2015.

TABLE 1: *Volume of Care Quality Complaints by Health Authority (including provincial totals)*

HEALTH AUTHORITY	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL 2014/15
Fraser Health	500	507	485	531	2,023
Interior Health	249	310	251	295	1,105
Island Health	362	422	396	417	1,597
Northern Health	78	57	70	77	282
Provincial Health Services Authority	112	113	112	122	459
Vancouver Coastal Health	381	431	401	428	1,641
BRITISH COLUMBIA	**1,682**	**1,840**	**1,715**	**1,870**	**7,107**

In addition to the 7,107 care quality complaints received by the PCQOs, the boards accepted 100 reviews, or approximately 1.4 per cent of the total PCQO complaints within the same timeframe. This suggests that the vast majority of health care complaints were resolved at the health authority level. The chart below shows the percentage of care quality complaints that escalated to the boards from each PCQO over the 2014/15 period. It should be noted that this graph represents a small sample size and is subject to fluctuations year-over-year. It is not intended to be an indication of PCQO performance, though the statistics indicate that health authorities are resolving over 98 per cent of complaints at the regional level.

CHART 1: *Percentage of Care Quality Complaints that become PCQRB Accepted Review Requests in 2014/15*



1 External complaints are defined by the ***Patient Care Quality Review Board Act*** and External Complaint Regulation, and may include complaints about services that are not funded or provided by the health authorities, or complaints that are best addressed by another entity.

Statistical Overview | *Patient Care Quality Review Boards*

In 2014/15, the boards saw a five per cent decrease in accepted review requests, 100 from 105 last year (three reviews were cancelled at the request of the complainant). However, the boards completed 98 reviews (up from 75 last year) – a 31 per cent increase in completed reviews. This represents the most reviews completed by the boards in one reporting year. The table below presents an overview of the boards' volume.

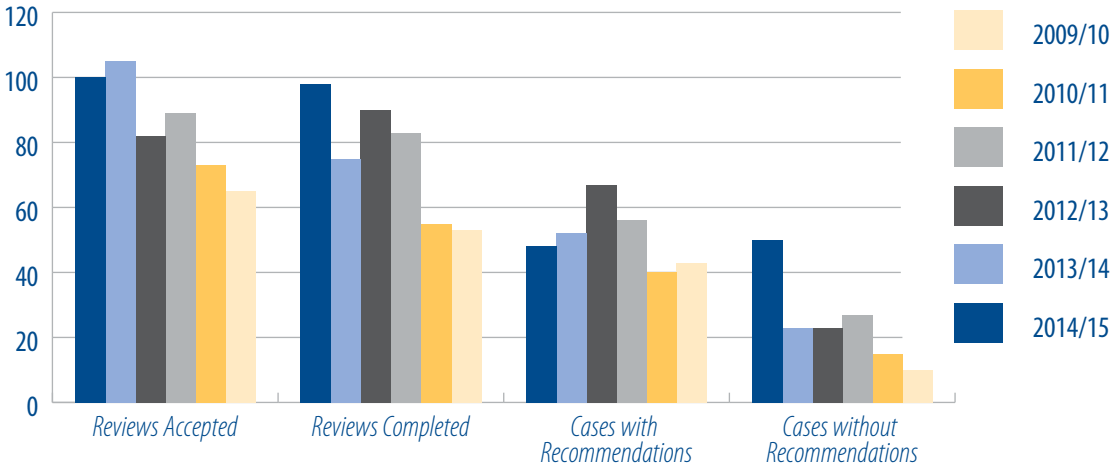
In 48 of the completed reviews (49 per cent), the boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself. In 50 of the completed reviews (51per cent), the boards did not make recommendations, having concluded that either the quality of care provided had been appropriate or that the circumstances of the complaint did not present an opportunity for care quality improvement. The boards made a total of 87 recommendations in 2014/15 – 86 to the health authorities and one to the Minister of Health.

TABLE 2: *Overview of Patient Care Quality Review Board Volume*

HEALTH AUTHORITY	Reviews Accepted	Reviews Completed	Cases with Recommendation(s)	Cases without Recommendation(s)
Fraser Health	37	23	14	9
Interior Health	20	24	9	15
Island Health	9	15	8	7
Northern Health	5	6	3	3
Provincial Health Services Authority	6	4	3	1
Vancouver Coastal Health	23	26	11	15
TOTAL	**100**	**98**	**48**	**50**

The boards made a total of 84 recommendations in 2013/14 – 83 to the health authorities and one to the Minister of Health.

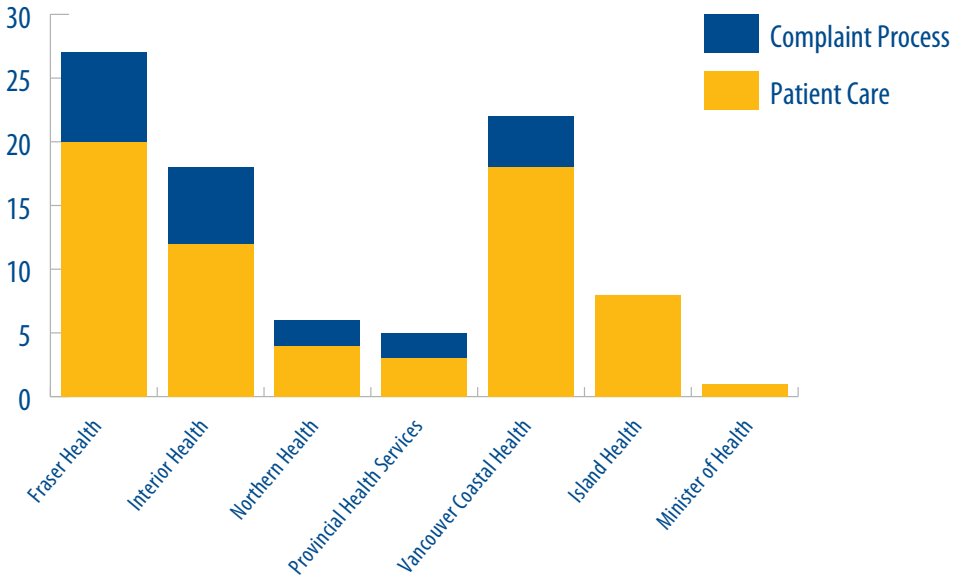
CHART 2: *Volume Comparison for Recommendations and Reviews*



Statistical Overview | *Patient Care Quality Review Boards*

Of the 86 total recommendations to health authorities, 65 were to improve the quality of patient care, and 21 were to improve the complaints process (see chart 3 below). In 19 of the completed reviews, the boards identified opportunities for the Patient Care Quality Offices (PCQOs) to improve the quality of their investigation or response. In the remaining 79 reviews, the boards found the PCQOs had responded appropriately.

CHART 3: *Recommendations Concerning Complaints Process vs. Patient Care*



The boards also collect information regarding the timeliness of health authority responses to board recommendations. Under the *Patient Care Quality Review Board Act*, health authorities are required to respond to recommendations within 30 business days, not including statutory holidays. Health authorities achieved this timeline in 35 of the 48 reviews that resulted in recommendations.

Finally, the boards track the timeliness of our own reviews. Under the legislation, the boards are expected to complete those reviews and respond within a maximum of 130 business days unless the board determines that an extension is warranted. The average time to complete a review and respond to the complainant was 129 business days. The median time was 128 days. On average, the board took eight business days to provide a response following their decision. The median number of business days was seven.

The chart below represents the subjects of all the complaints reviewed by the boards in 2014/15. The changes to the provincial data reporting structure referenced earlier are most noticeable in the chart below. Note that one complaint may encompass more than one care issue, so the total number of care issues will often be higher than the total number of complaints reviewed.

SECTOR	SUBJECT	#
Ambulance – critical care transfer	Care	1
	Rough handling	1
Ambulance – non-critical care transfer	Accessibility	1
	Communication	1
Acute care– cancer	Care	3
	Communication	2
	Accessibility	1
	Environmental	1
Acute care – mental health	Discharge arrangements	2
Acute care – other	Care	45
	Discharge arrangements	8
	Communication	7
	Environmental	5
	Accessibility	4
	Attitude and conduct	4
	Co-ordination	1
	Lost article	1
Administration	Care	2
	Administrative fairness	1
	Communication	1
	Inadequate or incorrect information	1
Ambulatory care – cancer	Accessibility	10
	Attitude and conduct	4
	Financial	1
Ambulatory care – other	Accessibility	5
	Attitude and conduct	5
	Care	1
	Communication	1
Ambulatory care – renal	Care	2
Emergency	Care	30
	Accessibility	6
	Attitude and conduct	5
	Co-ordination	2
	Communication	1
	Discharge arrangements	1
Home and community care (not including mental health)	Care	10
	Accessibility	7
	Attitude and conduct	2
	Administrative fairness	1
	Communication	1
	Co-ordination	1
	Financial	1
Mental health – community, substance use and housing	Care	6
	Accessibility	5
	Discharge arrangements	2
	Communication	1
Primary care	Care	2
Residential care	Care	14
	Accessibility	4
	Financial	3
	Residents' Bill of Rights	2
	Accommodation	1
	Challenging patient or family behaviour	1
	Communication	1
	Co-ordination	1
TOTAL		**233**

After completing a review, a board may make recommendations to the health authority and/or the Minister of Health to improve the quality of care and to improve the complaints process.

When making recommendations, the boards consider:

- The context of the complaint from both the health authority and the patient's perspective;
- The policies, procedures, guidelines, etc. that are applicable to the complaint;
- The evidence base for the recommendation;
- The potential impact of the recommendation; and
- The feasibility of implementing the recommendation.

The health authorities carefully consider recommendations and are required to respond, to both the board and the complainant, to indicate what action(s) will be taken to address them.

In 2014/15, the boards made one recommendation to the Minister of Health and 86 recommendations to the health authorities. The following presents each of the boards' recommendations for this reporting period, along with some highlights of actions taken in response.

Recommendations to the Minister of Health

1. That the Minister of Health have the appropriate committee at the Ministry of Health undertake a review of best practices on the communication of incidental findings from radiology reports, with a focus on:

i. Identification of incidental findings from radiology.

ii. Communication between radiologists and emergency room physicians.

iii. Communication of incidental findings to family physicians.

iv. Communication of incidental findings with patients and family members.

The committee should have representation consisting of radiologists, general practitioners and medical chiefs of staff, with the goal of developing recommendations on managing and improving the communication process. Consideration should include the use of electronic health records and discharge summaries to identify and highlight incidental findings.

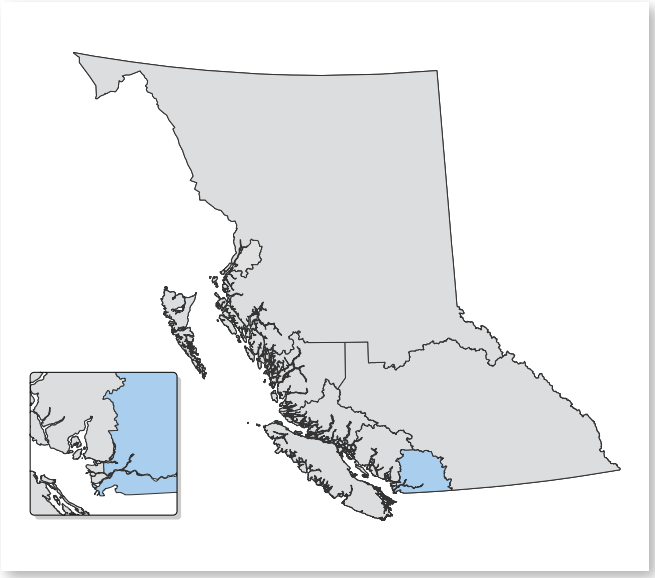
Summary of Response:

In response to the board's recommendation, Ministry of Health staff reviewed the circumstances of the case and consulted with appropriate program area experts. This consultation revealed that the management of incidental findings in radiology reports is a known concern in the radiology practice community, and that the board's recommendation is a timely reminder of the need to address this issue.

In order to make sure that this recommendation is given the appropriate attention, the ministry forwarded the board's recommendation to the Medical Imaging Advisory Committee (the Imaging Committee). The Imaging Committee is co-chaired by the ministry, and provides expert advice and recommendations on medical imaging issues and policy. The committee is a body of subject matter experts that is best positioned to consider the board's recommendation and advise the ministry on further action.

The Imaging Committee agreed to form a working group comprised of members nominated by medical directors of medical imaging from each health authority. The working group will consider the communication of incidental findings in radiology exams and make recommendations back to the Imaging Committee.

Recommendations and Responses | *Fraser Health*



Fraser Health is responsible for serving a densely populated and multi-culturally diverse region with more than 1.6 million British Columbians.

The boards completed their review of 22 cases from Fraser Health in 2014/15, resulting in 27 recommendations from 13 cases. Of the 27 recommendations, 20 were to improve care quality and seven were to improve the complaints process.

The board made recommendations on complaints ranging from closing the communication gap between patients and health care workers to improving home and community care services. In response to the board's recommendations, Fraser Health has reviewed its policies and health care strategies, as well as provided further information and arranged for staff education.

1. COMPLAINT REGARDING INVOLUNTARY MENTAL HEALTH ADMISSION.

Recommendations:

i. The board recommended the health authority make sure the complainant's complete medical file is available to the mental health team and allow the complainant an opportunity to voice any concerns or questions to the mental health team about their time in seclusion in June 2012.

Response:

i. The Fraser Health [facility] psychiatry (mental health) leadership team (i.e., department head, clinical programs director and manager) will schedule a meeting with the complainant to review a copy of their file, discuss the issues and work towards a resolution.

