BRITISH COLUMBIA

Patient Care Quality Review Boards



Annual Report 2016/2017

Table of Contents

Letter to the Minister of Health 01

Introduction 02

Executive Summary 03

About the Patient Care Quality Review Boards 04

2016/2017 Board Membership 05

Key Recommendation Themes in 2016/2017 06

Case Studies 07

Statistical Overview | Patient Care Quality Offices 08

Statistical Overview | Patient Care Quality Review Boards 09

Recommendations and Responses 12

Appendix A | Patient Care Quality Office Volumes 48

Appendix B | Financial Information 55

Further Information 56

Letter to the Minister of Health

The Honourable Adrian Dix
Minister of Health

Dear Minister,

It is our pleasure to present the Patient Care Quality Review Boards' Annual Report for the period of April 1, 2016 to March 31, 2017. This report has been prepared in accordance with sections 15(1) and 16(1) of the P*atient Care Quality Review Board Act*.

Independent of the health authorities, the Patient Care Quality Review Boards provide patients with a confidential means to address concerns about their care experiences within our health-care system, and ensure a fair and independent review of these concerns. The detailed process aims to resolve patient complaints, and identify and bring opportunities for care quality improvements to the attention of the health authorities and the Ministry of Health. To be effective, the review process depends upon the co-operation of the Ministry of Health, the health authorities' Patient Care Quality Offices and front-line health authority staff throughout the province.

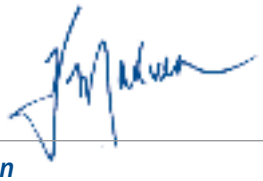
The chairs of the six Patient Care Quality Review Boards would like to take this opportunity to acknowledge the work of the dedicated staff in the Patient Care Quality Offices and the Review Boards' Secretariat. Their expertise and commitment is critical to the overall success of this program. Of course, opportunities for care quality improvement would not be possible without those patients, clients, residents and their loved ones who bring their personal health-care experiences to us.

The Patient Care Quality Review Boards would like to recognize the contribution of departing board chair, Dr. Jack Chritchley. As the first member appointed to the review boards in 2008, Dr. Chritchley helped establish the boards as part of a responsive health-care system that seeks to continuously improve the care experience for British Columbians. In his time with the boards, Dr. Chritchley served as chair of the Vancouver Coastal, Provincial Health Services and Fraser boards, was a member of the Northern board, and served as senior chair of the Board Chairs' Committee. He brought a wealth of medical expertise to board deliberations and his dedication has been an asset to the program.

Respectfully submitted,

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

Robert Holmes, Q.C.
Chair, Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards



Hanne Madsen
Chair, Fraser Patient Care Quality Review Board

Thomas Humphries
Chair, Interior Patient Care Quality Review Board

William Norton
Chair, Northern Patient Care Quality Review Board

Patient Care Quality Office

"One of the most rewarding things about working on a board is seeing your recommendations implemented. Even very small changes can make significant improvements in the patient's experience."

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

Introduction

The Patient Care Quality Review Boards were established by the *Patient Care Quality Review Board Act* to provide a clear, consistent, timely and transparent approach to addressing patient care quality complaints in British Columbia. 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 health system in British Columbia is complex and deals with hundreds of thousands of health-care interventions each year. In addition to providing patient care, the system engages in an ongoing process of reflection, learning and transformation in an effort to improve the products and services and the way in which health care is delivered. An important part of this improvement is the role that the Patient Care Quality Offices and the Patient Care Quality Review Boards play in reviewing and addressing the concerns raised by those who use the system.

In the event a person has a complaint about the quality of a health-care service received (or expected and not received), they are encouraged to raise that concern at the time and place the care is being provided (or should be provided). If this does not address their concerns, they may make a formal complaint to the health authority's Patient Care Quality Office. Should they remain dissatisfied with how their complaint was handled, they may then bring their complaint to the board for review.

In order to conduct an effective review of a complaint, the Patient Care Quality Review Boards Secretariat provides the board members with a complete understanding of a patient's experience as it relates to the complaint. This may include, but is not limited to, an overview of the complaint and the complainant's concerns and experiences, complete medical records, guidelines and policies, as well as the investigation and response by the Patient Care Quality Office. This allows the board to conduct a comprehensive review of the complaint as it relates to the care experience, and the way in which the complaint investigation was handled.

The board is then able to make recommendations to the Minister of Health and/or the health authority. These aim to improve health-care processes, policies and services, and to resolve individual concerns. The boards view each complaint as an opportunity to improve the quality of care within our health-care system.

The Patient Care Quality Review Boards' annual report provides an overview of the care quality concerns brought forward to the boards for review, and illustrates where recommendations by the board have resulted in improvements to our health-care system for the benefit of all British Columbians.

Executive Summary

Since the program's inception in 2008, the boards have completed 653 reviews, and made 776 recommendations to the health authorities and 18 recommendations to the Minister of Health. The boards may make multiple recommendations in one case.

In 2016/17, the boards accepted 73 review requests. The boards completed 98 reviews and made 84 recommendations to the health authorities in 52 of those cases. They made no recommendations to the Minister of Health in this year.

Some key themes arising from this year's recommendations to the health authorities centred on communication in emergency departments, patient transfers and lost valuables. In 2016/17, the boards did not make recommendations in 46 of the cases, either because the care quality provided was assessed as appropriate or because the circumstances of the complaint did not present an opportunity for care quality improvement.

The boards also track data about the types and number of enquiries they receive. In total, the boards received 530 enquiries in 2016/17, relating to a broad range of care quality issues. This includes enquiries by telephone, fax, email or letter in addition to the formal review requests.

Similarly, the health authorities' Patient Care Quality Offices also collect data regarding the number and types of complaints and enquiries they receive. This data is reported quarterly to the boards. This year, the offices received 7,435 complaints concerning care quality, which was about four per cent more than the 7,133 care quality complaints received last year. Of the 7,435 complaints received by the health authorities in 2016/17, 73 were escalated to the boards for independent review.

"Case reviews provide insight to system and care issues that may be recurring within health regions and/or provincially. Recommendations by the boards to the health authorities have resulted in changes to improve patient quality care in British Columbia."

HANNE MADSEN
chair, Fraser Patient Care Quality Review Board

"Our health-care system gives individuals a way to be heard, whether it involves a complaint about the technical aspects of health-care service or getting understandable information in a timely and respectful manner. Many people seek changes that will benefit others in the future if we learn from the problems they encountered and quality is continually improved."

ROBERT HOLMES Q.C.
chair, Vancouver Coastal/ Provincial Health Services Patient Care Quality Review Boards

About the Patient Care Quality Review Boards

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 of Health.

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, improve the quality of patient care, or resolve a specific care quality complaint.

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

The Review Process

Patients or their representatives 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 receives a review request, 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 advice or clarification from the health authority, the complainant, and medical, legal and 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.

The health authority then carefully considers the recommendations, and is required to respond to the board and the complainant about what action(s) will be taken to address them.

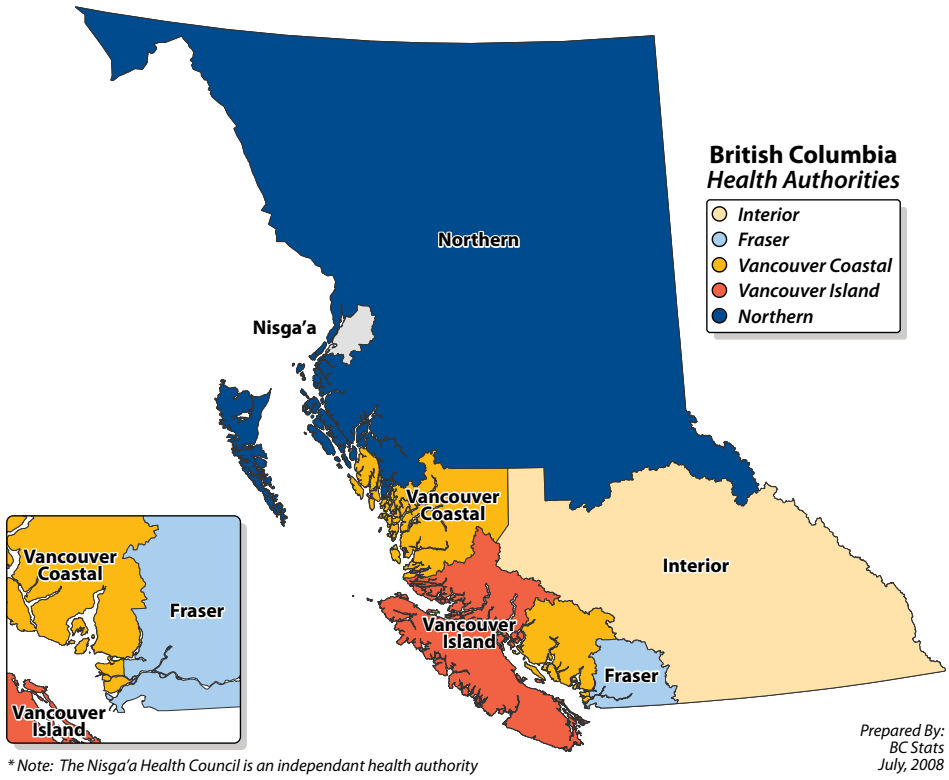
2016/2017 Board Membership

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 of Health. 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 the following departing board members: Dr. Jack Chritchley (Vancouver Coastal/Provincial Health Services/Fraser/Northern); Janis A. Volker (Vancouver Coastal/Provincial Health Services/Fraser); Dr. Linda J.A. Thomson (Vancouver Island); Lorna Dittmar (Northern); Gloria Morgan (Interior); Roger Sharman (Interior); and R. Hoops Harrison (Fraser).

"Each board is comprised of members from the region it serves, which allows the boards to understand the unique factors affecting that region and its people."

WILLIAM NORTON
chair, Northern Patient Care Quality Review Board



** Note: The Nisga'a Health Council is an independant health authority*

Fraser Patient Care Quality Review Board

Hanne Madsen, chair
Peter Buxton, Q.C.
Vivienne Chin
Dr. Romayne Gallagher
Dr. Gillian Hodge
Marion Lochhead
Rita Virk

Vancouver Coastal/ Provincial Health Services Patient Care Quality Review Boards

Robert D. Holmes, Q.C., chair
Barbara Hestrin
Ambrose Ng
Brian Stamp
Dr. Stephen Tredwell
Dr. Amrik Tung
Dr. Naznin Virji-Babul

Interior Patient Care Quality Review Board

Thomas Humphries, chair
Pauline Blais
Dr. Randall Fairey
Donna Horning
Steven Puhallo
Dr. Robert Ross

Northern Patient Care Quality Review Board

William Norton, chair
Dr. David Bowering
Lorraine Grant
Elizabeth MacRitchie
Allison Read

Vancouver Island Patient Care Quality Review Board

Richard J. Swift, Q.C., chair
Ann Beamish
Dr. Craig Beattie
G. Henry Ellis
Nancy Slater

"Our boards were the first of their kind in British Columbia. Since 2008, they have provided a venue for effective independent review of care quality issues within our health system on a case-by-case basis."

THOMAS HUMPHRIES
chair, Interior Patient Care Quality Review Board

Key Recommendation Themes in 2016/2017

Communication within Emergency Departments

The emergency department is one of the busiest areas in any hospital. Depending on the size of the hospital, hundreds of patients and their families can come and go on any given day. Patients are either treated and discharged, or admitted to hospital for further care. When a patient is discharged home from an emergency department, every effort is made to ensure discharge instructions are passed along to the patient and/or their family, and family physician and/or outpatient clinic. For patients and families, information and communication from physicians and hospital staff can sometimes be confusing and overwhelming. Communication between physicians in the emergency department and physicians in the community can also break down. As a result, the boards made a number of recommendations to improve communication in emergency departments between hospital staff and patients and their families, and with physicians in the community.

Lost Valuables

When patients arrive at a hospital, they may be upset or incapacitated by illness and unable to safeguard their possessions. Over the past two years, the Interior Review Board received a number of complaints from patients about possessions being lost during hospital admissions. The board found that Interior Health policies on caring for personal effects were not always clear, particularly when it comes to patients who are vulnerable or temporarily incapacitated. Also, staff did not always follow proper procedures for logging and safeguarding possessions. In response, the board made several recommendations: improving communication with the families of vulnerable patients when those patients are transferred or discharged; improving policies for safeguarding personal possessions; and ensuring staff know and follow the procedures for safeguarding patients' possessions.

Patient Transfers

Patient transfers occur in a variety of circumstances in a health-care setting – from patients moved by ambulance to hospital, hospital room to hospital room, and care facility to care facility. Over the past two years, the boards have made a number of recommendations to improve patient transfers including: using the Patient Transfer Network as an effective tool for patient transfer from hospital to hospital; informing residents in residential care facilities of the internal transfer policy at the time of intake; ensuring hospital staff understand who is responsible for informing family members if a patient must be moved to a different area of a hospital; and encouraging knowledge-sharing between paramedics, especially in rural areas, about the transfer of patients to the appropriate care facility.

Case Studies

Case Study | *Acute Care #1*

While in the intensive care unit, a male patient developed severe pain in his arm. Due to his medical history and the fact that he was having difficulty moving his arm, he asked a nurse for help. He felt the nurse did not take him seriously and asked to see a physician. The patient alleges the nurse responded that if a physician were available, they would attend to patients with more significant health concerns first. When he was examined by a physician, it was determined that he required immediate medical attention.

The patient contacted the health authority's Patient Care Quality Office and filed a complaint regarding the nurse's inadequate response to his health concerns. He was not satisfied with the health authority's response and requested a review by the board.

Upon review of the case, the board found there was a lapse in quality patient care and the patient's medical records lacked sufficient detail, particularly regarding his medical history. The board also learned from information provided by the health authority that the manager for the nurse in question had addressed the patient's concerns with the nurse. As such, the board recommended that the health authority remind all staff of the importance of appropriate and timely charting. The board advised the patient that should he have ongoing concerns about the care he received from the nurse, he may submit them to the College of Registered Nurses of British Columbia who addresses matters of clinical judgement and professional practice.

In response to the board's recommendation, the health authority committed to developing a strategy for improving the quality of patient charting at that site. The health authority also committed to working with their primary health-care team on implementing a new clinical information system across other organizations to improve documentation.

Case Study | *Acute Care #2*

A patient entered the shower room in a hospital with the assistance of his spouse. He and his spouse noticed blood in two spots in the shower. The patient's spouse reported the blood to the charge nurse. The patient and his spouse returned to the shower after the shower had reportedly been cleaned, and the blood remained in one area of the shower.

The patient's spouse submitted a complaint to the health authority's Patient Care Quality Office about the incident, suggesting signs be made indicating if a washroom was clean and ready for use. Not satisfied with the health authority's response, the complainant requested a review by the board.

The board found the instructions for using the shower room were not clear and agreed with the complainant's suggestion regarding a sign. As a result of the board's recommendation, the health authority changed the instructions on the signs.

Case Study | *Residential Care*

A resident in a residential care facility was advised that they would be moved to a different room. A family member contacted the Patient Care Quality Office and expressed concern that the move would be extremely disruptive and unsettling for the resident, and asked that management reconsider the move. The family did not feel their request was taken seriously and contacted the office to investigate the matter further. When the response by the Patient Care Quality Office did not resolve their concern, the family requested a review by the board.

The board empathized with the family member and the resident, but found that the facility had followed the appropriate process when deciding to move the resident to another room. However, the board found that residents of the facility were not advised that their assigned room may be subject to change if required by management.

The board recommended that the health authority inform residents of the internal transfer policy and procedures in place at the facility, including the possibility that a resident may be moved to a different room based on management's transfer criteria and discretion. As a result, the health authority updated the admission documentation within the facility. In addition, the regional residential team committed to looking at ways of standardizing this information at all residential care facilities within the health authority.

Statistical Overview | *Patient Care Quality Offices*

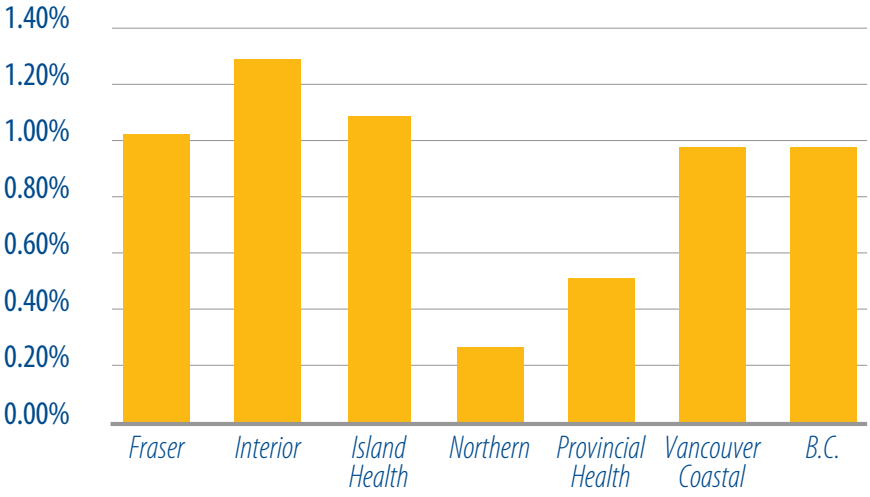
The boards collect data from the Patient Care Quality Offices regarding the number and type of complaints they receive for each quarter throughout the fiscal year. In 2016/17, there were 7,435 care quality complaints (an increase of 302 – or approximately four per cent – from the 7,133 complaints received in 2015/16). This included 299 external complaints and 1,328 inquiries in British Columbia (see Appendix A for details). The table below presents the volume of care quality complaints received by each office between April 1, 2016 and March 31, 2017.

TABLE 1: *Volume of Care Quality Complaints by Health Authority and B.C. 2016/17*

HEALTH AUTHORITY	Apr-June 2016	July-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Total 2016/17
Fraser Health	472	404	429	537	1842
Interior Health	284	276	259	344	1163
Island Health	433	438	390	505	1766
Northern Health	84	110	82	85	361
Provincial Health Services Authority	195	213	145	217	770
Vancouver Coastal Health	457	375	333	368	1533
BRITISH COLUMBIA	**1925**	**1816**	**1638**	**2056**	**7435**

The boards accepted 73 reviews – or about one per cent of the total office 7,435 care quality complaints received within the same timeframe. Chart 1 shows the percentage of care quality complaints that escalated to the boards from each office over the 2016/17 period. It is subject to fluctuations year-over-year and is not intended to be an indication of office performance.

CHART 1: *Percentage of Care Quality Complaints that became Patient Care Quality Review Board Accepted Reviews in 2016/17*



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*

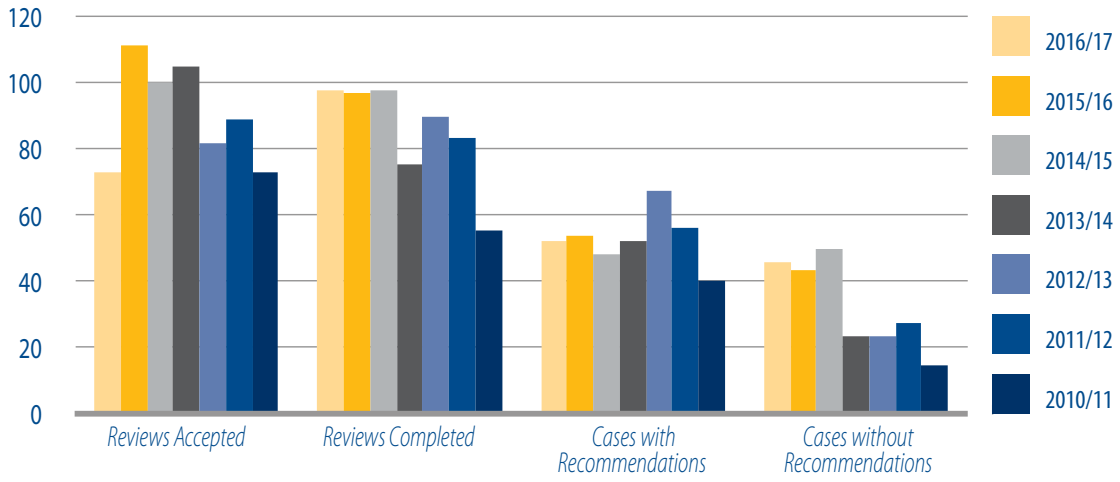
In 2016/17, the boards saw a 34 per cent decrease in accepted review requests – 73 compared to 111 last year. The boards completed 98 reviews (up one from 97 last year). The table below presents an overview of the boards' volume.

In 52 of the 98 completed reviews (53 per cent), the boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself. In 46 of the completed reviews (47 per 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 84 recommendations to the health authorities in 2016/17, and no recommendations to the Minister of Health.

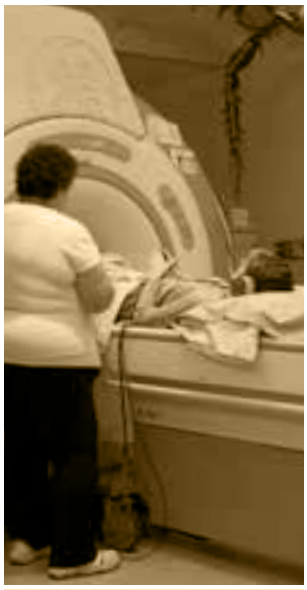
TABLE 2: *Overview of Patient Care Quality Review Board Volume 2016/17*

HEALTH AUTHORITY	Reviews Accepted	Reviews Completed	Cases with Recommendation(s)	Cases without Recommendation(s)
Fraser Health	19	23	12	11
Interior Health	15	22	10	12
Island Health	19	16	7	9
Northern Health	1	4	4	0
Provincial Health Services Authority	4	4	3	1
Vancouver Coastal Health	15	29	16	13
TOTAL	**73**	**98**	**52**	**46**

CHART 2: *Volume Comparison for Recommendations and Reviews*

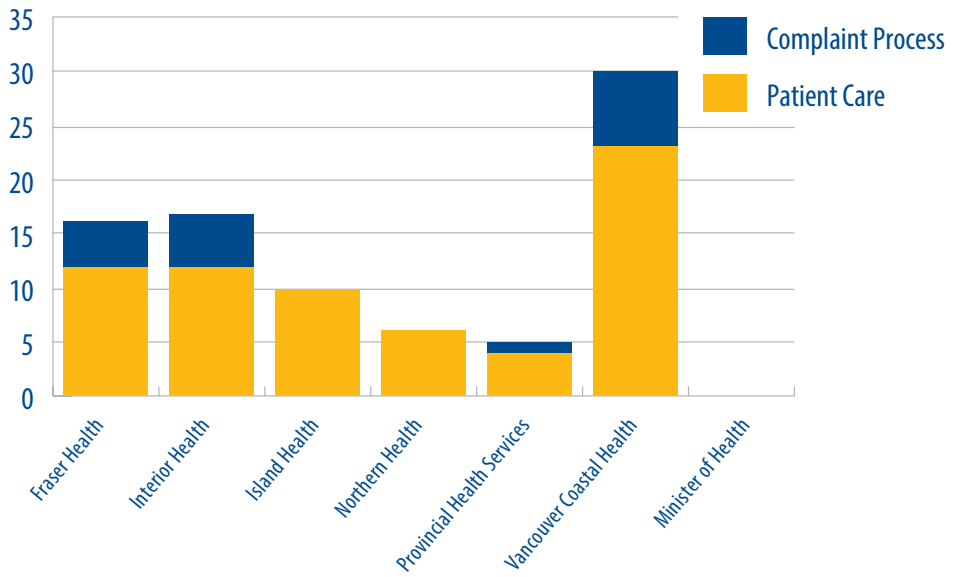


Statistical Overview | *Patient Care Quality Review Boards*



Of 84 recommendations to health authorities, 67 were to improve the quality of patient care and 17 were to improve the complaints process (see chart 3 below). In 15 of the 98 completed reviews, the boards identified opportunities for the Patient Care Quality Offices to improve the quality of their investigation or response. In the remaining 83 reviews, the boards found the offices had responded appropriately.

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



The boards also collect information regarding the timeliness of the health authorities' responses to their recommendations. Under the *Patient Care Quality Review Board Act*, health authorities are required to respond to recommendations within 30 business days. The health authorities achieved this timeline for 43 of the 52 reviews that resulted in recommendations (83 per cent).

Finally, the boards track the timeliness of their own reviews. Under the legislation, the boards are expected to complete a review and respond within a maximum of 130 business days unless the board determines that an extension is warranted. In 2016/17, the average time to complete a review and respond to the complainant was 153 business days. The median time was 151 days. On average, the board took just under seven business days to provide a response following their decision.

Statistical Overview | *Patient Care Quality Review Boards*

The chart below represents the subjects of all the complaints reviewed by the boards in 2016/17. Note that one complaint may encompass more than one care issue, so the total number of care issues (106) is higher than the total number of reviews completed (98).