2. COMPLAINT REGARDING PHYSICAL THERAPY CARE DEFICIENCIES DURING ACUTE CARE ADMISSION.

Recommendations:

i. The board recommended the health authority review its current demand for ceiling lifts with regard to the aging population, rise in obesity rates and safety requirements for staff, to make sure that reasonable resources are in place at each health care facility.

ii. The board recommended the health authority organize a meeting with the complainant and the physician's involved in the patient's care to review the care the patient received at [facility] and to provide further clarification to the complainant on any outstanding concerns they may have.

iii. The board recommended the health authority review current resourcing at the Patient Care Quality Office (PCQO), given that the response sent by the PCQO did not meet legislated requirements and was delayed by almost a year.

Response:

i. Fraser Health has developed a Safe Client Handling program/Ceiling Lift Installation plan. Given the average funding over the last five years, it is projected that it will take between four-to-eight years to complete this project without additional funding. For 2014/2015, capital will be allocated to high-risk departments with ceiling lift coverage that is less than 25 percent.

ii. The PCQO will facilitate a meeting with the family and the care team based on family and physician availability.

iii. The PCQO has undergone a service redesign in 2013/2014 and have executive team approval of the following actions to ensure its operations are more patient centered and that patients, clients, residents and families receive resolution of their concerns in a timely manner.

- ***a.*** Complaints Management policy (June 2014).
- ***b.*** Patient Care Quality Office Escalation policy (for when a response from the designated lead is not received within 15 business days).
- ***c.*** A monthly discussion of overdue events at the executive committee level.
- ***d.*** Approval of two additional patient care quality officers.
- ***e.*** A daily spreadsheet to the executive team summarizing the complaints that were received that day.

3. COMPLAINT REGARDING THE LACK OF REFERRAL TO A NEUROPSYCHIATRY FACILITY AFTER HEAD TRAUMA.

Recommendations:

i. The board recommended Fraser Health have their Patient Care Quality Office review their management of this complaint, determine what led to the office being unable to meet the requirements of the office pursuant to the ministerial directives under the *Patient Care Quality Review Board Act* and apologize to the complainant for the delay in responding.

Response:

i. The Patient Care Quality Office (PCQO) reviewed the circumstances and acknowledged that the requirements under the ministerial directives were not met. Factors that prevented a timely response to the board included workload for the previous staffing complement and timely physician response to arrange an appointment in a different health authority. A multi-pronged action plan is in progress to increase PCQO capacity, improve the complaints resolution process, and enable monitoring of complaints trends and improvement by the organization. The health authority is appointing an additional two full-time staff members to the PCQO to reduce delays in response to complaints. One of these positions will serve as a liaison between the PCQRB and the health authority and ensure all reviews and requests for additional information are completed on time. Other actions implemented already will assist the PCQO in meeting timelines. These include service redesign to a case management approach and an escalation policy to senior leadership if responses to complaints are not received from designated leads within 10 business days. The management team will now report to the Quality Committee at each Fraser Health board meeting the number of complaints outstanding and the number that are past the required time limit as the board is requiring immediate improvement to previous standards. Staff are also in the process of being empowered to respond immediately to any raised public concerns prior to the concerns being forwarded to the PCQO.

4. COMPLAINT REGARDING THE CARE PROVIDED BY HOME SUPPORT WORKERS CONTRACTED BY THE HEALTH AUTHORITY.

Recommendations:

i. The board recommended Fraser Health make sure:

- ***a.*** Proper managerial oversight and monitoring is undertaken by home support staff to ensure quality care is provided to the client;
- ***b.*** Fraser Home Health follow-up and document the complainant's care quality satisfaction three months from any service changes resulting from this review; and,
- ***c.*** The client's care plan is accurately followed.

Response:

i. Fraser Health has implemented proper managerial oversight and reinforced job accountabilities with supervisors and team leaders. The home support manager had a discussion with the complainant, and has formulated an agreed action plan with the goal of greater consistency of community health workers scheduled and fewer cancellations of visits. Recently, the complainant stated that the home support service has "drastically improved in the past few months."

5. COMPLAINT REGARDING LOST JEWELRY DURING SURGERY.

Recommendations:

i. The board recommended the health authority develops a standardized policy and procedure to ensure the tracking and safekeeping of patient valuables.

Response:

i. The Lower Mainland consolidated medical imaging department developed a standardized policy, which will be implemented across all patient care areas of Fraser Health by the end of 2014.

6. COMPLAINT REGARDING THE CARE RECEIVED WHILE IN ACUTE CARE.

Recommendations:

i. The board recommended the Patient Care Quality Office provide the complainant with the consultation for [date] as well as the consultation report for [date], and provide information on how they can request the rest of the medical chart from health records.

Response:

i. The Patient Care Quality Office provided the complainant with the consultation reports and information on how to request their chart in a letter dated [date].

7. COMPLAINT REGARDING CARE PROVIDED AND TIMELINESS OF PATIENT CARE QUALITY OFFICE RESPONSE.

Recommendations:

i. The board recommended the Fraser Health Patient Care Quality Office (PCQO) share with the complainant what changes have been made to the PCQO in the re-design of the service delivery model and how these changes will avoid issues such as this case in the future.

Response:

i. Fraser Health responded to the complainant by letter (sent [date]). Outlined the following changes to the PCQO:

- ***a.*** Changes to the process of managing complaints, escalation of delays to senior leadership for urgent action and attempts to deal with issues at the time they occur have ensured Fraser Health consistently completed more than 90 percent of complaint responses within 40 business days since April 2014 (the Ministry of Health target is 85 percent of responses completed within 40 business days).
- ***b.*** The PCQO is reviewing overdue files every two weeks to make sure actions are implemented for closure and any delays are kept to a minimum.
- ***c.*** Recently increased the staffing of the PCQO.
- ***d.*** The PCQO monitors and regularly reports to Fraser Health executive leaders and board, as well as the Ministry of Health on complaints resolution performance.

8. COMPLAINT REGARDING INADEQUATE CARE, INCLUDING MISSED APPOINTMENTS, BY HOME AND COMMUNITY CARE WORKERS.

Recommendations:

i. The board recommended the health authority make sure all the physicians who have admitting privileges at [facility] are made aware of the importance of listening to the family of patients, and that in cases where multiple physicians and/or program areas are involved, appropriate clinical information is shared and understood by the receiving responsible care providers.

Response:

i. [Facility] medical co-ordinator has reviewed the recommendation and has committed to the following actions to ensure better physician engagement with patients and families in the future:

- ***a.*** Arrange a roundtable discussion/review of this case with the clinical staff involved in the care of this patient. Hospital medical co-ordinator will consult with program medical director, quality improvement & patient safety, before proceeding to make sure this discussion is properly structured to afford Section 51 protection to those participating.
- ***b.*** A communication in the form of a memo will be sent in the fall to all physicians reinforcing the importance of listening to family members of patients without discussing the specifics of the case.
- ***c.*** The same message will be presented as part of the medical co-ordinators report at the subsequent meeting of the general medical staff, maintaining the confidentiality of the patient and physicians involved in the case.

9. COMPLAINT REGARDING MULTIPLE ASPECTS OF ACUTE CARE PROVIDED, INCLUDING SCENT POLICY ISSUES AND PATIENT CARE QUALITY OFFICE RESPONSIVENESS.

Recommendations:

i. The board recommended the health authority review its scent policy regarding scented products and enforce it. This review should include consideration regarding all types of scented products such as flowers (not just lilies) and pollen producing items that may compromise the patient's care.

ii. The board recommended the health authority:

- ***a.*** Review their professional policy regarding the transition of shifts when staff are taking breaks or changing shifts and that Fraser Health explain to the complainant how they ensure continuity of care continues on a regular basis during the entire shift, including break times.
- ***b.*** Provide to the complainant the process regarding the appropriate regulatory governing body to address the issue of the registered nurse taking a break during a critical time in the patient's care.

iii. The board recommended the health authority explain how it ensures continuity of care and:

- ***a.*** Focus on improvements in communications between staff and family on a continual basis.
- ***b.*** Identify and communicate how hospitalists transition on discharge planning for continued care.
- ***c.*** Explain how the health authority ensures continuity of care between hospitalists and the patient's family physician.

iv. That the health authority makes sure there is adequate resourcing of the Patient Care Quality Office to improve the timeliness of the process and meet the legislated requirements.

Response:

i. Fraser Health will continue to reinforce the Scented Products Policy. Signs are posted throughout facilities indicating facilities are "no scent" environments, which includes all scented plants. Ongoing compliance checks are performed regularly to ensure the policy is followed.

ii. ***a.*** Verbal handover between caregivers to their partners, at break times, is a professional standard and an expected conduct. Ongoing education to improve communication skills occurs regularly on each unit. The new 24 hour flow sheet for medicine contains a shift handover report that will be a permanent part of the client's chart.

b. Fraser Health abides by the B.C. Nurses' Union mandate for the length and number of breaks a registered nurse must take during their shift. All staff are paired with a "shift buddy" to care for clients while on breaks. Therefore, the patient's care continues during break times.

iii. ***a.*** Every patient on the medicine unit has a white board at their bedside, which is used for timelines and appropriate communication that highlights areas such as: clients preferred name, clients primary care provider(s) on that shift, goals of care, questions from family, estimated discharge date and mobilization instructions. Medicine care standards, implemented by April 2015, indicate all patients and identified family members will be provided with education and support regarding their diagnosis and/or new care needs for discharge, available community resources, and return of all personal belongings. These standards also align with College of Registered Nurses of British Columbia care standards.

b. All physicians must complete a discharge summary. The Fraser Health initiative (48/6), under discharge and care planning, is to be completed on every patient within the medicine unit and used to communicate the plan of care with all care providers.

Response (continued):

c. All physicians must complete a discharge summary, and this is sent to the patient's GP on record for the client. A process to notify physicians of delayed completion of documentation, including discharge summaries, was implemented in November 2014 and includes escalation to physician leaders for action.

iv. The Patient Care Quality Office has undergone a service redesign and appointed new staff and now achieves the legislated timeliness targets.

10. COMPLAINT REGARDING MENTAL HEALTH CARE IN THE EMERGENCY DEPARTMENT AND LACK OF FOLLOW-UP.

Recommendations:

i. The board recommended:

a. In the event a patient with a documented mental health diagnosis (e.g., depression, anxiety, suicide risk) who is identified as needing follow up care, leaves the emergency department (ED) prior to having their full assessment completed, a health care professional (ED staff) follows up with the patient in an attempt to ensure the patient's safety and that the efforts to contact the patient are charted in the ED record;

b. The health authority develop a protocol or guideline for that follow up; and,

c. If the ED staff decide not to follow up, then the reasons why should be charted in the ED record.

ii. The board recommended the health authority completes the Death and Dying Clinical Decision Support Tool and consults with the Ministry of Health for guidance and best practices.

Response:

i. The Fraser Health mental health and substance use (MHSU) and emergency department programs are developing a protocol for the management of patients with a documented MHSU diagnosis (e.g., depression, anxiety, suicide risk) who either:

1. Leave the emergency department (ED) without being seen by a physician; or

2. Leave the ED prior to completion of a full assessment and documented discharge plan.

To ensure patient safety and follow up, an ED health care professional will attempt to contact the patient and will document the outcome and plan for follow up in the patient record.

a. The above protocol will be developed and implemented in all emergency departments across Fraser Heath. It is anticipated that this protocol will be developed and implemented in all Fraser Health regional emergency departments by March 31, 2015.

b. This recommendation will be included in the protocol.

ii. A clinical decision support tool titled "Death and Dying (Adults) Social Work Guideline for Acute Care Services - Clinical Practice Guideline" is in development, and after review of the recommendations there is recognition that it must be expanded beyond social work as this discipline is not available 24/7 at most hospital sites. The work on this support tool will include consultation with the ministry as recommended, with end of life program and with other clinical team members present 24/7. It is anticipated this work will be completed by Sept. 30, 2015.

11. COMPLAINT REGARDING ALLEGATIONS OF PHYSICIAN NEGLECT RESULTING IN DEATH.

Recommendations:

i. The board recommended the health authority require the Patient Care Quality Office to provide the complainant with a further written response that includes answers to the five unresolved questions.

ii. The board recommended the health authority have the chief of staff at [facility] review the patient's chart to determine:

- ***a.*** Whether the patient received adequate pre-operative and post-operative physician visits and communication, and provide a written response on the findings to the complainant.
- ***b.*** How to bring about better interaction and communication between the family, the BC Cancer Agency, the most responsible surgeon and other physicians involved with the patient's care, and whether a frank discussion among the treating physicians followed by a discussion with the family would have resulted in a more appropriate focus on patient centered care as distinct from illness centered care.

iii. Considering that this patient had far advanced metastatic cancer spread to many organ systems, the board recommended the health authority consider using this case as an in-service to the relevant health professionals in this unit, for their consideration of the many medical, surgical, psychosocial aspects of appropriate care, and include the findings and any recommendations resulting from the review by the chief of staff.

Response:

i. A letter was sent from the medical co-ordinator for [facility], addressing the unresolved concerns to the complainant responding to the specified unresolved issues.

ii. ***a.*** The site medical co-ordinator reviewed the file and found that the physician was deficient in responding appropriately to the nursing staff and hence to the concerns of the family. The medical co-ordinator also found that the visits pre- and postoperatively, particularly preoperatively, were well below what Fraser Health would have anticipated in light of the service being provided in the patient's condition. Also, better communication with the patient and family would have been expected.