Sector	Subject	#
Acute care – cardiac	Care	1
	Attitude and conduct	1
Acute care – cancer	Communication	1
	Administrative fairness	1
Acute care – mental health	Accessibility	1
	Administrative fairness	2
	Attitude and conduct	3
	Care	2
Acute care – other	Accessibility	1
	Accommodation	2
	Attitude and conduct	2
	Care	37
	Safety	1
	Communication	1
Administration	Accessibility	1
	Communication	1
	Lost article	1
	Safety	1
	Administrative fairness	1
Ambulance – Pre hospital treatment and transport	Attitude and conduct	1
	Care	1
Ambulatory care – other	Attitude and conduct	1
	Safety	1
Ambulatory care – renal	Care	1

Sector	Subject	#
Emergency	Attitude and conduct	1
	Accessibility	2
	Care	14
	Discharge Arrangements	4
	Environmental	1
Home and community care (not including mental health)	Care	2
	Attitude and conduct	1
Mental health – community, substance use and housing	Care	3
	Residents' Bill of Rights	1
Primary care	Attitude and conduct	3
	Communication	1
Public health	Care	2
Residential care	Accessibility	2
	Care	3
TOTAL		**106**

Recommendations and Responses

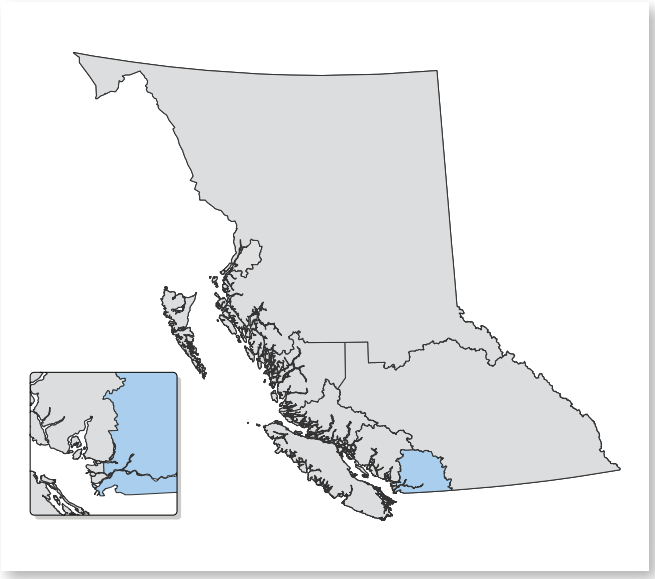
After completing a review, a board may make recommendations to the health authority and/or the Minister of Health to resolve concerns, improve care quality and/or improve the complaints process.

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 consider the 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 2016/17, the boards made 84 recommendations to the health authorities. The following presents the recommendations for which the boards received a response from the health authorities in this reporting period, along with highlights of actions taken in response.



Fraser Health is responsible for serving a densely populated and culturally diverse region of more than 1.8 million British Columbians stretching from Burnaby to White Rock to Hope.

The Fraser Board completed 23 case reviews in 2016/17, resulting in 16 recommendations from 12 cases. Of the 16 recommendations, 12 were to improve care quality and four were to improve the complaints process. There were no recommendations in 11 of the cases.

Headline: STAFFING LEVELS IN AN EMERGENCY DEPARTMENT.

Recommendations:

1. The health authority complete a review of patient flow in the emergency department at the hospital to determine if staffing levels are sufficient to meet patient demand.

Response:

2. A review of staffing levels was conducted by the Emergency program, which showed that hospital staffing levels are adequate for the volumes handled. Staffing levels at the hospital are in line with other health authority hospitals of similar size and similar annual visit volumes. As volumes do fluctuate seasonally, all effort is made to manage these volumes with staffing levels.

Headline: LACK OF ROOM AVAILABILITY IN THE HOSPITAL AND THE NUMBER OF PATIENTS IN HALLWAY BEDS.

Recommendations:

1. That the health authority provide the complainant with an update, including statistical information (if available), to illustrate that the use of hallway beds has decreased since the patient's stay at the hospital.

Response:

1. A working group of health authority executives, physicians and program leaders developed an Over Capacity Protocol Framework to give staff and physicians a process for relieving congestion at all health authority acute sites. The protocol is to be used when there is severe site congestion based on pre-defined triggers (i.e., a certain number of acute emergency department stretchers are occupied by admitted patients). These triggers will activate a co-ordinated response to help reduce congestion and improve patient flow. As a priority for executive, this is part of improving quality of care for patients.

   Due to these strategies, the number of patients in hallway beds at the hospital has decreased from an average of two patients in 2013 to no patients as of November 2015.

Headline: OUTPATIENT RENAL AND DIALYSIS PROCEDURES.

Recommendations:

1. The health authority take the appropriate steps to review and ensure the Acute Care Standard: Hemodialysis Protocol is consistently followed by all staff members by:
   - *a.* initiating an in-service teaching module to reinforce strategies in dealing with challenging patients;
   - *b.* taking and recording in-depth notes and documenting as to what should be done for care and what was actually done, and reviewing this with the patient when challenges begin; and
   - *c.* ensuring annual training is revisited on the renal unit.

Response:

1. The health authority Renal program, in consultation with the health authority Health Professional Practice, agreed to develop an in-service teaching module to reinforce strategies in dealing with challenging patient behaviours.
   - *a.* The Clinical Practice Guideline - Challenging Responsive Behaviours: Identification and Management for Adults in Acute Care was developed for adults in acute care settings. The Renal program agreed to adapt the guideline to meet its outpatient program operational model. Adaptations were completed in consultation with clinical nurse specialists, Risk Management and Workplace Health. Once the education plan is endorsed by the health authority's Renal Quality Performance Committee, the guideline will be used by the clinical nurse educators at each site.
   - *b.* As part of the guideline detailed above, the health authority agreed to review the documentation and use non-identifying examples to compare to the health authority Acute Standard: Hemodialysis Protocol. The guideline will reinforce the expected standards for practice and provide the process for reviewing the documentation with patients when challenges begin.
   - *c.* The health authority committed to in-service training and use of the guideline, as well as yearly (or as-required) reviews.

Headline: CARE AND DIAGNOSTIC TESTING OF A PATIENT IN HOSPITAL.

Recommendations:

1. The health authority ensure protocols regarding diagnostic imaging scans for patients, particularly elderly patients, who present with head and neck injuries, are included in their best practice standards.
2. The health authority establish a process or protocol for appointing a lead specialist in complex health-care cases and that in such cases, prompt consideration is given to transferring the patient to a higher level care centre.
3. The health authority provide confirmation that the strategies outlined by the Site Medical Physician at the hospital to improve the quality of patient care have been initiated.

Response:

1. Well-established protocols for imaging of cervical spine trauma are covered by the Canadian Cervical Spine Rules. There are also guidelines in place for the transfer of patients with potential or known cervical spine fractures. These rules are familiar to all emergency room physicians. The Department of Emergency Medicine reviewed these rules at a departmental meeting.
2. The executive medical director of Quality & Safety reviewed the recommendation and determined that current protocols are in place that appoint physicians to oversee care of patients (Most Responsible Physician (Acute Care), revised August 2010). The most responsible physician can seek advice from the site medical director for local patient and site-related issues. For regional expertise, the regional medical director for the specialty service is available. In addition, the escalation of care protocol can be used (Higher Level of Care and/or Life, Limb and Threatened Organ Policy, revised November 2016).

   The health authority committed to the executive medical director of Quality & Safety and the executive medical director of Physician Partnership and Performance to review the Most Responsible Physician policy to ensure the information is current.
3. The site medical director reviewed and updated the actions to improve spine pathology at the hospital, including:
   - ***a.*** Accelerating the plan for two orthopaedic surgeons to collaborate with multiple departments in the hospital.
     - This action was implemented immediately upon recognition of the issue.
   - ***b.*** Developing protocols for spinal immobilization outside of the emergency department.
     - Spinal trauma is still growing its operations at the hospital as it remains a low-incidence condition.
   - ***c.*** Increasing physician awareness of how to access the knowledge and skills of the orthopaedic surgeons.
     - Improving physician awareness has included one-on-one conversations with practitioners, informing medical leadership at meetings, and communication with the largest potential users of this service (emergency department and Hospitalist staff).

   A task group continues to work on improving site-based co-ordination, education and care of patients with spinal trauma.

Headline: CARE AND DISCHARGE FOLLOWING A PATIENT'S EMERGENCY DEPARTMENT VISIT.

Recommendations:

1. The charting and referral process in this case be reviewed by the emergency department head, and that the hospital develop a process and protocol to ensure that all recommended treatment including referrals and follow-up care have been requested and documented fully.
2. The orthopedic surgeon contact the family to discuss any steps the family has taken to correct the arm, and recommend any additional appropriate care.

Response:

1. The health authority committed to the Emergency Department Head reviewing the chart and the referral process. In this case, the referral was to be sent after the first visit but it is unclear if the fax was sent or if the fax number was incorrect. The chart did confirm that the fax was sent again and received by the referring physician. The emergency department will share their recommendations for process improvement with the health authority's Regional Head of Emergency.
2. The physician contacted the complainant to follow-up on the patient's recovery, and to discuss any potential next steps in his care.

Headline: LEVEL OF FOLLOW-UP CARE PROVIDED AFTER A FALL IN AN EMERGENCY DEPARTMENT AND COMMUNICATION WITH FAMILY.

Recommendations:

1. The health authority arrange a meeting between the neurologist and perhaps a social worker and the complainant to explain the medical terminology and the reasons regarding the 12-hour timeline prior to the patient's transfer to the hospital to help the complainant understand the details of the care the patient received.

Response:

1. The health authority committed to scheduling a meeting with the neurosurgeon and social worker based on the complainant's family and physician availability.

Headline: BIOPSY PERFORMED IN HOSPITAL.

Recommendations:

1. The health authority provide a copy of the radiologist's biopsy report to the complainant that she can take to her doctor for interpretation.

Response:

1. The health authority sent a copy of the radiologist's report to the complainant.

Headline: ACCESS TO MEDICAL IMAGING REPORTS.

Recommendations:

1. The health authority review the process in reporting radiologic diagnostic findings, which should:
   - **a.** Be inclusive for all referring practitioners throughout the health authority;
   - **b.** Ensure that accountability is paramount and streamline the triplicate process of the reporting systems utilized now; and,
   - **c.** Ensure that when conditions carry a risk of acute morbidity and/or mortality and may require prompt action that the results are communicated using a phone call or other method which will verify that the report has been received by the referring practitioner.

Response:

1. All referring practitioners are copied on reports. The health authority's medical imaging department completed a review and is confident that all nurse practitioners have access to the reports.
   - **a.** Access to reports is inclusive.
   - **b.** Reports are distributed to individual mailboxes on site, and all practitioners are granted access to electronic medical records and access to the picture archiving and communications system to view reports. A memo was sent to the health authority hospital practitioners reminding them of the options available to them.
   - **c.** The medical imaging department has a policy in place for managing urgent or unexpected findings. The policy states that the radiologist should attempt to co-ordinate their efforts with those of the referring physician in order to best serve the patient's well-being. In some circumstances, this may require direct communication (i.e., in person or by telephone) of unusual, unexpected or urgent findings to the referring physician in advance of the formal written report. The policy was discussed at a health authority medical imaging quality meeting. Additionally, a medical imaging policy for communicating critical results is under review by the medical imaging's executive team.

Headline: DELAYED SURGERY.

Recommendations:

1. The health authority review, independent of the medical staff at the hospital, of the inconsistency between the report of the Chief of Surgery to the Patient Care Quality Office and the post-surgical report clarifying the nature of the misunderstanding that delayed the repair of the complainant's ileostomy.

Response:

1. A review was completed by a general surgeon independent of the medical staff at the hospital. A response letter with an explanation for the misunderstanding was sent to the complainant.

Headline: DEATH OF A PATIENT FOLLOWING DISCHARGE FROM AN EMERGENCY DEPARTMENT.

Recommendations:

1. The health authority review their current process of interpreting electrocardiograms in the emergency department when a patient presents with possible cardiac issues and incorporate protocols that include:
   - ***a.*** Admitting a patient into a monitored bed until the patient's electrocardiogram has been reviewed by a cardiologist who has access to the relevant clinical information and the patient is determined to be fit for discharge;
   - ***b.*** Ensuring the patient is provided with appropriate information and recommendations for follow-up care prior to discharge; and
   - ***c.*** Retaining the original machine-generated electrocardiogram and interpretation for audit purposes.

Response:

1. The regional director of the health authority's Emergency Network reviewed the patient's hospital care. The regional director determined that the absence of cardiac monitoring was not a factor in the patient's outcome. The purpose of monitoring is to detect cardiac arrhythmias. However, research shows that clinically important arrhythmias are uncommon among patients presenting to the emergency department with chest pain and monitoring can be avoided in many patients, as was appropriate in this case. Chest pain is one of the most common presenting complaints to the emergency department, making up about five per cent of annual visits – or 35,000 patients – in the health authority. The vast majority of these patients do not see a cardiologist in the emergency department, which is consistent with practice in emergency departments across Canada.
   - ***a.*** Adopting this recommendation would result in hundreds of thousands of additional monitoring hours in the health authority. Placing patients who present with chest pain on cardiac monitoring would increase the length of stay for patients and result in much longer waiting times – keeping undiagnosed chest pain patients in the waiting rooms for many hours. Further, there are currently insufficient cardiologist resources in British Columbia to fulfill this request.
   - ***b.*** It is a priority for the health authority's Emergency Network to improve the care our patients receive and to clearly communicate all discharge procedures. The Emergency Network is working to make this happen.
   - ***c.*** ECG strips are taped to the triage form on all four sides – or mounted on a backing form if there are a number of them. If the strips go to Health Records unmounted, the chart is sent back to the emergency room for correct mounting. Additionally, Health Records does not cut the strips to fit the paper record. Paper strips are now scanned in with the rest of the chart into the electronic medical record.

Headline: PATIENT'S DISCHARGE FROM HOSPITAL WHILE IN LABOUR.

Recommendations:

1. The health authority conduct a review of the complainant's care at the hospital's maternal family medicine unit with the goal of determining if any improvements can be made to prevent similar incidents from occurring in the future. The review should be conducted by an expert in maternal care from outside of the hospital.
2. The health authority provide the complainant with an additional response, and that the response includes the following:
   a. The results of the review recommended above; and
   b. A complete response to all of the concerns raised by the complainant.

Response:

1. The medical director for the Maternal Infant Child and Youth program completed a thorough chart review of the complainant's care. Recommendations from the review were shared with program leadership.
2. A full response to all of the complainant's concerns was detailed in a letter, and a meeting was arranged between the complainant, the medical director, and the executive director of the Maternal Infant Child and Youth program.

Headline: DEATH OF A PATIENT AFTER FALLING AND HITTING HIS HEAD IN HOSPITAL.

Recommendations:

1. The health authority have the hospital conduct in-house education sessions for relevant staff on the Post-Fall Assessment and Management Algorithm and ensure that it is being implemented.

Response:

1. In March and April 2015, the hospital psychiatric unit staff were provided education on the Post-fall Assessment and the Management Algorithm by a practice consultant, patient care co-ordinator and clinical nurse educator. To educate the majority of staff, safety huddles made up of interdisciplinary teams (i.e., nurses, mental health workers, social workers, occupational therapists) were repeated weekly.

   The weekly safety huddles included education on the fall and injury reduction flow sheet (Universal Fall Precautions aka SAFE), degree of harm guidelines for fall-related injuries, importance of completing new clinical records, notifying the clinical nurse educator for serious falls and injury prevention, review of the post-fall, and assessment and management records.

   Education sessions have been held to reinforce the importance of accurate documentation, and how it reflects on a professional's credibility and practice. Staff were also reminded of the importance of closely monitoring those patients with special considerations, such as patients with a known bleeding disorder (i.e., currently on anticoagulant medication) or having an increased risk of intracranial hemorrhage.

   The regional clinical nurse specialist within the Mental Health and Substance Use program is leading the implementation of the Clinical Practice Guideline for Reduction of Falls and Fall-related Injuries at all health authority acute sites.

Recommendations and Responses | *Interior Health*

Interior Health is responsible for a broad geographic area of over 216,000 square kilometres, including larger cities and rural communities, with a population of about 740,000 people.

The Interior Health Board reviewed 22 cases in 2016/17, resulting in 17 recommendations in 10 of those cases – 12 for care quality improvement and five for improving the complaints process. There were no recommendations in 12 of the cases.

Headline: UNSATISFACTORY RESPONSE FROM THE PATIENT CARE QUALITY OFFICE.

Recommendations:

1. The Patient Care Quality Office provide the complainant with a detailed response to her unanswered questions.

Response:

1. The department head for the hospital emergency department wrote a detailed response to the Patient Care Quality Review Board. This letter was provided to the complainant along with a letter from the Patient Care Quality Office.

Headline: DECISION TO DENY A PATIENT ACCESS TO IN-HOME PHYSIOTHERAPY SERVICES.

Recommendations:

1. The health authority ensure that staff is reminded of and fully trained in policy and procedures pertaining to the Violence Prevention Program and that they complete the required documents and forms for threat management and the hazard assessment and reduction plan in cases of perceived aggressive behaviour from patients.

Response:

1. The implementation of the Workplace BC Violence Prevention High Risk strategy contained several program elements including: webinars, and a number of tools and resources for sites. These were rolled out to managers across the health authority in 2015 and again in 2016. The Violence Prevention program policy is reviewed annually by the policy steward and revised as required. The manager in this instance has followed up with the individual physiotherapist.

Headline: LOSS OF A PATIENT'S PERSONAL EFFECTS, AND NOTIFICATION OF FAMILY WHEN A VULNERABLE PATIENT IS TRANSFERRED.

Recommendations:

1. The health authority review its policy relating to notification of a vulnerable patient's family about that patient's transfer or discharge and consider an amendment to clarify when it is appropriate to notify the family.
2. The health authority ensure that when there is an inter-facility transfer where discharge is required, proper procedure is followed at the originating facility, including the safekeeping of patient belongings during inter-facility transfers.

Response:

1. The health authority does not have a policy that provides direction to staff on when to notify a vulnerable patient's family about transfer or discharge. It is assumed that staff will use appropriate judgment in determining when it is necessary to notify family. The management of the hospital where the events occurred has reminded staff of their obligation to notify family of transfers or discharges as appropriate.
2. In a previous response to the Patient Care Quality Review Board, the health authority committed to providing an online conferencing system to health authority managers, and to implement a communication strategy on policy pertaining to personal effects. Procedures for inter-facility transfers where discharge is required (including the safekeeping of patient belongings) will be included in this education and communication strategy.

Headline: LOSS OF A PATIENT'S PERSONAL EFFECTS WHILE HOSPITALIZED – INCAPABLE OR INCAPACITATED PATIENT.

Recommendations:

1. The health authority review its current policy and clarify the terms "incapable/incapacitated" in its Client Valuables & Personal Effects policy. Clarity is also required regarding under which circumstances the health authority has a greater obligation to incapable/incapacitated clients.
2. The health authority ensure the hospital admission form is completed by hospital staff and signed off by the patient, or in cases of incapacitation that this be documented.

Response:

1. Health authority policy is reviewed on a three-year policy review cycle. Interior Health agrees that clarity around the understanding of "incapable/incapacitated" and its obligation to incapable/incapacitated clients would improve the policy. This will be considered with all other comments and feedback at the time of the next policy review.
2. The health authority's registration team has discussed the issue of ensuring the admission form is completed by hospital registration staff and signed by the patient. They determined it is not always practical or feasible to have the patient sign the form. Information regarding the patient's attire and their level of independence in changing into a hospital gown should be documented in the clinical records. Reminders to clinical staff to document clearly and accurately are ongoing.

   At the hospital where this event occurred, protocols are now in place to assist staff in the appropriate handling of patient belongings and valuables. Registration staff provide patients or those accompanying them with a one-page information sheet that outlines appropriate actions around management of their personal effects. Emergency staff hand out name-labelled patient belonging boxes and bags to all admitted patients, as well as denture cups and a client valuables envelope as needed. Volunteer Services is responsible for placing these "admission kits" in a central area of the emergency department and replenishing them as needed.

Headline: LOSS OF A PATIENT'S PERSONAL EFFECTS WHILE HOSPITALIZED.

Recommendations:

1. All hospital staff are familiar with and follow the health authority policy regarding client valuables and personal effects, and the appropriate forms are completed by hospital staff and signed off by the patient on both admission and discharge.
2. The health authority provide to the patient the answer to their question as to how the staff knew who they were on admission to the hospital.

Response:

1. The director of Risk Management is the policy steward of the Client Valuables and Personal Effects policy. The director will educate health authority managers using online conferencing, and develop a policy communication strategy in collaboration with the communication's team.
2. The patient care quality officer who facilitated the response to this complaint has investigated this question and determined that BC Ambulance staff identified the patient on their records. This has been communicated to the patient in writing.

Headline: DOCUMENTATION OF CARE PLANNING AND REIMBURSEMENT OF TRAVEL COSTS.

Recommendations:

1. The health authority provide a written response to the complainant explaining why the complainant received a phone call from health authority administration personnel, who advised them they would be reimbursed for taxi fare and why that decision was changed.
2. The health authority amend its hospital care plan form to include signatures by both hospital staff and the patient.

Response:

1. The patient care quality officer wrote to the complainant to explain that the health authority staff was never able to identify the administration personnel who advised the complainant that the taxi fare would be reimbursed. The hospital administrator determined that since no documentation could be found supporting or refuting the call, the complainant would be reimbursed for the taxi fare. In future, Interior Health will require documented evidence that such a decision was made at the director level of the hospital.
2. The plan of care form referenced in the Patient Care Quality Review Board recommendation is part of the provincial 48/6 initiative. As this is a Ministry of Health project, the health authority does not have the ability to make changes to the form (i.e., adding a patient signature). The health authority uses complex care plans for patients who are frequent users of health-care services, or require managed risk or collaborative care agreements for certain aspects of care. In these situations, the care plan is shared with the patient and a patient signature is requested. In hindsight, this patient's care should have warranted a complex care plan with the patient's signature.

Headline: HANDLING OF EVIDENCE IN CASES OF POSSIBLE CRIMINAL ACTIVITY.

Recommendations:

1. The health authority initiate a region-wide policy or directive that clearly indicates how potential evidence is to be handled in any case where staff suspects criminal activity may have taken place in an institution.

Response:

1. The health authority is currently revising their Incident Management policy. This recommendation will be incorporated into the revised policy. A communication plan will be developed to disseminate the changes to the policy.

Headline: LACK OF COMMUNICATION BETWEEN MEDICAL STAFF AND FAMILY MEMBERS.

Recommendations:

1. The Patient Care Quality Office update, finalize and send the letter prepared for the complainant.
2. The health authority consider providing a reference brochure along with the Medical Orders for Scope of Treatment brochure, explaining designated levels of care and how they are determined. Topics covered should include an explanation of each level of care designation, who is authorized to determine and change level of care designations, the role of family when a patient is deemed competent to make decisions, and what happens if a patient is no longer competent to make decisions.

Response:

1. The health authority accepted the recommendation as written.
2. The Patient Care Quality Officer reviewed the draft correspondence and sent it to the complainant, which included the follow-up to the second recommendation.

Headline: POOR CLEANING PRACTICES AND MANAGEMENT OF INFECTION PREVENTION AND CONTROL.

Recommendations:

1. The health authority reword the directions on the shower room signs to specifically instruct patients to turn the sign over to indicate the shower is dirty and in need of cleaning.
2. The health authority instruct the Patient Care Quality Office to provide an explanation to the complainant as to why the blood in the shower room was not reported to Infection Control.

Response:

1. The signage has been rewritten with specific instructions and this has been communicated to the complainant.
2. The patient care quality officer provided written feedback to the complainant from the Health Service director at the hospital. The director expects staff to report events of this nature in the Patient Safety Learning System for follow-up by the appropriate people, including Infection Prevention and Control. This expectation has been communicated to staff.

   To ensure there is a consistent approach to this issue across the health authority, hospital management has forwarded the Patient Care Quality Review Board correspondence to the vice-presidents responsible for Hospital and Community Integrated Services and Residential Services.