- ***b.*** The site medical co-ordinator recommended that the most responsible physician and/or other physicians involved in the co-management of these types of cases facilitate dialogue to evolve a care plan for the patients. This care plan could then be better communicated to the patient and family. The ongoing communication strategies will be part of the current Fraser Health reorganization process.
- ***c.*** The site medical co-ordinator believes, after conducting his review, that had there been adequate discussion and communications during this time, there would have been a better understanding of the patient's clinical condition and the anticipated outcome.

iii. The site medical co-ordinator agreed that this case highlighted many issues with communication between health care providers and with the patients/families, and may be used for instructional purposes. This topic will be brought to the new vice-president of medicine when the position is filled.

12. COMPLAINT REGARDING ALLERGIC REACTION TO MEDICATION AND CONTRACTION OF COMMUNICABLE DISEASE WHILE IN CARE.

Recommendations:

i. The board recommended the health authority investigate the patient's treatment for back pain and subsequent readmission for acid reflux and hematemesis as a near miss. In particular, the board recommends:

- ***a.*** The health authority investigation considers if appropriate measures are being taken to prevent drugs being administered when it is known that patients have an allergy or sensitivity to that drug, or a similar drug.
- ***b.*** The health authority investigation considers if appropriate attention is being paid to patients' medical histories before medications are administered, especially the administration of NSAIDs for patients with gastrointestinal disorders.

ii. The board recommended the health authority update the policy, Communicable Disease – Prevention and Management of Occupational Exposure, so that it explicitly states that immunizations for health care workers are not mandatory and provides a rationale for this policy. The board further recommends the health authority clearly communicate this policy and rationale to the complainant.

Response:

i. ***a.*** Allergy information is communicated by manual transcription on order forms. If pharmacy does not see allergies entered for the encounter and nothing is written on the order form, they call the unit and ask the nurse to confirm the information, which is then entered into the electronic medical record. No form is completed if the patient does not identify allergies. A regional policy to identify and document patient/client allergies and adverse reactions to substances such as medication, contrast media, food, environment and latex, and to prevent their inadvertent administration/ application is expected to be completed by July 2015, with implementation immediately after.

b. Fraser Health reported that care teams adhere to the seven rights of medication administration throughout the medication administration process. Within the Clinical Protocol for Medication Practice, the actions are clear that the medication administration record or client chart/directive will be used to direct all medication preparation and administration, with a review of the order to ensure it is clear, complete, current, legible and appropriate for the client. A review of allergy status, precautions and contraindications for the medication is also completed. Condition specific support tools are available to assist with medication administration.

ii. The BC Centre for Disease Control's Communicable Disease Control Immunization Program manual guides all immunization practices in British Columbia. Although vaccination is not mandatory for employees who are non-immune to the vaccine-preventable communicable diseases for which Fraser Health offers vaccination, non-immune employees are strongly encouraged to receive vaccination in order to protect themselves as well as susceptible patients, residents, clients and co-workers. In the event of an exposure/outbreak of a vaccine-preventable communicable disease, employees may be excluded from work for the period of communicability. An employee may be excluded with pay if there are medically documented contraindications to receiving the vaccine (i.e., pregnancy is a contraindication for a live vaccine) and/or known severe reaction to the vaccine or any of its components. An employee may be excluded without pay if there are no medical contraindications or known severe reactions.

13. COMPLAINT REGARDING MISDIAGNOSIS OF STROKE SYMPTOMS AND FAILURE TO LISTEN TO THE PATIENT'S FAMILY.

Recommendations:

i. The board recommended Fraser Health triage staff receive sufficient in-service training to emphasize the importance of listening to the family and asking probing questions of the patient on presentation to provide the best diagnosis at the time, particularly when a stroke is a possibility or has been raised by the family.

ii. The board recommended Fraser Health makes sure that, when a change in diagnosis occurs that warrants a change in the Canadian Triage Acuity Scale level, this change is made.

iii. The board recommended Fraser Health must ensure there is appropriate documentation and charting of patient care in the emergency department, with emphasis on physician consultations that result in a diagnosis that requires an elevated priority of care.

iv. The board recommended Fraser Health review the [facility] service response times to make sure that guidelines for monitoring patients and taking vitals are done in a timely manner, charted and that physician's orders are clear as to when diagnostic procedures are to be performed, particularly whether they are to be done on an urgent basis.

v. The board recommended Fraser Health consider the feasibility and barriers to implementing the telestroke program at [facility] for the times when the on-site neurologist is not available.

vi. The board recommended Fraser Health provide a response to the complainant as to why the patient remained in the emergency department for seven hours between arrival and transfer to [facility].

Response:

i. Fraser Health triage nursing staff undergo specific training and attend a nationally accredited course on Canadian Triage Acuity Scale. Following this classroom training, triage nurses spend a minimum of two shifts partnered with experienced triage staff to learn which care locations are appropriate to meet the specific health care concerns of our patients.

ii. Additionally, nursing staff in the emergency team are required to attend a course to enhance communication skills with patients and their families. The purpose of the Canadian Triage Acuity Scale (CTAS) score is to provide an initial assessment on arrival rather than keeping track of a patient's on-going condition. Fraser Health has confirmed that the way triage nurses assign and use CTAS scores is consistent with national standards. As of October 2013, each patient's condition is reassessed by designated staff (triage registered nurse, licensed practical nurse) in the waiting areas of all their emergency departments to monitor/address changes in a patient's condition.

iii. The [facility] emergency department holds quarterly morbidity and mortality rounds to review cases like this one. This case was reviewed at the [date] meeting. At that meeting, the local department head of emergency emphasized the importance of physician's documenting all conversations with consultants in the patient's record. Each emergency department receives and reviews acute stroke data targets each month. This information is used to identify areas for improvement and to help to achieve best practice standards of care. Fraser Health has recently appointed an emergency physician (who is American board certified in emergency medicine and neuro-ICU), to lead the planning of the management of stroke. This physician has been actively promoting excellence in stroke care within the department, hospital and regionally, as well as reaching out to the community. He has appeared on local radio stations to educate listeners about stroke prevention and early warning signs and is helping to review and revise Fraser Health stroke programs. The health authority is reviewing several options to improve timely and effective stroke care, including the telestroke program and other means to give thrombolytic treatments in hospitals closer to home.

Response (continued):

iv. Emergency patients that have been triaged and are in the emergency waiting room have assessments and visuals done as per the National Emergency Nurses Association Canadian Triage Acuity Scale. At the morbidity and mortality rounds in April 2014, the importance of clear documentation regarding the timeliness of diagnostic procedures was emphasized.

v. The Fraser Health medicine program is reviewing the feasibility of implementing the telestroke program at [facility]. Telestroke is being considered in parallel with other strategies that will facilitate timely access to stroke consultations for patients presenting to [facility] with symptoms of acute stroke. Other strategies include transfer protocols to the [facility] and the development of a [facility] specific stroke service.

vi. The [facility] emergency department head, has reviewed the chart during the time the patient was at Fraser Health. When the patient presented to triage, it was felt they were suffering from a migraine, not stroke. Once assessed, the physician considered stroke in the differential diagnosis and began to establish contact with the [facility] stroke services.

Based on the suggestion of the [facility] stroke service, a CT angiogram was performed. The CT report identified an embolic thrombus within the basilar artery. The patient was transferred after this information was reported by the radiologist at [facility] and relayed to the [facility] stroke team. The [facility] stroke team requested transfer without administering thrombolytics first at [facility].

CASE STUDY

After a long history of illness and multiple admissions to an emergency department over the span of four months, a patient died while in hospital care.

A family member wrote to the health authority outlining that the patient received exceptional care and attention in their last days of life. However, there were multiple issues raised regarding the patient's care, including insufficient allergy considerations and nursing staff attentiveness. While the health authority responded to all but one of the concerns, the complainant requested a review of the health authority's response.

The board made a number of recommendations, including:

- A review and enforcement of the hospital's scent policy;
- A review of their policy regarding shift transitions;
- A focus on communication improvements between staff and family to ensure continuity of care;
- Ensuring continuity of care between hospitalists and family physicians; and
- Providing a response to the board within the legislated timelines.

This led to the reinforcement of the scent policy, with ongoing checks; a new shift handover sheet is now a permanent part of charting; patients and family members are now provided with information and support regarding diagnoses, discharge care needs and community resources; a new process was implemented to notify physicians if a delay occurs in documenting a discharge summary; and the office has assigned new staff to meet legislated timelines.

The complainant, upon receiving the board's decision, responded in writing and thanked the board for listening, understanding and caring about their concerns.

Recommendations and Responses | *Interior Health*

Interior Health is responsible for a broad geographic area of over 216,000 square kilometres, including both larger cities and rural communities, with a population of more than 742,000 people.

The board reviewed 24 cases from Interior Health in 2014/15, resulting in 18 recommendations in nine of those cases – 12 for care quality improvement and six for improving the complaints process. There were no recommendations in 15 of the cases.

Many of the board's recommendations to Interior Health focussed on improving communication with patients, residents, clients and/or their families. For example, recommending in specific cases that the health authority meet or correspond with patients, clients, residents or their families to further explain the care provided. In two cases, the board made recommendations where it observed the Patient Care Quality Office had difficulty obtaining information from program areas to inform its investigation.

In response to the recommendations, Interior Health will provide training to staff on facility policies, with particular attention to falls management. Furthermore, numerous complaints were followed-up by the health authority as the board recommended improved and/or additional communication with complainants to ensure their concerns were addressed.

1. COMPLAINT REGARDING THE ATTITUDE AND CONDUCT OF A SOCIAL WORKER.

Recommendations:

i. The board recommended Interior Health have [facility] staff consider referring a patient's family to a social worker when medical health care providers determine that a family conflict may be affecting the patient's care and/or care planning.

ii. That Interior Health review how it records the identity of a representative duly appointed under a Representation Agreement made pursuant to the *Representation Agreement Act* in its hospital records to ensure that health care providers are informed that such an agreement exists, and that they can readily access the appointed representative's name and contact information. It is recognized that the name of such a substitute or alternative decision maker may differ from next of kin and/or person to notify designations.

Response:

i. There is currently no acute care social work position at [facility], therefore staff would be unable to make this referral.

ii. As part of the initiative to implement 48/6 within the health authority, an Interprofessional Plan of Care form is being introduced to health care professionals working in acute care sites. The form currently has a place to record the existence of an advance care plan and Advance Directive. In October 2014, a review of the form took place. The Interior Health 48/6 Coordinating Committee considered the addition of the existence of a Representation Agreement to the form at that time.

2. COMPLAINT REGARDING MEDICATION, COMMUNICATION, FAMILY INCLUSION ON CARE PLANNING AND PALLIATIVE CARE PRACTICES.

Recommendations:

i. The board recommended Interior Health have all staff of the Polson special care unit review the Clinical Practice Standard and Procedure section 4.3.2 Pre-Printed Orders (including Guiding Principles for Pre-Printed Orders) regarding acceptable issuing and use of physician's orders and the differences between pre-printed and standing orders.

Response:

i. The team leader has reviewed and discussed the Guiding Principles for Pre-Printed Orders (the Clinical Practice Standard and Procedure has been replaced with this document) with all of the registered nurses on the Polson special care unit. They are clear on the acceptable issuing and use of physician's orders and the differences between pre-printed orders and standing orders.

3. COMPLAINT REGARDING INAPPROPRIATE CANCELLATION OF HOME CARE SERVICES.

Recommendations:

i. The board recommended the health authority should advise the complainant in writing why his home care services were withdrawn in November 2013, including specifics about the safety concerns for staff.

ii. The board recommended the complainant should be reassessed with the goal of being reintegrated into the clinic's home care services. The complainant's general practitioner's comments should be taken into account when devising a scheduled ratio of home care visits vs. the times the complainant attends the clinic in person.

iii. The board recommended that, in following the Policy of Community Integration Health Services Manual, a detailed hospital administration risk management profile re-assessment should be conducted as per policy. If the reassessment determines that [the complainant] will not receive in-home services, a copy of the re-assessment should then be provided to the patient as per principles of administrative fairness.

iv. The board recommended the health authority should consider drafting another Community Care Service Agreement with the client. A clear set of parameters for client behaviour, as well as expectations of all parties in the context of heath authority services may help to generate improved conditions for staff and client. It can be made clear to the client that, should he break any provisions of the new agreement, his home care services will be withdrawn. Dates indicating when the agreement is drafted, as well as when each party signs the agreement, should be clear.

Response:

i. The manager for home health services wrote to the complainant with an apology and explanation regarding the rationale for withdrawing services.

ii. The complainant was reassessed prior to the conclusion of the board's review. A new care plan has been developed and discussed with the complainant. In the manager for home health services' correspondence to the complainant, the manager outlined the Interior Health policy for community clinics, and the pamphlet explaining this policy was included in the community clinic.

iii. A Hazard Assessment & Reduction Plan re-assessment was conducted prior to the conclusion of the Patient Care Quality Review Board review. This re-assessment is included in the correspondence to the complainant, as well as the rationale for two staff members to be present when care is being delivered.

iv. In the manager of home health services' correspondence with the complainant, the manager outlined the expectations for behavior and the plan of care and rationale. Interior Health policy that supports the expectations for behavior and plan of care is included with the correspondence.

4. COMPLAINT REGARDING MULTIPLE SURGICAL CANCELLATIONS AND THE COST OF TRAVEL.

Recommendations:

i. The board recommended the health authority review its scheduling process and develop a record keeping and communication protocol in keeping with the Interior Health Authority Surgical Services Practices Clinical Practice Standard and Procedure policy so that in the event of unforeseen capacity issues and cancellations, this information will be properly recorded and shared with the patient.

ii. The board recommended the health authority remind all Patient Care Quality Office and hospital staff of policies such as the Interior Health Authority Hardship policy, and that these policies are to be implemented when surgical cancellations involve travel and expenses for patients.