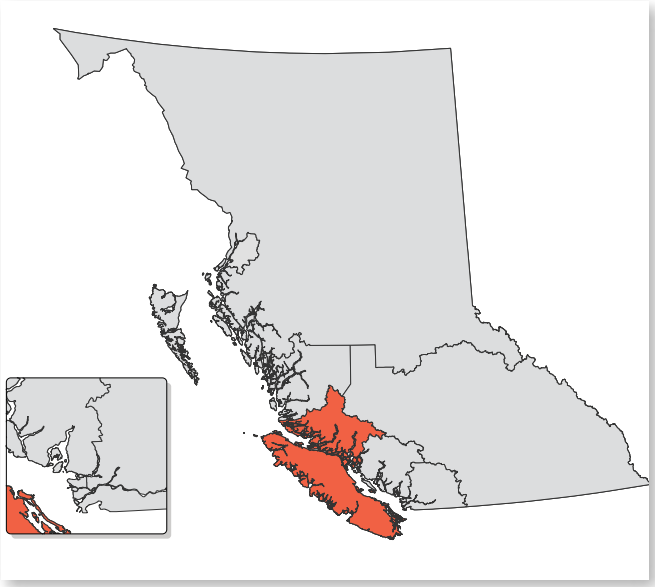
Headline: MIXED GENDER HOSPITAL ROOM ASSIGNMENTS.

Recommendations:

1. The health authority review their policy on patient room assignment and develop a process or system which best enables staff of all departments to record:
   a. when a patient is assigned to a mixed gender room;
   b. the discussions that occur with patients and their families to review the room assignment; and
   c. staff compliance and implementation of the policy on a daily basis with patients assigned to mixed gender rooms.
2. The health authority develop a training process to ensure that staff are aware of the room assignment policy and how to implement it consistently. In addition, the health authority revise section 3.4(b) of the policy to clarify for staff that mixed gender room assignments must be reviewed with the patient and, if appropriate, also with the family.

Response:

1. The health authority will document circumstances around mixed gender rooms in the patient's health record, and any concerns that are voiced by patients and families will be included in the orientation and training described under the recommendation. Documentation should include the specific concern, the plan established to address the concern and, should barriers to remedy be encountered, the requirement to escalate the concern to the appropriate supervisor/manager to assist with problem-solving. The electronic patient record already includes a field where admission staff can enter the reason for placement in a specific room type. This includes the need to place a patient in a mixed gender room.
2. The health authority will add information on the policy to the orientation and training for nurses in-charge, supervisors and managers. The executive director will update the policy to clarify the obligation to discuss mixed gender room assignments with patients and, as appropriate, family.



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

The board reviewed 16 cases in 2016/17, resulting in ten recommendations in seven of those cases. All ten recommendations were for care quality improvement. The board made no recommendations in nine cases.

Headline: CARE AND ADMINISTRATION IN A HOSPITAL.

Recommendations:

1. The health authority ensure that the complainant's letter to the Patient Care Quality Office and the response provided by the Patient Care Quality Office be shared with the unit managers and staff involved in the complainant's care.

Response:

1. The unit's site manager and clinical co-ordinator met and determined the following:

- Copies of the two letters referenced in the recommendation will be placed in a file folder – available to all staff for review in the clinical co-ordinator's office;
- The clinical co-ordinator and site manager will send an email notifying staff of the file folder and encouraging them to review the letters;
- The clinical co-ordinator will review the patient's letter at morning huddle;
- The letter will be available on the unit for review; and
- Staff will be asked by email and at the morning huddle to connect with their clinical co-ordinator/site manager if they have questions or comments, or to place suggestions for improvement on the unit's quality improvement board.

Headline: DEATH FOLLOWING A FALL IN HOSPITAL.

Recommendations:

1. The health authority review their Falls Prevention and Least Restraints policies and ensure that bed alarms are in place and activated for people getting in and out of bed.
2. The health authority review its policies with relevant staff at the hospital with regard to reporting deaths to the Coroner's office as per legislated guidelines.

Response:

1. Messaging has been shared with site management/leadership about the appropriate use of restraints and falls prevention. The health authority committed to purchasing additional bed alarms health authority committed to further education and the topic will be addressed at the next site leadership meeting. The health authority will purchase additional bed alarms to make sure enough bed alarms are in stock for all patients at risk of falls.
2. Clinical staff and inpatient units will review the relevant policies at their respective staff meetings over the next two months. As these meetings are taking place over the summer months when some physicians will be away, reminders with respect to reporting deaths to the Coroners Service will also be sent to physicians and physician groups. Medical directors will also remind physicians during site leadership meetings.

Headline: PATIENT DEATH FOLLOWING SURGERY.

Recommendations:

1. The health authority provide patients receiving surgical procedures in hospital with a hardcopy list of the risks associated with that procedure prior to being asked to sign the consent form for surgery.
2. The health authority review current post-surgical care practices at the hospital for both weekdays and weekends to ensure that an appropriate level of care is established based on surgical standards.

Response:

1. Risks associated with procedures are highly variable and can be very specific to the individual patient. To assist us in developing appropriate materials, the health authority will be reviewing practices at other hospitals across the country. We will also seek input from the Surgical and Endoscopy Program Clinical Governance Councils. Most importantly, we will consult with patient advisors for input and feedback.
2. Weekend post-procedural care practices are consistent with weekday practices at the hospital. Nursing staffing levels on inpatient medical units remain the same on weekends. The patient was transferred to a medical bed for monitoring after their procedure, as is consistent with practice throughout the week.

Headline: CONSENT, AND THE AUTHORITY OF THE HEATLH CARE REPRESENTATIVE TO MAKE HEALTH CARE DECISIONS FOR A HOSPITAL PATIENT.

Recommendations:

1. The health authority initiate an in-service training module for all personnel who work with patients who are near or in the end-stages of life to determine what the protocols for informed consent and the revocation of a representation agreement are with reference to:
    - *The Health Care Act;*
    - *The Representation Agreement Act ;*
    - *The Adult Guardian Act;*
    - *The Public Guardian and Trustee Act; and*
    - *The Health Care (Consent) and Facilities (Admissions) Act.*

Response:

1. The health authority will develop an Inter-professional Practice Guideline and supporting checklist for situations when an incapable adult's legal representative is believed to be unable or unwilling to fulfill their responsibilities under the *Representation Agreement Act*.

    The guideline and checklist will clearly outline the appropriate steps that must be taken when assessing whether to potentially seek revocation of or override a representation agreement including:

    - Engaging the Public Guardian and Trustee;
    - Informing the legal representative of the potential revocation of the representation agreement, the legal basis for the action, and
    - the legal representative's right to seek legal advice.

    The guideline, checklist and training will be updated in response to legislation changes. Training will be provided to support the implementation of the guideline and will incorporate guidance from:

    - *The Health Care (Consent) and Facilities (Admissions) Act;*
    - *The Representation Agreement Act;*
    - *The Adult Guardianship Act; and*
    - *The Public Guardian and Trustee Act.*

    Training on the use of the guideline and checklist will be provided to all health authority social workers who are designated responders under the health authority's Abuse, Neglect or Self-Neglect of Vulnerable Adults policy. These social workers will act as a resource for all personnel who work with patients who are near or in the end-stages of life.

Headline: QUALITY OF CARE IN HOSPITAL, LACK OF COMMUNICATION WITH THE PATIENT'S FAMILY, AND POOR HOUSEKEEPING.

Recommendations:

1. Hospital management ensures hospital staff understand that it is the responsibility of the transferring unit to contact the family when a patient is moved to a different area for health care.
2. The hospital set up a formalized monitoring system for housekeeping and strengthen its agreement with cleaning contractors to ensure proper cleaning techniques are met.

Response:

1. A number of steps have been taken to ensure hospital staff understand their responsibility for contacting families. These include:
    - Reminding all nurses at the hospital of the requirement to notify family or next of kin when a transfer to a different health-care area takes place. These reminders were emailed and included in weekly updates from the clinical nurse educator.
    - Including a standing item at all staff meetings reiterating the expectation of notifying the family or next of kin prior to transfer of a family member to a different health-care area.
    - Reviewing the requirement that the family or next of kin be notified prior to transfer to a different health-care area with all new nurses during their orientation.
    - Reminding all hospital physicians in an email from the regional executive medical director that it is the responsibility of the most responsible physician or the physician initiating the move to make all reasonable efforts to advise the family or next of kin of a move. All moves to a higher level of care are to be reviewed by unit leaders to make sure family or next of kin are notified.
    - Noting any patient who required a transfer to another health-care area in the co-ordinator of site operations written summary at the end of the day. The co-ordinator of site operations is responsible for ensuring that all efforts have been made to contact the family and/or next of kin. If the co-ordinator is unable to contact the family, this information is documented in the summary to allow for further follow up. The summary is sent to nursing and site leadership daily.
2. While the health authority has a formalized monitoring system for auditing housekeeping standards and practices at the hospital, further system enhancements have been made:
    - *a.* An additional housekeeping position was created to support high-risk areas such as acute care, diagnostics and treatment, and surgical units;
    - *b.* A new full-time housekeeping supervisor was hired to support the maintenance of the cleaning outcome standards and staff training;
    - *c.* Housekeeping audit results will be reviewed with hospital site leadership on a regular basis and leadership will be invited to observe the audit process.
    - *d.* The health authority is increasing the number of ultraviolet (UV) audits conducted by the contracted housekeeping company by 50 per cent, increasing the number of UV audits conducted at the hospital to 45. UV light auditing is conducted by certified auditors and uses UV light to measure the cleaning of frequently touched areas in rooms. The responsible housekeeper for the area being audited is present at the time of the reading to reinforce the importance of consistent cleaning.

Headline: COMMUNICATION AND PAEDIATRIC CARE IN AN EMERGENCY DEPARTMENT.

Recommendations:

1. The chief of pediatrics at the hospital reviews the overall treatment of the patient and determines if the following were appropriate: treatment plan; communication and consent; charting; medications used for treatment; and discharge arrangements.

   Once the review is complete, they should provide recommendations for improvements to the hospital emergency department and advise the complainant of those recommendations.

Response:

1. As the hospital does not have a chief of pediatrics, the department head for pediatrics and a medical director of clinical operations and trauma will conduct the review.

Headline: OUTPATIENT CARE AT A MENTAL HEALTH AND SUBSTANCE USE PROGRAM.

Recommendations:

1. The health authority review their current consent policies to ensure that they reflect authorization from the patient to include a student to be involved in their care, either through a signed document or noted in the medical chart.

Response:

1. The health authority will review its current consent policies.

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

The Northern Health Board reviewed four cases in 2016/17, which resulted in six recommendations for care quality improvements and no recommendations for improving the complaints process.

Headline: ADMINISTRATION OF MEDICATION FOR PATIENTS IN THE EMERGENCY DEPARTMENT WHO ARE WAITING TO BE ADMITTED.

Recommendations:

1. The health authority review the policy that prohibits staff in the emergency department from providing medication to patients who are not in monitored beds. The review should examine:
   - ***a.*** If the present policy allows staff to exercise discretion in appropriate circumstances;
   - ***b.*** If the present policy can be amended to allow medication to be administered to patients who are not in beds but have provided informed consent; and,
   - ***c.*** to identify an alternate action plan to promptly provide the necessary monitoring to allow the administration of the medication.
2. The health authority take full advantage of the complainant's feedback as an opportunity to drive improvement by:
   - ***a.*** Offering the complainant the opportunity to attend a meeting for a patient journey mapping review. This meeting should include representatives from long term care, palliative care, the emergency department and the internal medicine unit.
   - ***b.*** Using the complainant's letter to the patient care quality office as a case study to improve care in the hospital and coordination between home and community care and the hospital.

Response:

1. The emergency department manager is reviewing current policy and unit practice to ensure staff has adequate guidance to use discretion in the administration of medications to patients in unmonitored beds.
2. Health authority management will invite the complainant to meet with them to present their case, to chart the complainant's experience, and to listen to the complainant's story of the patient's care experiences with the hospital and community services. Through this process, hospital management will offer the complainant the opportunity to be part of the system redesign that is currently underway. The Health Service administrator, the director of Access and Flow, and the director of Community Services will participate, representing the service areas suggested in the recommendation.

Headline: CONTINGENCY PLANNING TO ENSURE ACCESS TO EQUIPMENT.

Recommendations:

1. The health authority review this case and create a plan to ensure that staff in the emergency department has access to necessary equipment in the event that equipment in the emergency department is faulty or unavailable.
2. The health authority have an ophthalmologist provide staff at the hospital emergency department with an in-service education session regarding acute eye injuries and their treatment. This should include an explanation of the need for timely diagnosis and treatment of suspected closed-angle glaucoma.

Response:

1. The hospital management has reviewed the equipment involved in this complaint and will be replacing the ophthalmology equipment in the emergency department. Alternate equipment is available for use in the interim. Management is also reviewing the process for equipment repair and servicing – establishing a clear escalation process to repair critical diagnostic equipment and making sure equipment is accessible during any equipment downtime.
2. The emergency department manager is working with the medical department head of the emergency department to arrange an education rounds open to all staff and physicians on acute eye injuries and their treatment, with a focus on glaucoma.

Headline: RESIDENTIAL CARE TRANSFERS.

Recommendations:

1. The health authority ensure that when a new resident undergoes the initial assessment and the care plan process, they be informed about the facility's internal transfer policy and procedures, including the possibility the resident may be moved from their room or ward based on management's transfer criteria and discretion.

Response:

1. The residential care and assisted living facility has updated its admission documents to include information on the internal resident transfer policy and the potential, in certain circumstances, for a resident to be moved to a new room or unit. This depends on the resident's own health and safety and the needs of new residents.

   Additionally, the regional residential care team is working to standardize this information at all health authority residential care facilities, so that residents and families receive the same information when a person is admitted into residential care throughout the health authority.

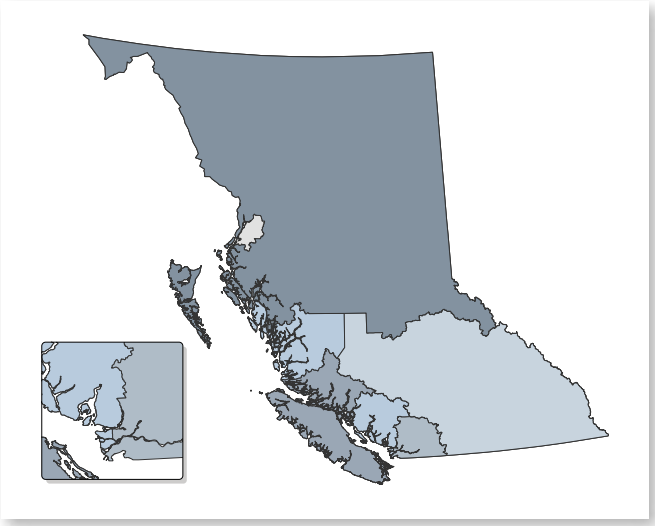
Headline: CLARIFYING ACCESS TO THE SUPPORTED INDEPENDENT LIVING PROGRAM.

Recommendations:

1. That the health authority review the Supported Independent Living Program's operational definitions and provide a transparent outline that gives clarity to clients and front end workers with regard to meeting the initial criteria prior to an assessment being performed for access to this program and all other requirements of the application process.

Response:

1. The three directors of Specialized Services met to review the approach taken to access the Supported Independent Living program across the health authority. Criteria checklists are in place to support clinicians and clients in determining whether a client is eligible to receive the subsidy. Additionally, clinicians have an outline of information that can be made available to clients regarding the eligibility criteria. Education was recently provided to mental health clinicians in one region of the health authority. This education focused on the Supported Independent Living program and how to apply the criteria when considering whether a client may benefit from the subsidy. Other regions within the health authority have committed to completing similar education.



Instead of a geographic region, the Provincial Health Services Authority is responsible for specific provincial agencies and services including: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Mental Health and Substance Use Services, BC Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, Cardiac Services BC, Perinatal Services BC, BC Emergency Health Services, BC Autism Assessment Network, BC Early Hearing Program, BC Surgical Patient Registry, Health Emergency Management BC, Indigenous Health, Lower Mainland Pathology and Laboratory Medicine, Mobile Medicine Unit, Population and Public Health, Provincial Infection Control Network of BC, Provincial Language Service, Services Francophones, Stroke Services BC, Trans Care BC and Trauma Services BC.

The board reviewed four cases during this period, resulting in four recommendations for care quality improvement and one for improving the complaints process in three of those cases. There were no recommendations in one of the cases.

Headline: BC AMBULANCE SERVICES IN RURAL AREAS.

Recommendations:

1. BC Ambulance Service review and develop improved methods of encouraging knowledge sharing between paramedics in rural areas through regular in-service meetings or education forums, and pairing senior paramedics with more junior ones where possible, to provide practical information specific to the region/geographic area and when to use services, such as an on-call physician for advice on how to provide the best course of care for the patient.

Response:

1. BC Emergency Health Services uses a peer-supported orientation model that varies depending on the setting (i.e., rural or urban). Paramedics moving to a Vancouver post often have experience from other areas of the province and are provided with orientation as part of a group intake process. Paramedics coming into a rural setting are often brand new hires and are given a one-on-one orientation by their local unit chief. As part of this, the unit chief reviews local protocols, health-care facilities and their services, radio channels, response area boundaries, etc. All paramedics are encouraged to provide peer support through information sharing and knowledge transfer; this will be reiterated as part of future orientation sessions.

All BC Emergency Health Services paramedics are required to take Emergency Physician On-Line Support training, which is an introduction to 911 and inter-facility transfer physician support. The program provides direction on when to use the services. Implementation of the Emergency Physician On-Line Support program has had considerable success. Between July 2015 and June 2016, the program received an average of more than 1,600 calls a month, signalling strong uptake and awareness.

As noted above, all BC Emergency Health Services paramedics currently receive Emergency Physician On-Line Support training and it is reinforced through regular operational team meetings, safety huddles, bulletins, leadership forums and other venues. Pending changes to the BC Emergency Health Services Destination Policy will provide an additional opportunity to reinforce this message. The Provincial Health Services Authority agrees that the opportunity to further reinforce good practice exists when paramedics are partnered together. However, because the scheduling and partnering of paramedics is determined by a collective agreement, changes to how paramedics are partnered are not possible at this time.

Headline: QUESTIONS ABOUT CARE AND TREATMENT: RADIATION THERAPY.

Recommendations:

1. An appropriate medical professional from the BC Cancer Agency review the patient's medical records, (particularly the results of the CT scan) and state directly whether there was any evidence of radiation therapy treatment on the patient's lung.
2. The health authority:
   a. Inform the complainant how the patient can obtain a copy of their charts and complete medical record;
   b. Suggest the name (or names) of an internal medicine specialist outside of the BC Cancer Agency who can answer the patient's questions and further investigate ongoing pain issues while making a plan to help manage the pain; and,
   c. Cooperate with any such outside consultant in providing information to the patient about the treatment that has been provided.

Response:

1. A thorough review was conducted by the provincial medical physics leader and was the foundation for the BC Cancer Agency's direct response to the complainant. The review confirmed there was no evidence of radiation therapy treatment on the patient's lung.
2. As recommended by the board, the BC Cancer Agency:
   a. Informed the complainant and the patient in writing how to obtain a copy of the patient's complete file and medical charts;
   b. Provided the names of an internal medicine specialist and pain specialist outside of the BC Cancer Agency to consult with and answer the patient's questions. Provided an explanation regarding the referral process and the BC Cancer Agency's commitment to assist the patient through the process; and
   c. Worked with the specialists and other medical professionals involved in the patient's care to inform the patient about the treatment that was received.

In addition to the recommendations from the board, the health authority acknowledged the BC Cancer Agency's unintentional delay in responding to the complainant, and how the apology for the delay was interpreted. To mitigate the risk of this occurring again, the BC Cancer Agency has improved their complaint handling process. The health authority is confident the new process will eliminate future delays of this nature. The BC Cancer Agency extended further apologies to the complainant and the patient for the delayed response.

Headline: BC AMBULANCES SERVICES PARAMEDIC ASSESSMENT.

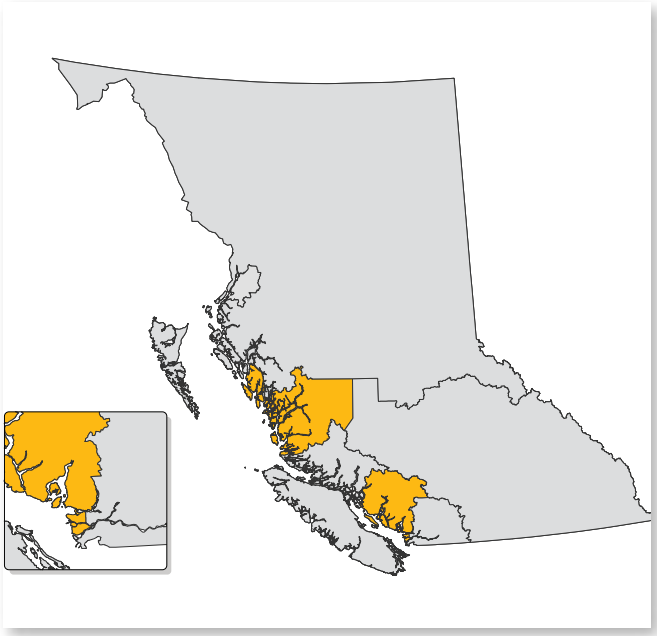
Recommendations:

1. The health authority review with emergency dispatch centres whether it would be appropriate to obtain additional information regarding an emergency scene such as a patient's weight and height as well as any obstructions at the scene such as a flight of stairs, tight corners or pathways and to consider how to manage that information and whether to call for the assistance of other first responders.
2. The health authority have BC Ambulance Service review the Guidelines and Procedures for Walking Patients, Appendix II and ensure that they are appropriate; and if deemed appropriate and not in need of revision, review them with paramedics to ensure that they are followed.

Response:

1. In 2015, BC Emergency Health Services considered the potential of obtaining additional information from 911 callers in conjunction with WorkSafeBC. They concluded that incorporating these types of additional questions into the existing Medical Priority Dispatch System could potentially introduce broader risks to patient care, and;
   a. Increase the burden on an already taxed ambulance system if multiple ambulances are simultaneously dispatched – leading to longer response time for patients.
   b. Take away from a call-taker's ability to respond quickly to the next priority call (the purpose behind the Medical Priority Dispatch System) due to the additional questions that don't affect the priority assessment of a call. Dispatch centres measure call responses in seconds.

   First responders (where programs are in place) are simultaneously alerted at the earliest point in a call based on clinical acuity. The first responder organizations determine what category of calls they will respond to.
2. The BC Emergency Health Services Treatment Guidelines are intended to provide a framework that supports critical thinking, professional judgement and assessment. The Guidelines for Ambulating Patients will be reviewed as part of a post-implementation evaluation process.



Vancouver Coastal Health is responsible for serving 25 per cent of B.C.s population – about one million people, including the residents of Vancouver, Richmond, North Shore and Coast Garibaldi, Sea-to-Sky, Sunshine Coast, Powell River, Bella Bella and Bella Coola.

The board reviewed 29 cases from Vancouver Coastal Health in 2016/17, resulting in 30 recommendations in 16 of those cases – 23 recommendations were for care quality improvement, while seven were to improve the complaints process. The board made no recommendations in 13 cases.

Headline: PLANNING AND CO-ORDINATION OF INTER-FACILITY PATIENT TRANSFERS.

Recommendations:

1. The head of the hospital emergency department:
   - ***a.*** Investigate why the Patient Transfer Network was not utilized in this case and review the investigation with the emergency department physician involved;
   - ***b.*** Review the use of the Patient Transfer Network by emergency department physicians at the hospital over the past year and determine if there were specific circumstances or factors that led to the inefficient use or under-utilization of the Patient Network System; and,
   - ***c.*** In the event that any problems are identified in using the Patient Transfer Network, that they are reported and forwarded in writing to the hospital's Chief of Medical Staff, to the Patient Transfer Network (BC Emergency Health Services) and to the Ministry of Health.

Response:

1. Health authority and hospital physicians are familiar with the benefits of the Patient Transfer Network to connect with other health-care partners in order to expedite the transfer of patients to other care settings. When quality improvement opportunities arise with the Patient Transfer Network or any other component of the health-care system, clinical and operational leaders start a review process to discuss and plan improvement(s).

Headline: COMMUNICATION AND CO-ORDINATION OF CARE BETWEEN PHYSICIANS.

Recommendations:

1. The health authority conduct the following:
   a. Arrange for a review by medical specialists in both the emergency and radiology departments from outside the hospital to advise jointly on improvements to the coordination of care between the emergency department and community physicians and the communication between the responsible physicians and the radiologists.
   b. Develop a comprehensive in-service for all staff of both departments highlighting the importance of paying attention to the families' version of the patient's history, and to specifically consider the care approach to patients noted to have multiple visits for the same complaint, and to assess the thoroughness of care provided to those who are elderly.
   c. Provide the results of the review to the complainant.

Response:

1. The regional heads of the hospital's emergency medicine unit and medical imaging department reviewed the co-ordination of care, and strategies to improve communications between emergency and community physicians. The findings and suggestions for improvement will be incorporated into the Regional Quality and Safety rounds for emergency physicians. The results will also be reviewed with the family.

Headline: CARE IN A HOSPITAL'S URGENT CARE CLINIC.

Recommendations:

1. The hospital's urgent care medical department provide an explanation to the patient and clarify why toxicology and other lab tests were not requested or performed by medical staff when the patient first presented at the urgent care unit seeking health care.