Response:

i. Interior Health surgical services executive has recently reviewed the scheduling process. They will review the intent of Section 5 documentation considerations-patient postponement note in the Practice Guideline Operating Room: Patient Postponements to discern the intent and clarity. Surgical services executive will review the circumstances of this case at their next meeting in January 2015 and, subsequently, reinforce the need to make a notation in the chart regarding postponement with the perioperative committees at each site.

ii. The director of risk management at the Patient Care Quality Office (PCQO) has sent the hardship policy to all PCQO staff and reminded staff to look for Interior Health policy when responding to complainants. The health service administrator at [facility] has committed to reminding all management staff regarding the policy, and finally surgical services executive will communicate via memo to the perioperative committees at each site regarding the hardship policy and send a copy of the policy.

5. COMPLAINT REGARDING SUB-OPTIMAL EMERGENCY CARE, STAFF ATTITUDE, AND TRANSFER PROCEDURES.

Recommendations:

i. The board recommended the health authority make sure the Patient Care Quality Office (PCQO) provides comprehensive explanations of the quality assurance and PCQO functions across all its health facilities.

ii. The board recommended the health authority ensure the PCQO provide complainants with a clear explanation of:

- ***a.*** the complaint investigation process;
- ***b.*** what procedures will be carried out by whom;
- ***c.*** the legislated timelines; and,
- ***d.*** in the event of a formal quality review under the terms of Section 51 of the *Evidence Act*, the PCQO must explain to complainants that they are excluded from direct participation in the investigation but will be made aware of the conclusions when they become available.

Response:

i. & ii. Since this event has occurred, several process improvements have been enacted to Interior Health's Incident Management policy (AK0400):

- A decision review team meeting, involving both regional and health facility leadership, is convened within 72 hours of the event. Facility leadership then communicates relevant information to the appropriate physicians and health care staff at the site as appropriate to the observance of Section 51 of the *Evidence Act*.
- Presentations and discussion have occurred at all regional Medical Advisory Committee meetings detailing the process of quality assurance, with physician representatives taking that information back to their respective facilities and departments, as well as site administration taking the information back to their respective facility management team(s).
- Lunch and Learn sessions discussing the role of the Patient Care Quality Office and the process of critical Incidents reviewed under Section 51 of the *Evidence Act* are regular occurrences with staff and management throughout the region.
- An iLearn module detailing the process of investigation as articulated in policy AK0400 (Incident Management) is under construction. This learning module will be available to all Interior Health staff.
- At times, there will be a concurrent critical incident review and a Patient Care Quality Office (PCQO) complaint. In these instances, a teleconference with the director, risk management; manager PCQO/patient safety investigations, and the respective patient safety investigator and patient care quality officer is convened. On this call, the following will be defined and delineated: the complaint investigation process; what procedures will be carried out by whom; timelines; and the duty to explain Section 51 of the *Evidence Act* to the patient/family/complainant. Confirmation of how, when, and by whom the patient/family member will be interviewed will also be discussed. At a later time, confirmation on who will meet with the family to discuss actions arising out of the review will also occur.

6. COMPLAINT REGARDING IMPROPER WOUND CARE.

Recommendations:

i. The board recommended the health authority ensure that [town] home and community care maintains an adequate number of nurses that are certified to perform conservative sharp wound debridement.

Response:

i. Conservative sharp wound debridement (CSWD) competency requires registered nurses complete an education module, observe a practitioner certified in CSWD and be observed completing a number of treatments. Finally, registered nurses must maintain competency by completing a number of CSWD treatments in a calendar year.

[Town] Home Health is a rural program. Volumes for CSWD may not always meet the requirement for nurses to remain certified. Currently there are three registered nurses who have completed the requirements to be certified in CSWD. It is estimated that at the current time there is enough volume that two to three nurses can maintain competency.

7. COMPLAINT REGARDING MULTIPLE ISSUES ALLEGING POOR CARE IN AN ACUTE CARE FACILITY.

Recommendations:

i. The board recommended the health authority report to the complainant what mechanism has been put in place for assigning a most responsible physician to take ownership of a suspected or confirmed case of tuberculosis.

ii. The board recommended the health authority direct the Patient Care Quality Office (PCQO) to arrange a meeting with the complainant, if the complainant still wishes, to provide answers to their unresolved care quality concerns.

Response:

i & ii. The PCQO manager for patient safety investigations who was the contact for the complainant, connected with the complainant by phone. While the complainant acknowledged he PCQO had discussed all of the outstanding concerns with them, those concerns will be addressed once again during a meeting. The physician and the PCQO officer have agreed to meet with the complainant as soon as possible to discuss the recommendations from the Tuberculosis Response Committee report, including mechanisms put in place to assign most responsible physician and any other outstanding concerns the complainant might have.

8. COMPLAINT REGARDING CARE PROVIDED IN A RESIDENTIAL CARE FACILITY.

Recommendations:

i. The board recommended the health authority direct the Patient Care Quality Office to provide the complainants in this case with a copy of the Dementia Observational System records from [residential care facility] for this resident.

ii. The board recommended the health authority direct the Patient Care Quality Office to provide a response to the complainants' concern regarding the temperature in the resident's room at [residential care facility].

Response:

i. Interior Health, through the Patient Care Quality Office (PCQO), will write to the complainant and include a copy of the Request for Release of Information and advise the complainants that they can request a copy of the resident's Dementia Observational System record from the residential facility.

ii. The PCQO will write to the complainants in response to the issue of room temperature.

9. COMPLAINTS REGARDING DISCHARGE PLANNING FROM AN ACUTE CARE FACILITY.

Recommendations:

i. The board recommended the health authority consider this case and develop a policy with respect to the discharge of vulnerable patients from acute care, similar to that of Interior Health Discharge of Vulnerable Emergency Department Patients policy (AH1060) and the steps to be followed.

ii. The board recommended that the Patient Care Quality Office provide the complainant with an explanation as to why they did not comment on the [date] discharge of the patient.

Response:

i. This recommendation was considered by senior Interior Health staff. In considering the board's suggestion and all of the circumstances of this case, it was decided that a policy would not change the outcome in this situation. The current 48/6 initiative, which has already been implemented at all sites provides adequate process, resources and guidance on appropriate planning for transitions in care. As well, the patient was not considered vulnerable in this situation. The patient was deemed capable to make their own health care decisions and could understand the consequence of the decision to return home and accept or reject supports upon leaving the acute care setting. There was family available when the patient returned home. It was also discussed that staff did everything possible to make sure a safe discharge was accomplished and were unable to change the patient's decision making around leaving the hospital against medical advice without home health supports.

ii. The patient care quality officer assigned to the complainant's file was no longer with Interior Health so the question could not be explored. Instead, a reminder to all patient care quality officers to ensure they address all issues identified by complainants was shared at the next team meeting.

CASE STUDY

An elderly resident in a long-term care facility tripped and fell, resulting in an emergency department admission. Assessed as having a hip fracture, the patient went for surgery. After surgery, the patient's condition deteriorated and the patient died from complications related to their hip fracture.

A family member raised concerns to the facility administrator about the care provided to the patient. Not receiving a response, the family member contacted the health authority who addressed all but one of the family member's questions in writing. Since the family member felt the health authority response contained incorrect information and did not address their recommendation to improve training for staff working with visually impaired patients, they applied for a review with the board.

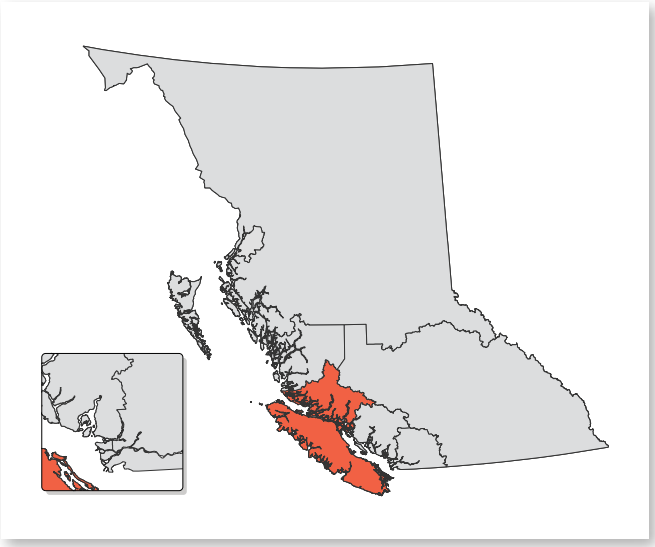
Although the board found the patient received appropriate care from the facility, the board found improved communication was needed with family members involved in patient care. The board recommended the health authority create a communication protocol between hospitals and residential care facilities upon the death of a patient so that all affected persons are aware of the event.

As a result, a new protocol is being put in place and an electronic notification system is being piloted, which will alert family physicians when their patients are admitted to, discharged from or die in hospital.

"I am so happy that I now feel like I can really put this to rest, that this won't happen to somebody else in my community."

COMPLAINANT:

Recommendations and Responses | *Island Health*



Island Health is responsible for more than 765,000 people spread over the islands and the mainland.

The board reviewed 15 cases from Island Health in 2014/15, resulting in eight recommendations in eight of those cases – all eight recommendations were for care quality improvement. The board made no recommendations in seven cases.

The board made multiple recommendations on the themes of discharge arrangements, communication and staff training. Recommendations included improving communication with families and patients and to provide patients admitted under the *Mental Health Act* with information about their admission as soon as possible.

Island Health took action by developing a series of training sessions for staff, well as ensuring that patient communication would occur in a timely and effective manner and that a delirium management care and charting protocol would be completed and fully implemented.

1. COMPLAINT REGARDING HOME CARE SERVICE HOURS.

Recommendations:

i. The board recommended the health authority have the complainant's case manager assist with sourcing an organization that can provide advice and assistance on the Choice in Supports for Independent Living (CSIL) application process.

Response:

i. Island Health home and community care has arranged for [town] Family Life to support the client in completing the CSIL application and notified them of this arrangement on [date].

2. COMPLAINT REGARDING CONSENT FOR MENTAL HEALTH TREATMENT.

Recommendations:

i. The board recommended the health authority use this case as an example to review their policies and procedures for obtaining informed consent for mental health treatment, and that the review include appropriate consultation with both legal and medical expertise. Further, that the results of the review are used to provide in-service training to health care professionals.

Response:

i. The mental health and substance use (MHSU) practice resource team will be engaged to review current policies and procedures and to provide recommendations to MHSU leadership. Island Health committed to completing a current state review by February 2015. This review will be guided by the Health Care (Consent) and Care Facility (Admission) Act, which sets out the processes for obtaining informed consent from voluntary patients. It will also be guided by the *Mental Health Act*, which sets out the process for obtaining consent from involuntary patients.

MHSU leadership are committed to providing continuing professional development (CPD) to ensure physicians and mental health clinical nurse educators are trained and confident in all procedures outlined in the relevant legislation.

MHSU will develop, in consultation with Island Health's risk management department, a CPD session. Once developed, the CPD will be presented across MHSU services. A learning module will also be made available on the MHSU Safety Hub located on Island Health's intranet. Further face-to-face educational sessions will also be available on demand as needed.

3. COMPLAINT REGARDING MULTIPLE ISSUES WHILE IN ACUTE CARE.

Recommendations:

i. The board recommended the health authority provide the patient and complainant with a progress update regarding the health authority's implementation of the most responsible clinician model.

Response:

i. The [facility] rehab unit now assigns one key team member (typically the physiotherapist, occupational therapist or clinical nurse leader) during the rehabilitation stay. The focus of this most responsible clinician is to ensure communication with regard to the rehabilitation plan, with particular focus on discharge planning.

4. COMPLAINT REGARDING CARE RECEIVED IN A RESIDENTIAL CARE FACILITY.

Recommendations:

i. The board recommended the health authority ensure that there is a protocol in place for hospitals to communicate with residential care facilities upon the death of a patient, so that all affected personnel are aware of the event.

Response:

i. Island Health reported that, as part of the Patient Access and Care Transitions Steering Committee's mandate to enhance communication and co-ordination across program/service areas related to patient flow and transitions of care, the committee is taking leadership on the development and implementation of a protocol. It is expected the protocol will be in place by Sept. 30, 2014. In addition, Island Health is currently piloting technology to electronically notify family physicians when their patients are admitted to or discharged from hospital (including when the patient dies). This technology will gradually roll out across the health authority over the coming year.

5. COMPLAINT REGARDING SURGICAL ERROR LEADING TO UNTREATED SEPTIC SHOCK.

Recommendations:

i. The board recommended the health authority use this complaint as an example for in-service training for medical staff to address concerns such as:

- ***a.*** Recognizing the warning signs and need for closer monitoring of a patient requiring critical care.
- ***b.*** Pharmacy protocol must be adhered to in all instances and medications must not be administered outside of protocol.
- ***c.*** The timelines of physician's charting should include vital signs, critical care protocol and the dictating of reports.

Response:

i. The surgical nurse educator completed an in depth education and training in February 2015 with the surgical short stay nursing staff, around monitoring and understanding the early warning signs of sepsis.

- ***a.*** With the implementation of iHealth, a special module will be available at [facility] that will support early detection of sepsis in a patient. The recording of all results will be done at point of care, creating the "patient story" for the health care provider. For example, blood pressure, temperature and white blood cell count will pop up on screen, alerting the nurse to consider sepsis.
- ***b.*** Bar code scanning for all medication delivery will be implemented in June 2015. Bar coding will ensure all allergies are captured and if the medication is a risk to the patient, an override and confirmation will be required.
- ***c.*** Physician documentation is currently done through voice recognition. The reports are typed and uploaded into the Cerner application within 72 hours.