Response:

1. The health authority will, on behalf of the department of emergency medicine at the urgent care clinic, explain to the patient that toxicology and other lab tests were not requested or performed when she originally presented at the clinic because they were determined not to be necessary or helpful. The health authority considers this was an appropriate assessment as was indicated by documented clinical presentation. Also, the care plan at discharge noted that the patient was to be seen by an endocrinologist.

Headline: CARE AT A HOSPITAL EMERGENCY DEPARTMENT.

Recommendations:

1. The health authority, along with the chief of the emergency department review this case:
   a. To determine what ought to be done to provide care for patients who present with long standing health issues including persistent pain, even if it is determined that emergency hospital intervention is not necessary and that the review consider other avenues of care like urgent care clinics and referral to specialty services;
   b. To evaluate how to improve communication (e.g., in writing) with urgent care clinics and community physicians so that discharge plans and advice to patients are not left up to the patient to remember and repeat.
2. The health authority explain to the complainant the limitations on the emergency department and why the emergency department physician did not to refer her to urgent care or directly to a specialist during her visit.

Response:

1.
   a. The health authority considered the situation and maintains its approach, believing it is best practice for patients who experience chronic pain to be managed by their family physician who can then determine whether a specialist referral is warranted. A doctor (family physician or pain specialist) who has a therapeutic and ongoing relationship with a patient is in a better position to manage their care. Emergency department care is more episodic by the very nature of what emergency medicine is and can offer. The hospital emergency department and emergency doctors will continue to follow best practice. Urgent care centres and emergency departments are not primary care services, and refer patients back to their family doctors who have a patient's complete medical history.
   b. The hospital emergency department has begun dictating all emergency physician assessments to improve legibility and result in quicker turnaround to a patient's family doctor. These reports notify the family doctor that their patient has visited the department and what steps were taken during their visit. It will remain the responsibility of the family doctor (or the most responsible practitioner in the community) to co-ordinate the patient's care. Beginning in August 2015, this practice is being gradually adopted by the emergency department at the hospital. There are plans to roll this dictation system to other hospitals within the health authority within a few years, replacing existing methods of communication with primary care and other health-care partners.
2. As mentioned in 1a, the health authority considers that best practice was implemented in this case. They have sent a letter to the patient explaining this and why the emergency department or urgent care centre is not the appropriate place to manage a chronic health concern being followed by a family doctor.

Headline: RESPONDING TO AN ADVERSE EVENT DURING CARDIAC SURGERY.

Recommendations:

1. The health authority develop and institute as a requirement for revascularization/stenting procedures a checklist similar to the pre-surgical checklist whereby:
   a. The attending physician and surgical nurse, or two physicians, voice to each other that they have checked the system and no air has been detected;
   b. Record that check on an appropriate chart note; and
   c. Not proceed with the injection into the patient's heart until those steps are done.
2. The health authority ensure that all medical devices are kept for further inspection and testing whenever there is a critical incident or adverse event, including by regular reminders to medical staff that their own assessment of such devices immediately following such incidents or events is not a proper basis for discarding the device and does not align with policy.

Response:

1. Steps (such as checking for air-free system) are already routinely checked by the nursing staff and operators at the start of the surgical procedure. This pre-surgical checklist does not eliminate the risk of air embolism, which occurs in 0.1- 0.3 per cent of coronary angiography. Nevertheless, the health authority will institute the additional recommended verbalization of the pre-surgical checklist, and document this in the medical records in the catheterization laboratory prior to proceeding with coronary angiogram procedures.
2. The health authority has asked catheterization laboratory physicians and nursing staff to keep medical devices that may have caused injury/harm for expert review in cases of critical incidents. In the future, physicians and staff will aim to secure all equipment potentially contributing to incident cases. This will be highlighted as part of the communication for implementing the recently updated Incident Management policy.

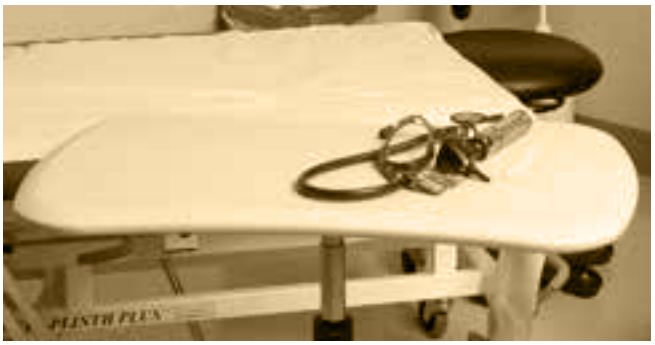
Headline: RESPONDING TO A PATIENT'S FALL AT A HOSPITAL.

Recommendations:

1. The hospital medical department provide a substantive explanation to the complainant addressing the care concerns they presented, specifically:
    - Explain what the position of the bedrails on and height of the patient's bed at the time of his fall.
    - Explain what is meant by saying that it was understood that safety precautions for this patient had to be in place and in what respect that did not happen.
    - If the bedrails were not up or the bed was in a high position, explain why that is so, given the patient's condition.
    - Investigate the statement submitted by the complainant and signed by the patient indicating that a staff member was present at the time of the fall. Determine who was in the room with the patient at the time of the fall and what their role is.
    - Explain why the first person the hospital acknowledges to have entered the room after the fall was not a nurse.
    - Explain whether the hospital falls protocol was followed and in what respects it was not, including why it took several hours to contact the family.
    - Explain why charting was not done by the nurse or nurses involved in the care of the patient immediately after the fall.
    - Clarify the recommendations and status of their implementation of the Safety Event Investigation subject to Section 51(5) c.ii of the *Evidence Act* which states results of the finding may be disclosed "in a manner that precludes the identification in any manner of the persons whose condition or treatment has been studied, evaluated or investigated."
2. The health authority review this matter, with a view to ensuring an improvement of the charting practice at the hospital.

Response:

1. The Patient Care Quality Office and operations leaders have responded to the complainant addressing these points.
2. Operations and Professional Practice leaders are developing a strategy for improving the quality of patient charting at the hospital, and will involve the College of Registered Nurses of British Columbia and other partners in the strategy.



Headline: DENIAL OF HOME CARE SERVICES.

Recommendations:

1. The health authority provide their clients with a central navigator or point of contact who fully understands the program areas to assist them in accessing the appropriate programs and services in a coordinated way by:
    - providing information about the costs involved for each service or program;
    - clarifying the criteria and eligibility requirements that govern the service or program;
    - explaining what other programs or services may be available within the community; and
    - explaining the benefits of the program regarding the caregiver and time off while the client utilizes the program.
2. The health authority request that the facility review how the well-being of the caregiver factors into their assessment for overnight respite care and, if these factors are not considered in the assessment, provide an explanation.
3. The health authority work with the client to reassess their needs and support them in accessing the respite care and other services for which they are eligible and that would support their full-time caregiver.

Response:

1. These functions are currently performed by each client's case manager and specialized staff as applicable. The health authority will be considering the development of written materials to reinforce the verbal explanation of available programs.
2. Caregiver burden is a consideration in assessments for client services, including the offer of supports such as in-home safety checks, home support and Adult Day programs. The health authority acknowledges better communication of the criteria for overnight respite would be a benefit, and has begun a review of the criteria.
3. As with any client, this client has been invited to request a reassessment considering the current situation and the established criteria for eligibility of various programs. The client has been reminded again with the update on these recommendations.

Headline: QUALITY OF CARE, POOR COMMUNICATION, LACK OF TRANSLATION SERVICES AND LACK OF CONSENT AT A HOSPITAL.

Recommendations:

1. The health authority conduct a review or survey of its nursing and medical staff at this hospital to determine whether they have been fully educated on when and how to use interpreter services, focusing on the health authority policy requirements that interpreters are used when there is a language barrier of any kind.
2. The health authority ask the hospital chief of medicine investigate whether the approach to consent in this case is an aberration or is a systemic reflection of hospital culture, and whether it is determined to be a systemic issue or not:
    a. Review hospital's consent process;
    b. Determine what solutions are going to be implemented to adhere to the consent process;
    c. Undertake what changes are necessary if this is a systemic issue; and,
    d. Report back to the hospital Chief Operating Officer.
3. The health authority have the Chief of Nursing staff, the Chief of Medical Staff and the Chief of Anaesthesia review with their respective staff the importance of continuous communication and consent, specifically:
    a. To use active listening, requesting verbal explanations from the patient, to identify if a patient understands what is being said;
    b. That before taking any step, active listening should be implemented to ensure the patient understands what is occurring, be it medication administration, catheter insertion or removal;
    c. Prior to any step, the patient's name band be checked and patient information confirmed;
    d. After any step is performed, explain the result to the patient as per the care and discharge plan requirements; and
    e. Keep the family informed and involved in care, if available.
4. The health authority consult with an external expert from an accredited British Columbia teaching hospital to review this file and provide a report to the health authority on any updates or improvements specific to:
    a. Charting
    b. Communication, including but not restricted to: admission, pre-operative documentation and discharge care plans, specific to:
        i. Nursing
        ii. Physician
        iii. Anaesthesiologists
    c. Consent processes specific to:
        i. Nursing
        ii. Physician
        iii. Anaesthesiologists
    d. Determine the medical and nursing standard of care for patient weight charting.
5. The Patient Care Quality Office issue a written apology to the complainant that acknowledges the complainant's concerns, and discusses solutions to resolve their concerns especially in regard to hospital communication, consent, care, and documentation.

6. As requested by the complainant, after the results of the above recommendations are received, so as to be able to fully inform the patient of any updates and improvements, the appropriate Patient Care Quality Office and hospital staff sit down with the:
   a. Patient
   b. Complainant or other family member or members, if available
   c. An interpreter/translator
   d. Urologist
   e. Operations Leader

   to discuss the following:
   a. The reasons for and the type used in the patient's operation;
   b. Why the patient was not provided food when the operation was delayed;
   c. Why the patient was not weighed;
   d. Advise the patient what has been learned from the consultation;
   e. Update the patient regarding communication, consent and care concerns and discuss improvements made to:
      i. Hospital medical care
      ii. Hospital nursing care
      iii. Hospital anaesthesiology care
   f. Acknowledge and discuss the points made by the complainant.

Response:

1. Interpreters are used at the hospital on a regular basis. In this situation, the health authority accepts there were shortcomings in the documentation about the patient's ability to communicate. From the review of the chart and discussion with health-care providers, the providers were confident they had effectively communicated with the patient about consent and other aspects of his care. Nevertheless, the health authority will use this case to highlight the importance of making sure patients and family members understand all the facets of their care experience.
2. The Patient Care Quality Office notes that the health authority policy concerning translation / interpreter services is restricted to consent decisions, and is confident staff are aware of the policy.

   The director of Risk Management and regional director of Client Relations and Risk Management will review the organizations' current consent policies and align them with the Ministry of Health's new directives. Efforts are underway to develop more tools to engage patients and family members, and to further the integration of patient- and family-centered care strategies.
3. Beginning in 2012, one of the health authority's strategic directions has been a care experience that reflects a person- and family-centered care approach to the planning, delivery, and evaluation of health care, which is grounded in mutually beneficial partnerships among health-care providers, the people served and their families.

   The organization's practice consultant and educators for this strategic direction are working with staff across the organization to ensure that patients, residents and family will experience culturally safe, socially just, person- and family-centered care.
4. The care provided to this patient and his family members was reviewed by the operations leader with the ward staff, as well as by others in the organization. The health authority has identified the areas for improvement and noted those in response to previous recommendations. They will incorporate these lessons into existing strategies.
5. A letter of apology was sent.
6. The family was invited to meet with hospital personnel.

Headline: POOR MEDICAL CHARTING.

Recommendations:

1. The health authority ensure all hospital staff are provided with a reminder of the importance of appropriate and timely charting.

Response:

1. The health authority understands and empathizes with the patient's experience and reiterated their apology. The operations and professional practice leaders are developing a strategy to improve the quality of patient charting at the site, and will involve the College of Registered Nurses of B.C. and other partners in the strategy. The health authority is also working with primary health care and other health authorities on the implementation of a new clinical information system that will bring consistent clinical documentation across these organizations

Headline: PATIENTS TAKING THEIR OWN VITAL SIGNS AT A CLINIC.

Recommendations:

1. The health authority have the hospital's Medical Oversight Committee and Medical Records Committee review the practice of patients tracking and monitoring their own vital signs from both the point of view of patient safety and the integrity and validity of their medical record. The board concluded that if no formal protocol exists, one should be developed to document the process.