  Voice recognition will be uploaded directly into the physician consults when the new iHealth application is implemented in June 2015. This will allow for review of the information in a timely manner. Vital signs will be uploaded immediately and available in Cerner for all clinicians to view at any time.

6. COMPLAINT REGARDING REDUCTION OF HOME CARE SUPPORT HOURS.

Recommendations:

i. The board recommended the client's evening home care hours be reinstated to the level they were at prior to July 2013 (one hour) unless there is a current reassessment with input and agreement by the client's health care professionals to a care plan that ensures the client's needs are being adequately met.

Response:

i. Due to the client's condition, there is a need for consistent community health workers and consistent application of the care plan. As a result, it was felt that the best solution was to contract with a private company, Nurse Next Door, to provide services. A meeting was held with the client and a family member to discuss this approach and an agreement was reached.

The contracted services provide an extra 15 minutes/visit, three times a day above the hours previously provided (the client's hours have increased by 45 minutes per day, seven days a week). This client is now receiving 82.5 hours of care per month. Further meetings are planned with the client and will be followed as needed (i.e., if there is a change in function) or annually.

7. COMPLAINT REGARDING INADEQUATE STAFFING AND INSUFFICIENT CARE PLANNING AT RESIDENTIAL FACILITY.

Recommendations:

i. The board recommended the health authority make sure the resident is assessed to determine current needs, set out a current care plan and, once the assessment is complete, audit the implementation of the care plan at [residential facility].

Response:

i. Resident assessment and care planning is ongoing based on the individual's health care needs. Health care needs are incorporated into a care plan, which is dated based on the last review and updated to reflect the resident's current needs. The care plan is formally reviewed on a quarterly basis or more frequently, if required, due to changing care needs. Any changes to the care plan are recorded and dated.

A clinical nurse specialist from senior's health will audit the appropriateness and thoroughness of the care planning by reviewing the care plan and the resident's health record. Audits will be conducted monthly for the first three months and then the frequency will be re-evaluated. If the audits are found to be satisfactory, they will take place quarterly for the remainder of the year.

Following each audit, findings will be documented via a report and submitted to the site manager and the residential services director. Compilation of these findings, including adjustments to the resident's care needs from the first six months audits, will be forwarded to the Patient Care Quality Office.

8. COMPLAINT REGARDING UNTREATED AND UNDOCUMENTED INFECTION AFTER SURGERY.

Recommendations:

i. That the health authority provide an in-service for all [facility] staff involved in the patient discharge process, aimed at ensuring effective communication between staff members and that any concerns of the patient/family are documented and addressed prior to discharge.

Response:

i. Unit managers are working with clinical nurse educators to provide in-service training for all nursing staff, to ensure effective communication and appropriate assessment and response to concerns raised by family members, should they arise. This includes documentation of feedback from the patient/ family.

In addition, in follow up to the concerns brought forward in this review, the manager of the pre-admission clinic and unit manager met to develop a post-operative teaching discharge sheet that supports discharge and allows a form to go with the patient's family; one form stays with the chart and one goes to the GP's office.

Development of this form is being created for all surgical teams. The surgical services team is working on a document with the surgeons to support orthopedic patients that Island Health committed will be implemented by Nov. 1, 2014. It was also reviewed at the next Quality Council meeting.

A call-to-care program was also initiated, in which patients are all called a day after their surgery (day care) to see if there are any outstanding issues that were not captured at discharge.

Recommendations and Responses | *Northern Health*

Northern Health is responsible for serving over two-thirds of B.C.'s landscape, with about 300,000 people spread over a broad geographical area.

The board reviewed six cases from Northern Health in 2014/15, resulting in six recommendations in three of those cases - four for care quality improvement and two for improving the complaints process. There were no recommendations in three cases.

Recommendations by the Northern board this year involved improvements to home care support, discharge of acute care patients, emergency department triage procedures and complaint management. The health authority was receptive to the recommendations and has been working to implement them in the region.

1. COMPLAINT REGARDING HOME CARE SERVICES RECEIVED.

Recommendations:

i. That the health authority reviews and confirms client complaints are provided to the contract manager or home support service supervisor to ensure services are being provided as stated and that service disruptions or cancellations are reasonable for quality assurance and improvement purposes.

Response:

i. Northern Health fully implemented the recommended action by circulating a memo to all Health Service administrators to remind employees of the Northern Health Authority Decision Support Tool (1-9-2-050). This policy outlines the process for handling complaints about home and community care services.

2. COMPLAINT REGARDING DISCHARGE PROCESS FROM ACUTE CARE.

Recommendations:

i. That the health authority develops a specific protocol or policy pertaining to the discharge of patients from acute care and the steps to be followed.

Response:

i. The [facility] management has been working on making sure that every inpatient has an individualized care plan, part of which would include a discharge plan. However, there currently is no health authority policy or protocol specific to discharge of patients in acute care. Northern Health committed to the development of an interim protocol by April 2015

3. COMPLAINT REGARDING HEART ATTACK IN EMERGENCY DEPARTMENT.

Recommendations:

i. That the health authority ensures patients and their families are informed in advance of a scheduled family meeting about who will be in attendance, particularly if someone whose attendance is requested or would reasonably be expected, is not going to attend.

ii. That the health authority have the appropriate [facility] staff meet with the complainant and the family to provide:

- ***a.*** The Quality Assurance Review recommendations;
- ***b.*** A detailed account of how the proposed recommendations will address the family's specific concerns about the care the patient received; and
- ***c.*** An explanation of whether the electrocardiography results indicated that the patient had fine ventricular fibrillation.

iii. That the health authority ensures [facility] triage nurses reassess patients in accordance with Canadian Triage and Acuity Scale (CTAS) guidelines (i.e., every 30 minutes while waiting for physician assessment, as directed by the patient's CTAS acuity level) and inform patients and their families of any delays.

iv. That the health authority ensures the Patient Care Quality Office follows-up with a program area when it receives general information in response to a complaint specific question or concern.

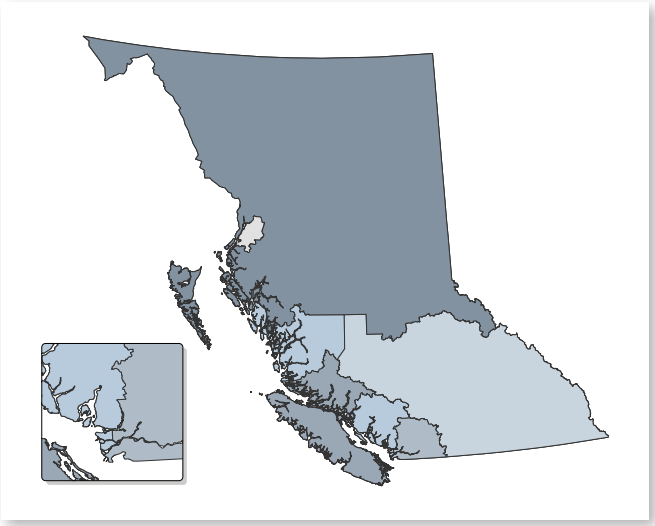
Response:

i. Northern Health's practice has been to have a senior operational leader and a senior medical leader attend a meeting with a family where there has been a poor patient outcome. It is not common practice for front line staff or physicians at [facility] to attend such a meeting. The Northern Health Patient Care Quality Office (PCQO) was unaware that they had not met their expectations in this regard. In the future they will be clear with the family as to who will be in attendance at such a meeting.

ii. The health service administrator is prepared to meet with the family to discuss any questions they may have regarding the charted care in the patient's health record as well as the recommendations and actions that have been implemented following the PCQO's review of care. The PCQO would explain to the family the meaning of fine ventricular fibrillation. The health service administrator's office will make contact with the family to make suitable arrangements for a family meeting.

iii. Northern Health agreed with the recommendation. The [facility] has already begun to develop and implement a quality improvement initiative to ensure reliable reassessment of all emergency department patients, including patients in triage, hallway and waiting room to align with the Canadian Triage and Acuity Scale standards. This work is currently in the early stages.

iv. Northern Health agreed with the recommendation. It is standard practice for the PCQO to follow-up very closely with the program area in order to provide a meaningful reply to the complainant.



Instead of a geographic region, the Provincial Health Services Authority (PHSA) is responsible for specific provincial agencies and services. There are numerous agencies and programs that fall under the purview of the PHSA. These include: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Mental Health and Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, Cardiac Services BC, Perinatal Services BC, BC Ambulance Service, BC Autism Assessment Network, Health Shared Services BC, PHSA Aboriginal Health program, Provincial Blood Coordinating Office, Provincial Infection Control Network of BC, Provincial Surgical Services program, Provincial Emergency Services project, trauma, specialized diagnostics, specialized cancer surgery and telehealth.

The board reviewed four cases from PHSA this period, resulting in five recommendations in three of those cases - three for care quality improvement and two for improving the complaints process. There were no recommendations in one of the cases. Board recommendations focused on staff education and awareness as well as complaint management.

Because of PHSA's specific population, the board received fewer review requests from those patients, clients and residents whom accessed these provincial services. The board made recommendations relating to improving staff training and ensuring high quality patient care by paramedic staff.

1. COMPLAINT REGARDING DELAYED AMBULANCE TRANSFER AND NEGLIGENT HANDLING BY PARAMEDICS.

Recommendations:

i. The board recommended that the health authority work with BC Ambulance Service (BCAS) to ensure appropriate continuing education and training programs are in place, that align with the commitments of the BCAS Code of Ethics to address the following objectives:

- ***a.*** Training standards for regional managers (e.g., unit chiefs) to make sure appropriate managerial oversight, performance monitoring and enforcement of the code of ethics;
- ***b.*** Appropriate training for the paramedics involved in this case to reinforce the importance of a patient centered approach to care

Response:

i. ***a.*** BC Emergency Health Services (BCEHS) has already begun a review of its current orientation process. The orientation program is being revised using a modular approach. Each module will include consistent items relevant to all staff (including the updated code of ethics), augmented by a detailed look at the specifics necessary for categorical job performance/orientation. Current module development focuses on new paramedic hires. Modules have also been identified for BCAS unit chiefs and for Patient Transfer Network new hires.

b. Paramedics involved in this case have had the benefit of an educational conversation with appropriate BCEHS clinical and operational leadership

2. COMPLAINT ALLEGING AN UNFOUNDED MENTAL HEALTH DIAGNOSIS BY PARAMEDICS.

Recommendations:

i. The board recommended the health authority direct the British Columbia Ambulance Service (BCAS) to complete an appropriate investigation of the complainant's concerns including, if the complainant consents, a review of her medical records to determine whether a medical history of bipolar disorder was previously determined or recorded.

If the review determines the recorded medical history was unfounded, BCAS should:

a. Provide the complainant with a detailed response explaining how the error was made; and

b. Amend the patient care record to state that there is no evidence to support the paramedic's statement.

ii. The board recommended the health authority direct BCAS to review how it liaises with the Patient Care Quality Office when responding to requests for information to ensure that the Patient Care Quality Office receives complete information in a timely manner.

iii. The board recommended the health authority direct BCAS to revise its Patient Care Reports policy to direct paramedics to include the source of information recorded in the medical/surgical history.

Response:

i. BC Emergency Health Services (BCEHS) confirmed that the patient's patient care record has been annotated. BCEHS also confirmed that the patient appealed to the Office of the Information and Privacy Commissioner who held that BCEHS had "appropriately annotated the record and has provided notification as required by s.29 of [the *Freedom of Information and Protection of Privacy Act*] FIPPA."

BCEHS will undertake a further review of the patient's case, including (with appropriate consent) a review of hospital medical records. The patient will be provided with a detailed summary of the process and, if appropriate, further annotations to the patient care record will be made.

ii. In an effort to ensure not only timely response to requests for information, but a robust analysis process, BCEHS began implementing several strategies to improve review and response processes that support Patient Care Quality Office activities in February. Resources have been reallocated and the newly installed leadership team at BCEHS has a mandate to review and support investigative processes in the organization.

iii. BCEHS acknowledged there is an opportunity to review documentation practices with respect to recording of medical/surgical history. Prior to implementing any specific changes to policy, a review of best practices will be undertaken that will also consider related documentation practices within a nursing environment.

3. COMPLAINT REGARDING THE RESPONSE TIME AND CARE PROVIDED BY BC AMBULANCE SERVICE TO A REMOTE LOCATION.

Recommendations:

i. The board recommended the health authority use this case as a case study for paramedics to review the following: managing infant patients (review of the Pediatric Assessment Triangle); assessment and recognition of allergic reaction versus anaphylaxis; trouble shooting equipment malfunctions; and, availability and appropriate use of BC Ambulance Service Emergency Physician Online Support Service.

Response:

i. The BC Emergency Health Services (BCEHS) Maintenance of Competency program focuses on four foundational pillars of competency - trauma, CPR, pediatrics and airway management. The Pediatric Education for Pre-Hospital Professionals (PEPP) is available annually. PEPP is a certification program developed by the American Association of Pediatrics and covers such topics as pediatric assessment (using the Pediatric Assessment Triangle), respiratory emergencies, shock, resuscitation, medical emergencies, trauma etc. There were 31 sessions slated to run across BCEHS between November 2014 and February 2015.

BCEHS will explore opportunities to implement quarterly "case rounds" as a mechanism to share learnings and will use this case as appropriate.

CASE STUDY

Having recently undergone surgery, a patient presented a hospital's emergency department (ED) complaining of severe headaches. Based on the Canadian ED Triage and Acuity Scale, the patient was assessed as "R3 Urgent" (Level 3 urgent is associated with conditions that could potentially progress to a serious problem requiring emergency intervention). The patient's vital signs were checked and they were asked to remain in the ED's waiting room until being seen by a physician.

After waiting in the ED for a few hours, the patient walked outside and approached a paramedic to transport them to a different hospital for treatment. The paramedic advised the patient to go back to the ED and discuss the request with nursing staff. However, the patient went back inside and instead placed a call to 911 and requested an ambulance. The dispatcher informed the patient that ambulances are not permitted to transport patients between hospitals this way. As a result, the patient made their own way to a different hospital.

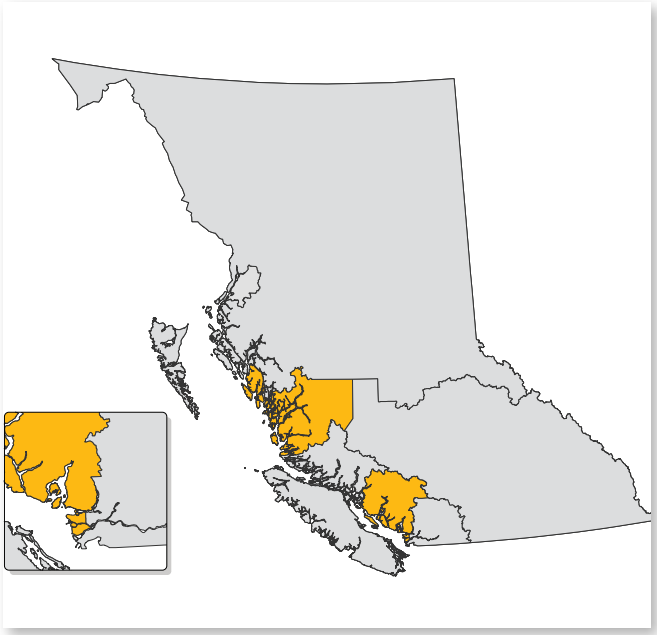
It was not clear to the patient why the request for ambulance service was denied, and similarly, felt that communication between themselves, the BC Ambulance Service (BCAS) dispatcher and other health professionals was unclear and, at times, disrespectful.

The board investigated and considered all the information provided by both the patient and the Patient Care Quality Office, including an evaluation of an audio recording made between the patient and the BCAS dispatcher.

Based on their findings, the board found that the dispatcher had explained in specific detail, that transporting individuals from one hospital to another was not something BCAS could do if the patient had already been assessed. The patient was also informed that leaving the hospital and placing a call to BCAS from the street, would have resulted in BCAS transporting the patient to the hospital where the original assessment had been made. The BCAS dispatcher also explained that transporting a patient requires proper discharge, and that a protocol must be followed when an inter-facility transfer is necessary.

On further review of the file, the board concluded that communication between the patient and the dispatcher was clear and respectful, and that the Patient Care Quality Office's review of this complaint was appropriate.

Recommendations and Responses | *Vancouver Coastal Health*



Vancouver Coastal Health (VCH) is responsible for serving two regions, totalling more than one million people.

The board reviewed 26 cases from VCH in 2014/15, resulting in 22 recommendations in 11 of those cases - 18 recommendations were for care quality improvement, while four were to improve the complaints process. The board made no recommendations in 15 cases.

The recommendations to VCH covered a broad range of issues, such as: discharge planning, respectful communication, staff training on fall prevention, residential care concerns, health care consent and wound care. In response, the health authority reviewed specific instances of care, has had staff members meet with patients and their families and has reviewed and improved numerous policies and procedures.

1. COMPLAINT MULTIPLE ISSUES WITH CARE RECEIVED IN ACUTE CARE FACILITY.

Recommendations:

i. The board recommended the health authority:

- ***a.*** review its current policy regarding patients who cannot be located at their assigned location in the hospital so as to determine whether and why the patient has left the hospital, and
- ***b.*** if no policy exists for that situation, consider revising the existing policy relating to charting a "discharge against medical advice" or developing a new policy that ensures reasonable efforts are made to contact the patient, either directly or through notification to the emergency contact number or next of kin.

ii. The board recommended the health authority ensure that patient care quality officers are using the appropriate Patient Care Quality Office title in correspondence with complainants.

Response:

i. Providence Health Care brought the recommendation forward to its Quality, Patient Safety and Clinical Risk Management Steering Committee for discussion. This is the governing committee for all quality and safety issues at [facility].

The decision was made to refer the recommendation to a pre-existing committee for further review and implementation. The Harm Reduction Committee is a multidisciplinary group that is looking at how VCH manages the most difficult patients with mental health and addictions issues. This is the same population that is most likely to leave against medical advice, so the members are well suited to this consideration. Specifically, they will be tasked with revising the existing policy and practice standards to incorporate some element of a risk assessment that will guide the health care teams on when to attempt to contact the patient or the emergency contact person or next of kin following an against medical advice departure, and will share their findings and recommendations with VCH.

ii. The necessary changes have been made to make sure the patient care quality officers are using the required title in all correspondence with complainants.

2. COMPLAINT REGARDING SPECIALIST DENTAL CARE AVAILABILITY.

Recommendations:

i. The board recommended the health authority follow-up with the complainant in regard to the additional questions which arose from the Patient Care Quality Office's (PCQO) response letter.

Response:

i. The PCQO has extended an invitation to the complainant to identify outstanding questions.

3. COMPLAINT REGARDING A LACK OF NURSING CARE AT A RESIDENTIAL CARE FACILITY.

Recommendations:

i. The board recommended the health authority direct the general manager of [facility] to conduct a complete and thorough investigation into the complainant's issues regarding the care and assessment of the resident. The investigation should include the following:

- ***a.*** Interviewing the care givers involved in this case.
- ***b.*** Reviewing the charting to ensure that it meets requirements and best practices.
- ***c.*** Reviewing protocols for when staff should call family members.
- ***d.*** Reviewing protocols for when staff should call a physician.
- ***e.*** Reviewing what steps staff should take when the on-call physician is not available.

Upon conclusion of the investigation, the general manager of [facility] provide any in-service training that may be required, and have a meeting with the complainant to review and discuss the findings of the investigation.

ii. That the health authority review with staff at [facility] the importance of listening to the advice and information from families and incorporate that into their assessment and care of residents.

iii. The board recommended the health authority have the Patient Care Quality Office (PCQO) use this case as a learning opportunity to review with the local PCQO the manner in which this care quality complaint was processed pursuant to the *Patient Care Quality Review Board Act*.

Response:

i. The investigation has been completed, and communication initiated with the complainant to discuss the findings and actions arising. In-service training was organized for September 2014.

ii. The manager and educator of [facility] are providing in-service training on the importance of listening to family members for information and advice that will be used to inform their assessments and assist in caring for the residents. This training and education is part of the in-service training noted above.

iii. The PCQO team has implemented an approach to dealing with complaints involving various cohorts of family members, and has adopted more consistent use of task management tools to ensure timely and effective fulfillment of commitments.

4. COMPLAINT REGARDING DELAYED SPECIALIST REFERRAL AND LACK OF ACCESS TO MEDICAL RECORDS.

Recommendations:

i. The board recommended the health authority undertake a review of the communication protocol for front line staff with the intent of improving the response to urgent requests for medical records, including medical imaging records.

Response:

i. The health authority apologized for the delay by front line staff in clarifying and acting on this client's request for records. The health authority noted that it would not be standard practice to challenge an applicant's reason for seeking a copy of his or her personal information. The health authority will continue efforts to ensure awareness among front line staff of the commitment and processes to attend to clients' requests for their personal information.

5. COMPLAINT REGARDING THE WAIT TIME TO SEE A PSYCHIATRIC NURSE IN THE EMERGENCY DEPARTMENT AND THE ATTITUDE AND CONDUCT OF THE NURSE.

Recommendations:

i. The board recommended the health authority review this patient's experience at [facility] emergency department regarding:

- ***a.*** her treatment;
- ***b.*** her wait for treatment;
- ***c.*** mental health patient placement within the department; and
- ***d.*** medical charting during her stay, with a view to possible improvements in mental health patient care and further opportunities for training staff in the emergency department on how to respond appropriately to patients presenting with mental health conditions.

Response:

i. The health authority reported that, although the initial review of the complaint did consider these matters, the teams will reflect further on the comments by the board in ongoing in-services with staff concerning communication and empathy in interactions with staff, involving the general emergency department (ED) staff as well as the psychiatric triage nurses whose roles were created to optimize care and treatment for ED patients with mental health issues. The health authority is confident that the monitoring by the staff was appropriate and physicians would have been reengaged based on identification by nursing of any issue of concern. Nevertheless, the case will be brought forward at the next emergency/psychiatry monthly meeting for discussion and shared learning among the medical and other staff.

6. COMPLAINT REGARDING THE USE OF CHOICE IN SUPPORTS FOR INDEPENDENT LIVING FUNDS FOR PHYSIOTHERAPY SERVICES.

Recommendations:

i. The board recommended the health authority and client work with the client's general physician to determine her eligibility for home health services as provided for under the Home and Community Care policy, develop an occupational therapy and physiotherapy care plan, and that the plan be regularly reviewed and updated.

ii. The board recommended the health authority make sure that the care providers, home health case managers and Patient Care Quality Offices:

- ***a.*** Are provided information and training sufficient to ensure they are familiar, not just with the requirements and limitations of the Choice in Supports for Independent Living (CSIL) program and home support services, but also with the Home and Community Care policy and the availability of home health services available to clients.
- ***b.*** Are trained to work with clients in a resolution-oriented manner to assist them to meet appropriate health care needs rather than focusing on the limitations of a particular program, such as the CSIL program.

Response:

i. The health authority reported that it understood and empathized that the client seeks services beyond those for which he/she is eligible. The team had already been communicating about and providing the services for which the client is eligible, specifically to have the VCH community physiotherapist assess the client and develop a plan of care (i.e., exercises) which the family or CSIL worker would carry out. The VCH physiotherapist remains available to reassess the client should the family physician identify a change in condition warranting reassessment.

The health authority updated the website to clarify the distinction between short term rehabilitation services that are provided by VCH and home support rehabilitation services, which are limited to assessment and care planning. Consistent with Home and Community Care policy, long term rehabilitation for chronic conditions is not a service available through VCH.

7. COMPLAINT ALLEGING ADVERSE EVENT DURING SURGERY CONTRIBUTING TO LONG-TERM EFFECTS.

Recommendations:

i. The board recommended the health authority arrange for a qualified health care provider to meet with the complainant to inform them, in plain language, about: whether the operative risks associated with the patient's pre-operative dysphagia were discussed when the patient consented to the glossectomy procedure; if not, why not; and how the patient's pre-existing dysphagia may have contributed to vocal cord paralysis.

ii. The board recommended the health authority investigate this adverse event accordingly to avoid similar occurrences in future and, if possible, provide the complainant with an explanation of what caused the patient's vocal cord paralysis.

Response:

i. The health authority believes that the review conducted by the previous head of the department of Surgery was comprehensive. His report provides as clear a description as is possible of the situation. If necessary, the complainant's family physician may be able to help them to understand. The health authority does not consider that an additional meeting with a qualified health care provider will be of benefit.

ii. VCH reported that the review conducted by the previous head of the department of Surgery was comprehensive, and explored to the extent possible the circumstances that may have contributed to the condition. Given that, VCH did not feel that additional investigation would be of benefit.

8. COMPLAINT ALLEGING STAFF MISCONDUCT DURING CARDIAC TESTING.

Recommendations:

i. The board recommended the health authority review its policies with regards to obtaining and documenting consent from patients for the provision of health care (as defined in the *Health Care (Consent) and Care Facility (Admission) Act*) by a person other than a health care provider as defined in the act.

Response:

i. Vancouver Coastal Health and Providence Health Care have reviewed the respective policies and did not make any changes. It remains the responsibility – and the opportunity – for the professional proposing the health care to explain the health care and obtain informed consent. Providers involved in providing direct care are expected to maintain communication with the patient and engage colleagues should any question or other matter arise.

9. COMPLAINT REGARDING SURGICAL SPONGES LEFT IN THE PATIENT, RESULTING IN INFECTION AND FURTHER PROCEDURES REQUIRED.

Recommendations:

i. The board recommended the health authority provides an explanation of how the anastomotic leak occurred, as well as the subsequent post-operative bleed and sepsis.

ii. The board recommended the health authority provides the complainant and patient with a sincere apology for:

- ***a.*** the sponge being left in the wound;
- ***b.*** the error in writing on her chart that what ultimately was detected to be the sponge was "mesh" and not a problem;
- ***c.*** the lack of active and empathetic listening and responses to the patient's concerns, including pain and its management; and
- ***d.*** the lapses in communication with the patient and caregivers, including discharge planning and follow-up care.

iii. The board recommended the [facility] conduct a review in six months on the implementation of the recommendations stemming from the critical incident review to make sure they are being followed, and then report the results of the review in writing to the complainant and patient.

iv. The board recommended the health authority consider:

- ***a.*** Replacing surgical sponges of the kind used in this case with ones that have a barcode to ensure accurate counts of sponges before and after surgery; or,
- ***b.*** Use sponges with barium-saturated threads that are woven into one side which can allow the sponges to be seen on radiology images; and,
- ***c.*** Seek input on best practices from the Patient Safety and Quality Council.

v. The board recommended that if a patient is at high risk for wound healing, that a wound care specialist be actively involved in ongoing wound care.

Response:

i. The health authority reported it was confident that, in the management of the clinical care, the surgeon discussed with the patient the various aspects of the clinical situation and that no further explanation is warranted or desired. If the patient does have questions that remain outstanding, the Patient Care Quality Office (PCQO) would facilitate another discussion with the surgeon.

ii. While the PCQO and clinicians have provided apologies to the complainant and the patient, a written apology was inadvertently overlooked. The PCQO has now documented the apology for the patient and will in future reinforce in correspondence the apologies that have been made verbally.

iii. The PCQO has reported to the patient and complainant confirmation of implementation of actions taken following the critical incident review, along with the documented apology noted above.

iv.

- ***a.*** Given the inconsistent benefit afforded by this measure, VCH would be concerned about the impact on efficiency operation of perioperative settings and resulting access to surgical care.
- ***b.*** Radio-opaque sponges are already in standard use in perioperative settings at [facility] and [facility].
- ***c.*** The health authority reported it is confident that [facility] and [facility] surgical and patient safety leaders maintain currency with best practices.

v. As one of the recommended actions of the critical incident review, this action is already in place.

10. COMPLAINT ALLEGING NEGLIGENT CARE IN A RESIDENTIAL FACILITY LEADING TO FALLS.

Recommendations:

i. The board recommended the health authority ensure through a review that the [facility] follows the Falls and Injury Prevention Guideline in Residential Care policy, specifically Appendix P – Education.

ii. The board recommended the health authority implement a refresher teaching module to all staff to identify the fall risk factors so that best practices are used when staff are transferring residents. This module should include the post fall protocol to make sure policy and regulation is followed in all incidents, they are charted correctly, and the physician and family are notified within the regulated timelines of an incident or injury to a resident.

- ***a.*** The review should include how these policies and procedures must be followed fully by health authority staff and contracted staff alike.
- ***b.*** The implementation of this teaching module must be reported to the health authority and the complainant in three months, and explain how this improves the safety and quality of care for its residents and family members.

iii. That the health authority provide to the complainant the process regarding its freedom of information and records release policy, including the timeframe and cost, in order that the complainant may have access to the resident's files to determine health status prior to the fall and injury.

Response:

i. The event which is the focus on the complaint was not considered a reportable incident by any of the facility staff, the community care facility licensing (CCFL) officer who initially investigated the incident after the complainant contacted them, or the VCH Patient Care Quality Office in preparing the complaint response. However, given the ongoing nature of this complaint, the board's decision letter, and the importance of falls and injury prevention in residential care sites, VCH has contacted the [facility] leadership team, the CCFL officer responsible for [facility] and the VCH manager for contracted residential care, and determined that [facility] is fully compliant with all expectations in this area. The current director of care for [facility] has advised the following improvements have been made:

- ***a.*** Hiring of an experienced nurse educator to support any gaps in falls education.
- ***b.*** The facility has several super low beds, has purchased a number of the recommended falls mats from the provincial guideline, and has educated the staff on their appropriate use to best support resident's that are high falls risk.
- ***c.*** Implemented daily safety huddles and review all resident's that have had any kind of clinical event or incident so how these events occurred can be reviewed with staff, providing opportunities to coach and improve.
- ***d.*** Ongoing education on falls and least restraint scheduled for all staff members for roll out in September 2015.
- ***e.*** A robust Falls Prevention and Harm Reduction policy was implemented in 2011 and updated in 2012.
- ***f.*** This policy will be reviewed and updated in September 2015, with all staff during education of the provincial guideline.
- ***g.*** Some other improvements include: bed and chair alarms, a new call bell system currently being installed with two-way voice, and the de-cluttering of rooms that have been flagged by resident care aides as cluttered and high risk for falls and injury to residents.
- ***h.*** VCH committed to initiating a pilot project for December 2014 with Safe Care B.C. on Safe Patient Handling Procedures to prevent injury to staff as well as residents.

Response (continued):

ii. In September 2011, the VCH manager for contracted residential care, and the practice team finished development and began implementation of the Regional Falls Prevention Clinical Practice Guidelines across all owned and operated residential care sites. This process was successfully completed region wide, with additional on-going supports going forward provided by the clinical practice team to the residential care sites in the form of refresher sessions and follow-up education after a serious falls related incident.

In addition, VCH has created a regional falls and injury prevention program and a full time program lead, who provides a 45 minute falls prevention orientation to all newly hired staff at the regional residential care orientation program. VCH has also developed on-line education modules for new hires and current staff members who may need to update their practice regarding falls prevention education on our electronic clinical teaching system. The manager is also available upon request to act in a consult capacity to assist any of the residential care sites with particularly challenging resident situations.

VCH is working with [facility] to conduct a refresher session on falls and injury prevention.

iii. The health authority provided the complainant with the VCHA Medical Records Release of Information brochure as well a detailed explanation on the freedom of information process.

11. COMPLAINT REGARDING INSUFFICIENT CARE AND MONITORING IN AN ACUTE CARE FACILITY.

Recommendation:

i. The board recommended the health authority proceeds with the planned Adverse Drug Reaction Clinic and, after an appropriate interval, evaluates its benefit with a view to considering its application throughout the health authority.

Response:

i. The Adverse Drug Reaction Clinic is not an approved project of Providence Health Care or Vancouver Coastal Health. For all patients undergoing elective surgery, there are already mechanisms in place for them to meet with an anesthesiologist prior to surgery, for referring and treating physicians to investigate potential allergies, and for knowledge of a patient's allergies to be communicated with the rest of the health care team.

Appendix A | *Patient Care Quality Office Volumes*

Appendix A details the volume of all complaints and inquiries received by the health authority Patient Care Quality Offices (PCQOs) in 2014/15, and compares the top five issues, or subjects of complaint, within the province and each health authority for 2010/11, 2011/12, 2012/13 and 2013/14.[2]

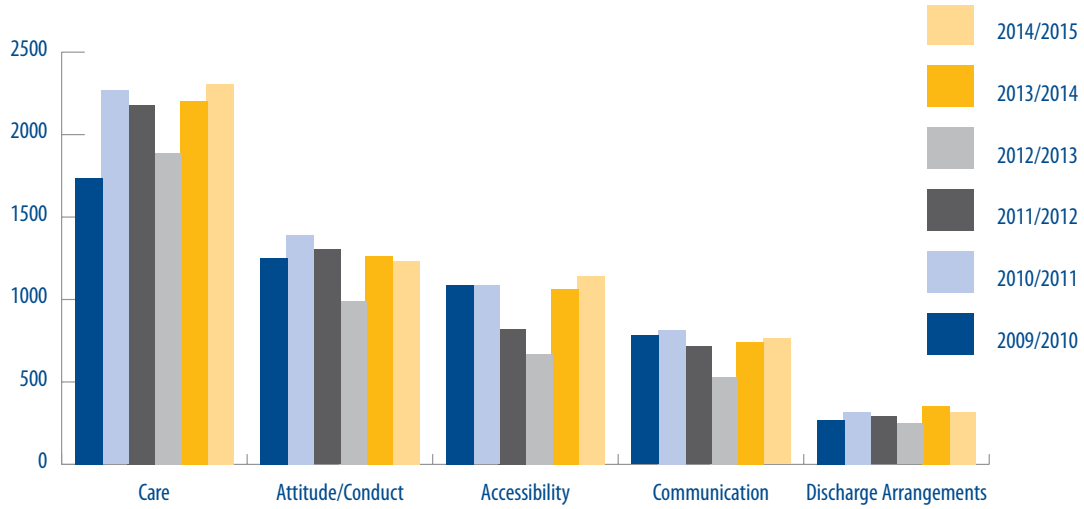
British Columbia

TABLE 3: *Patient Care Quality Office Volume, B.C., 2014/15*

B.C.	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	47	39	46	39	171
Care Quality Complaints	1,682	1,840	1,715	1,870	7,107
Inquiries	368	464	423	392	1,647
TOTAL VOLUME	**2,097**	**2,343**	**2,184**	**2,301**	**8,925**

By definition, most care quality concerns relate to care (e.g., deficiencies in care, misdiagnosis, or medication-related concerns). Therefore, complaints tend to be concentrated in that category. In B.C., PCQOs logged 2,308 complaints related to care. Attitude and conduct followed with 1,234 complaints. Accessibility (e.g., wait times for surgery or test results, availability of services) was the third most frequently reported issue at 1,141. Communication was fourth at 764, followed by discharge arrangements at 318.

CHART 4: *Patient Care Quality Office Top Five Subjects, B.C., 2014/15*



2 The PCQOs categorize patient complaints using a common reporting framework. Complaints are first categorized according to health sector – including acute care, ambulatory care, emergency care, home and community care, mental health and addictions, residential care, and public health, among others – then further broken down by subject. Last year, we reported the top ten issues by sector and subject. This year, we have reported the top five subjects across sectors, which give a more accurate picture of the key concerns patients bring to their PCQOs. Note: One complaint typically encompasses more than one care issue, so the total number of care issues will generally be higher than the total number of complaints.

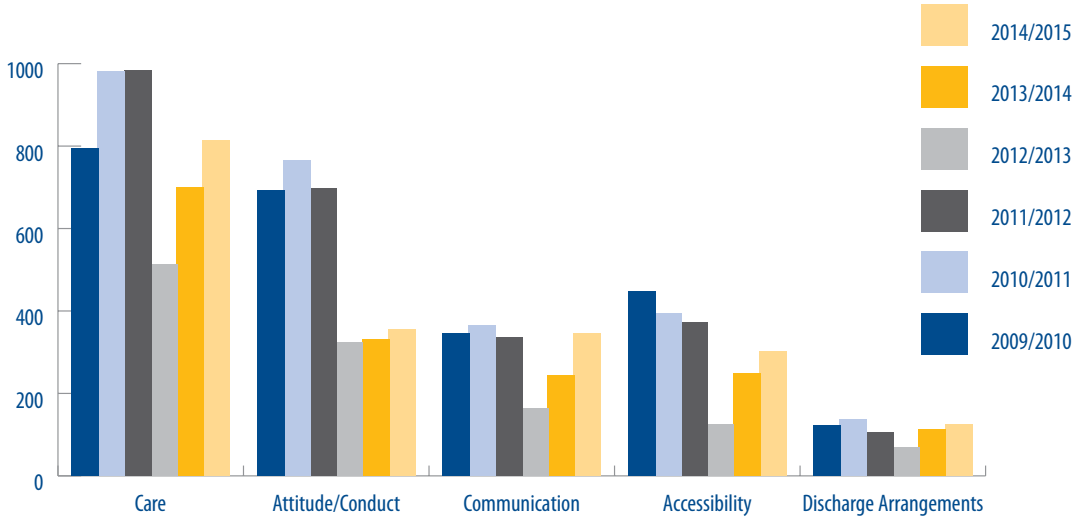
Fraser Health

TABLE 4: *Patient Care Quality Office Volume, Fraser Health, 2014/15*

FRASER HEALTH	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	19	12	22	17	70
Care Quality Complaints	500	507	485	531	2,023
Inquiries	113	126	116	131	486
TOTAL VOLUME	**632**	**645**	**623**	**679**	**2,579**

Fraser Health logged 814 complaints in the care category, which represents an increase of 115 over 2013/14. Attitude and conduct was the second most frequently reported concern with 356 complaints, followed by communication at 346 and accessibility at 301. Discharge arrangement complaints totalled 126 for the year. Four of the five categories saw an increase in complaints from 2013/14.

CHART 5: *Patient Care Quality Office Top Five Subjects, Fraser Health, 2014/15*



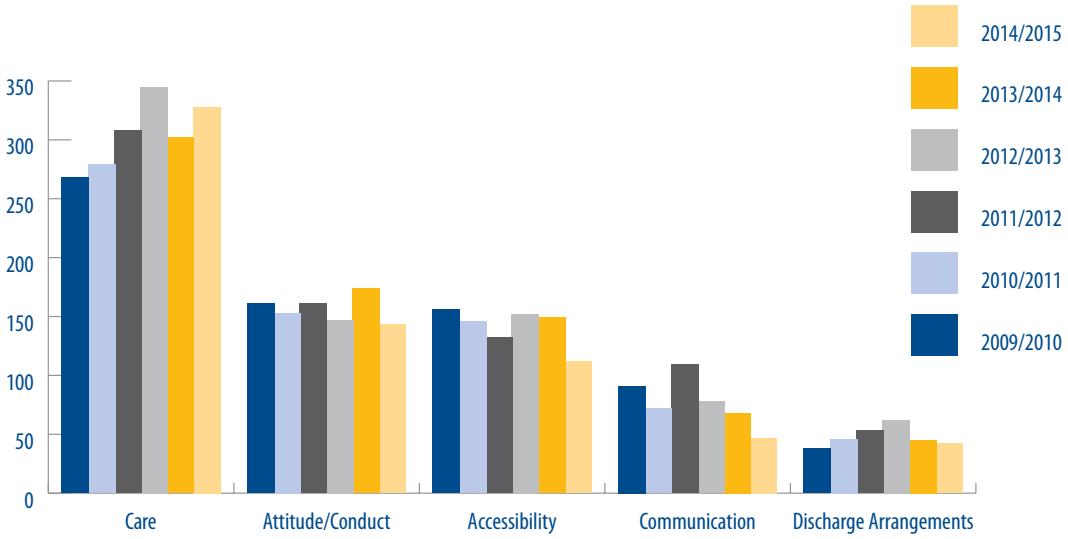
Interior Health

TABLE 5: *Patient Care Quality Office Volume, Interior Health, 2014/15*

INTERIOR HEALTH	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	7	8	5	2	22
Care Quality Complaints	249	310	251	295	1,105
Inquiries	24	135	25	36	220
TOTAL VOLUME	**280**	**453**	**281**	**333**	**1,347**

Interior Health logged 328 complaints in the care category, which represents an increase of 25 from last year. Attitude and conduct was the second most frequently reported concern with 143 complaints. Accessibility was third with 112 complaints, followed by communication at 47 and discharge arrangements was fifth with 42 complaints.

CHART 6: *Patient Care Quality Office Top Five Subjects, Interior Health, 2014/15*



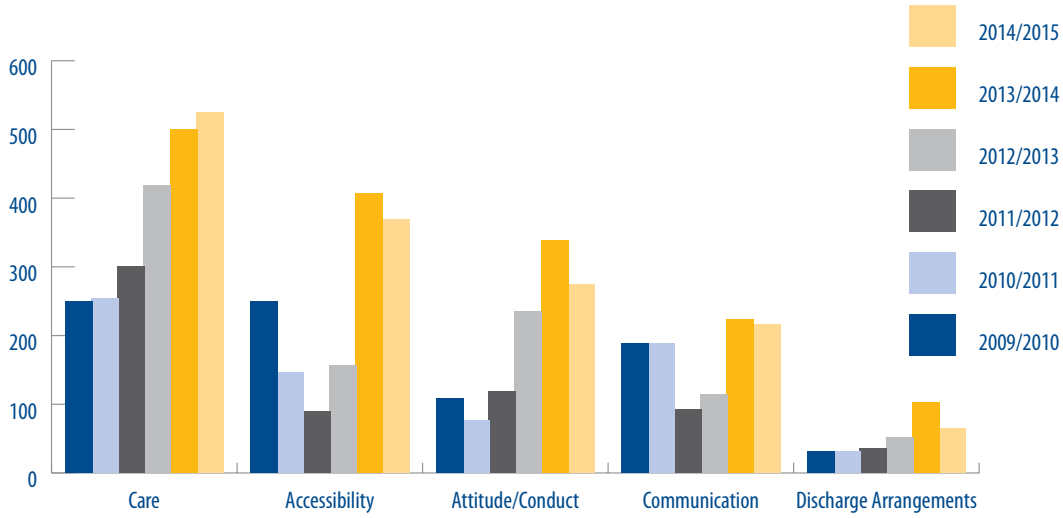
Island Health

TABLE 6: *Patient Care Quality Office Volume, Island Health, 2014/15*

ISLAND HEALTH	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	1	1	3	2	7
Care Quality Complaints	362	422	396	417	1,597
Inquiries	52	53	74	62	241
TOTAL VOLUME	**415**	**476**	**473**	**481**	**1,845**

Island Health logged 525 concerns in the care category, an increase of 25 from 2013/14. Accessibility complaints were down slightly to 369 following a large increase a year ago. Attitude and Conduct complaints also fell from 339 down to 275 in 2014/15. Communication complaints stayed at much the same level with 216 complaints. Finally, Island Health logged 65 complaints about discharge arrangements in 2014/15, down from 102 last year.

CHART 7: *Patient Care Quality Office Top Five Subjects, Island Health, 2014/15*



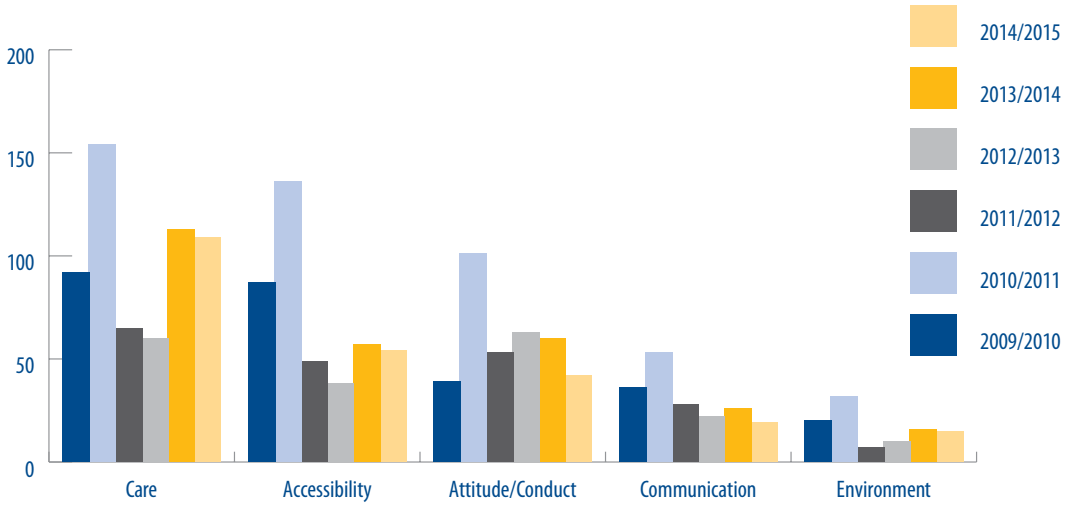
Northern Health

TABLE 7: *Patient Care Quality Office Volume, Northern Health, 2014/15*

NORTHERN HEALTH	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	9	6	7	10	32
Care Quality Complaints	78	57	70	77	282
Inquiries	8	7	19	35	69
TOTAL VOLUME	**95**	**70**	**96**	**122**	**383**

Northern Health logged 113 complaints in their care category, nearly doubling last year's total of 60. Complaints about attitude and conduct were the next most frequently reported concern at 60, followed closely by accessibility at 57. Communication accounted for 26 complaints, while environment concerns were logged on 16 occasions. While the geographic area is large, Northern Health serves a smaller population relative to the other health authorities. As such, the smaller population may explain the lower volumes of care quality complaints.

CHART 8: *Patient Care Quality Office Top Five Subjects, Northern Health, 2014/15*



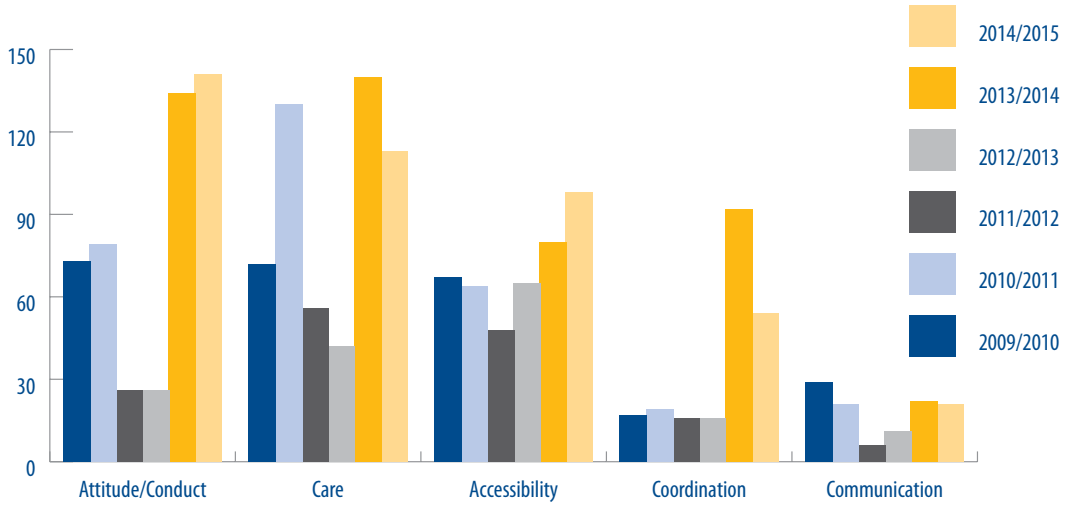
Provincial Health Services Authority

TABLE 8: *Patient Care Quality Office Volume, PHSA, 2014/15*

PHSA	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	0	1	1	4	6
Care Quality Complaints	112	113	112	122	459
Inquiries	129	88	123	72	412
TOTAL VOLUME	**241**	**202**	**236**	**198**	**877**

This year, the Provincial Health Services Authority logged 141 complaints about attitude and conduct. Care was the second most frequently reported care quality complaint at 113 followed by accessibility at 98. Co-ordination was fourth with 54 complaints, down from 92 last year. Communication complaints virtually held steady with 21. As reported last year, due to a shift in reporting procedures, "Ambulance Related" complaints were spread amongst the existing subjects. This accounts for the more consistent numbers the past two years, as compared to years previous.

CHART 9: *Patient Care Quality Office Top Five Subjects, PHSA, 2014/15*



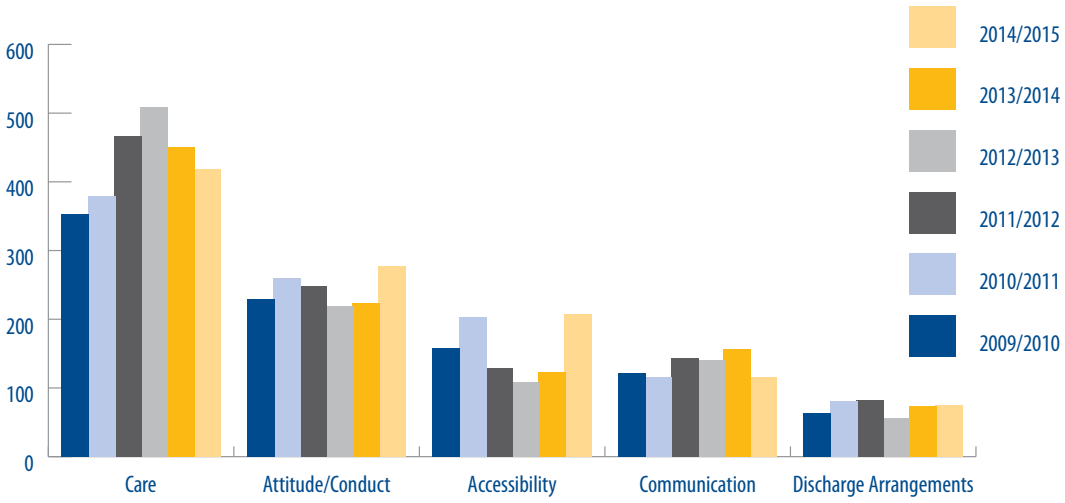
Vancouver Coastal Health

TABLE 9: *Patient Care Quality Office Volume, Vancouver Coastal Health, 2014/15*

VANCOUVER COASTAL HEALTH	APR-JUNE 2014	JULY-SEPT 2014	OCT-DEC 2014	JAN-MAR 2015	TOTAL
External Complaints	11	11	8	4	34
Care Quality Complaints	381	431	401	428	1,641
Inquiries	42	55	66	56	219
TOTAL VOLUME	**434**	**497**	**475**	**488**	**1,894**

Vancouver Coastal Health logged 419 complaints in the care category, a decrease of 32 from 2013/14. Attitude and conduct followed at 277, up 54 from the previous year. Accessibility complaints rose by 74 to 207, while communication complaints dropped by 42, down to115. Discharge arrangements complaints came in fifth at 75.

CHART 10: *Patient Care Quality Office Top Five Subjects, Vancouver Coastal Health, 2014/15*



Appendix B | *Financial Information*

(Source: Corporate Accounting Services Financial Reports)

EXPENDITURES	ACTUAL $ 2014/15
Board Members	
Board Meeting fees and expenses	$121,202.88
TOTAL	**$121,202.88**
Board Support	
Board Support Personnel	$942,160.06
Board Support Travel	$21,542.62
Legal Expenses and Professional Services	$18,953.10
Office Business and Info Systems	$17,011.81
TOTAL	**$999,667.59**
TOTAL EXPENDITURES	**$1,120,870.47**

Further Information

Patient Care Quality Review Board Act

A copy of the *Patient Care Quality Review Board Act* may be obtained from *www.patientcarequalityreviewboard.ca* or by calling BC Laws toll-free at 1 866 236-5544.

Patient Care Quality Review Boards

For more information about whe Patient Care Quality Review Boards or to request a review, please contact:

Patient Care Quality Review Boards
PO Box 9643, Victoria, BC V8W 9P1
Toll-free: 1 866 952-2448
Fax: 250 952-2428
Email: *contact@patientcarequalityreviewBoard.ca*

Patient Care Quality Office

To make a complaint regarding the quality of care that you or a loved one received, please contact the health authority Patient Care Quality Office in your region:

Fraser Health

11762 Laity St, 4th floor, Maple Ridge, BC V2X 5A3
Phone: 877 880-8823 (toll-free)
Fax: 604 463-1888
Email: *pcqoffice@fraserhealth.ca*
Website: *www.fraserhealth.ca*

Interior Health

220-1815 Kirschner Road, Kelowna, BC V1Y 4N7
Phone: 1-877-442-2001 (toll-free)
Fax: 250-870-4670
Email: *patient.concerns@interiorhealth.ca*
Website: *www.interiorhealth.ca*

Island Health

Royal Jubilee Hospital, Memorial Pavilion, Watson Wing,
Rm 315, 1952 Bay Street, Victoria, BC V8R 1J8
Phone: 1 877 977-5797 (toll-free)
Fax: 250 370-8137
Email: *patientcarequalityoffice@viha.ca*
Website: *www.viha.ca*

Northern Health

6th floor, 299 Victoria Street, Prince George, BC V2L 5B8
Phone: 1 877 677-7715 (toll-free)
Fax: 250 565-2640
Email: *patientcarequalityoffice@northernhealth.ca*
Website: *www.northernhealth.ca*

Provincial Health Services Authority

(Includes provincial agencies and services such as BC Cancer Agency, BC Renal Agency, BC Transplant, and BC Women's and Children's Hospital)

4th Floor, Women's Health Centre, Room F404
4500 Oak Street, Vancouver, BC V6H 3N1
Phone: 1 888 875-3256 (toll-free)
Fax: 604 875-3813
Email: *pcqo@phsa.ca*
Website: *www.phsa.ca*

Vancouver Coastal Health

855 West 12th Avenue, CP-117,
Vancouver, BC V5Z 1M9
Phone: 1 877 993-9199 (toll-free)
Fax: 604 875-5545
Email: *pcqo@vch.ca*
Website: *www.vch.ca*

BRITISH COLUMBIA

Patient Care Quality Review Boards