Response:

1. The process of patient-taken vitals at the clinic was reviewed with the perspective of safety, professional practice, documentation and patient involvement. The clinic determined that engaging patients in their own care in this way is reasonable and supported by the literature. The clinic is confident that measures are already in place to validate the patient-taken vitals from a safety perspective, as well as to support patients not well enough to participate or otherwise challenged by the practice despite the assistance of staff and the written guidance and other supports.

Headline: MENTAL HEALTH CARE PROVIDED IN AN EMERGENCY DEPARTMENT.

Recommendations:

1. The health authority directly discuss with the Head of Psychiatry the Patient Care Quality Office complaint process and the importance of responding to requests for investigation in a timely manner.

Response:

1. The health authority spoke with the head of psychiatry about their expectation that all health authority staff welcome, promptly investigate, and sensitively address all concerns or complaints. The Patient Care Quality Office has the support of the health authority board in engaging their colleagues in responding in a timely manner to investigation requests.

Headline: FAILURE TO FOLLOW SAFETY STANDARDS AND PROTOCOLS DURING A CARDIAC STRESS TEST PROCEDURE.

Recommendations:

1. The health authority and hospital review this matter:
   - ***a.*** to ensure that it has in place a falls prevention policy applicable to ambulatory care facilities and that all hospital staff are trained on the fall policy and understand how to initiate procedural protocols in urgent situations;
   - ***b.*** to ensure people who fall are cared for appropriately including follow-up recommendations;
   - ***c.*** to ensure all incidents are reported and documented appropriately; and,
   - ***d.*** have legal counsel consider the implications of the *Occupiers Liability Act* regarding matters such as this where injuries are sustained on hospital premises and incorporate revisions to training and protocols that meet applicable standards of care.
2. The health authority provide the complainant an additional response which will include the following:
   - ***a.*** the results of the review recommended above; and,
   - ***b.*** an apology regarding the matter.

Response:

1. ***a. b.*** As part of an ongoing quality improvement process, the falls prevention policy is currently under review. Lessons learned from this complaint will be integrated into this process and an understanding of the updated policy will be part of ongoing staff orientation and education.

   c. Vancouver Coastal Health expects incidents to be documented and managed according to the Incident Management policy, as was the case with this event.

   d. The health authority informed the board they are aware of its legal obligations. Complainants have the option to present a claim for consideration. The Patient Care Quality Office can and does advise complainants how to make a claim.
2. ***a. b.*** The health authority advised the complainant of the policy review process and have once again apologized for the deviations from protocol.

Headline: COMMUNICATION WHEN MULTIPLE PHYSICIANS ARE INVOLVED IN A PATIENT'S CARE.

Recommendations:

1. The health authority have the hospital Oncology unit review how this case was handled, including the multiple assignments of a "Most Responsible Physician" and how that impacted communication with the patient and the family; and, identify how communications with the patient and family members, specifically regarding informed consent and timely identification of decisions regarding care, could be improved.
2. The health authority re-evaluate the term "most responsible physician" to ensure it is being used in an effective and practical manner; examine the way in which information is communicated between one physician to another; how and when changes in a designation are made; whether an administrative protocol (for review by the department head) should be developed for situations where more than two most responsible physicians are designated for a patient within a defined limited period of time; and that the role of the most responsible physician and their availability is made clear to patients and family members at the outset of a patient's admission and continuing thereafter.

Response:

1. The health authority advised the board that the hospital does not have an oncology unit; teams providing care to patients with a cancer diagnosis on any of the units work in partnership with colleagues from the BC Cancer Agency. Clinical leadership will work with colleagues at the BC Cancer Agency to consider strategies to improve communication between patients and families, the co-ordination of care, and build on lessons learned from this case.
2. The health authority agreed that physicians in the role of the most responsible physician have specific and significant responsibilities in assessing, planning, and co-ordinating care using effective communication with patients and families. The health authority is considering the development of a policy or guidance document to clarify the role and responsibilities of the most responsible physician as a critical partner in patient- and family-centred care.

Headline: SAFETY IN A RESIDENTIAL CARE FACILITY.

Recommendations:

1. An apology letter be sent to the complainant which would:
   - ***a.*** Thank the complainant for bringing the safety concern to the attention of facility staff and the Patient Care Quality Office.
   - ***b.*** Acknowledge the complainant's original safety concern was proper.
   - ***c.*** Acknowledge that staff did not follow policy regarding reporting and proper handling of faulty equipment.
2. Staff be given a refresher on the Workplace Wellness and Safety policy and include:
   - ***a.*** Training on the proper execution of the policy; and,
   - ***b.*** Empowering staff to take prompt and appropriate action when they find or receive reports of faulty equipment.

Response:

1. ***a. b.*** The vice-president and general counsel sent an apology to the complainant expressing their gratitude on behalf of the health authority for his efforts to resolve this issue.

   c. While the Patient Care Quality Office acknowledged the complainant's concerns in their letter to him, they respectfully disagreed that staff did not follow policy regarding the reporting and proper handling of equipment. The documents referenced by the board relate to the management of equipment and were created after this event – they are guides, not policy.
2. ***a. b.*** The documents identified by the board as policy were guidance documents created after this case. The guidelines have been fully implemented at the residential facility and will be introduced to the health authority's other residential sites.

Headline: ENSURING CONTINUITY OF SERVICE AND COMMUNICATING WITH CLIENTS ABOUT CHANGES IN CAREGIVERS OR SERVICE PROVIDERS.

Recommendations:

1. The health authority develop and implement a plan that will allow ongoing services to exist between the client and her previous health authority contracted tele-health counsellor.
2. The health authority provide:
   - ***a.*** A rationale to the complainant for any significant changes made at the caregiver level;
   - ***b.*** In future, the reason for changes in caregivers or services to all impacted clients; and,
   - ***c.*** In future, include a review of the impact of contractual changes involving changes in caregivers or services on a client population and where clinically appropriate, allow for the grandfathering of caregiver relationships and services to client populations.

Response:

1. The health authority strives to be sensitive to the needs of each and every client, while being responsible stewards of health-care resources. The health authority is confident that the services available through the transition program are suitable for the client, and no unique circumstance warrant continued reliance on a private sector provider.
2. Considerable patient-centred effort and attention was given to clients affected by the change in service. Nevertheless, the rationale for the change was not well profiled in the process during this particular transition.

   a. The health authority provided the affected clients with a detailed explanation of the rationale for the changes.

   b. and ***c.*** A reminder was sent to program leaders of the importance of transition communication, and to include patient-centred consideration of client impacts and transition planning – not only the "what" and "how does this affect me" but also the "why" and "why now" concerning the change. The Patient Care Quality Office sent a quality learning summary to leaders of all health authority regional programs for their consideration in future change management.

Headline: MENTAL HEALTH SERVICES.

Recommendations:

1. The health authority, through the complainant's mental health team, continue to support the complainant in finding satisfactory work through the WorkBC program, and that the mental health team explain the Board's decision, so that the complainant understands the Board's review and recommendation.

Response:

1. Following the Board's recommendation, the complainant was discharged from the mental health program, and as a result the health authority no longer supports the complainant in his interactions with the WorkBC program. The health authority noted that they remain open to receiving the complainant back into the program if in the future he meets the criteria for participation.

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 in 2016/17. It also compares the number of times the top five subjects of concern are logged within the province and each health authority for 2012/13, 2013/14, 2014/2015, 2015/2016 and 2016/17.[2]

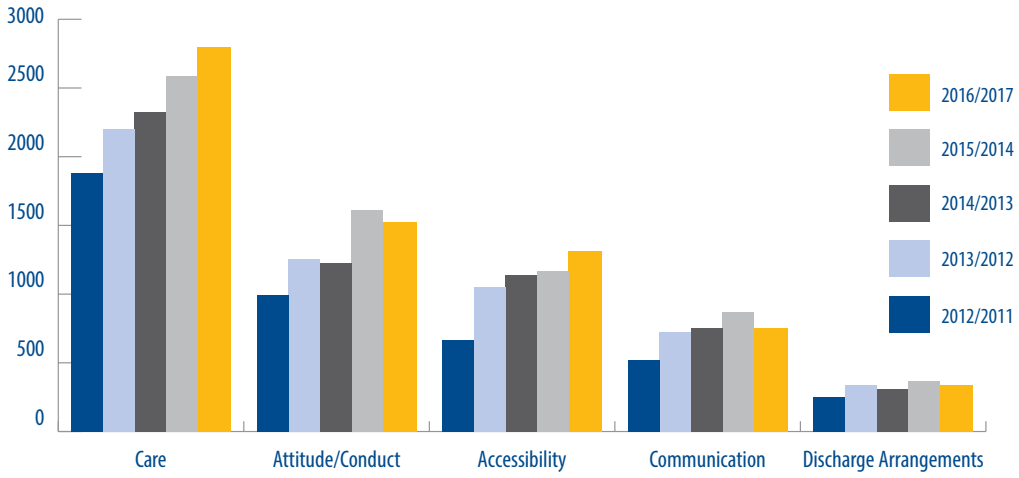
British Columbia

TABLE 3: *Patient Care Quality Office Volume, B.C., 2016/17*

B.C.	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	81	69	66	83	299
Care Quality Complaints	1,925	1,816	1,638	2,056	7435
Inquiries	297	333	316	382	1328
TOTAL VOLUME	**2,303**	**2,218**	**2,020**	**2,521**	**9,062**

By definition, most care quality concerns relate to care (e.g., deficiencies in care, misdiagnosis or medication-related concerns). In B.C., Patient Care Quality Offices logged care as a subject of concern 2,783 times. Attitude and conduct followed with 1,536 times logged. Accessibility (e.g., wait times for surgery or test results, availability of services) was the third most frequently logged subject at 1,311. Communication was fourth at 760, followed by discharge arrangements at 353.

CHART 4: *Patient Care Quality Office Top 5 Subjects of Concern, B.C., 2016/17*



2 The Patient Care Quality Offices categorize and log patient complaints using a common reporting framework. The reporting framework first categorizes complaints by health sector, including acute care, ambulatory care, emergency care, home and community care, mental health and addictions, residential care, and public health, among others. The complaints are further categorized by as many subjects of concern that apply and it is common for each complaint to have multiple subjects. For the purpose of this report, only the top five subjects of concern have been included for the province and each health authority illustrating the key subjects of concerns patients bring forward.

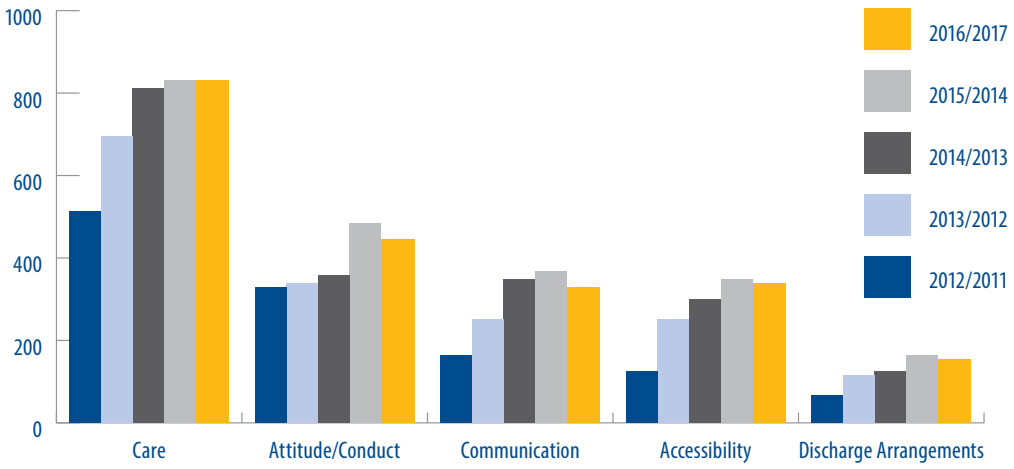
Fraser Health

TABLE 4: *Table 4: Patient Care Quality Office Volume, Fraser Health, 2016/17*

FRASER HEALTH	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	37	32	29	36	134
Care Quality Complaints	472	404	429	537	1842
Inquiries	57	90	63	108	318
TOTAL VOLUME	**566**	**526**	**521**	**681**	**2294**

The most frequently reported concerns brought forward to Fraser Health in 2016/2017 were about care with this subject category being logged 837 times, followed by attitude and conduct at 441, accessibility at 337, communication at 325, and discharge arrangements at 148.

CHART 5: *Patient Care Quality Office Top Five Subjects of Concern, Fraser Health, 2016/17*



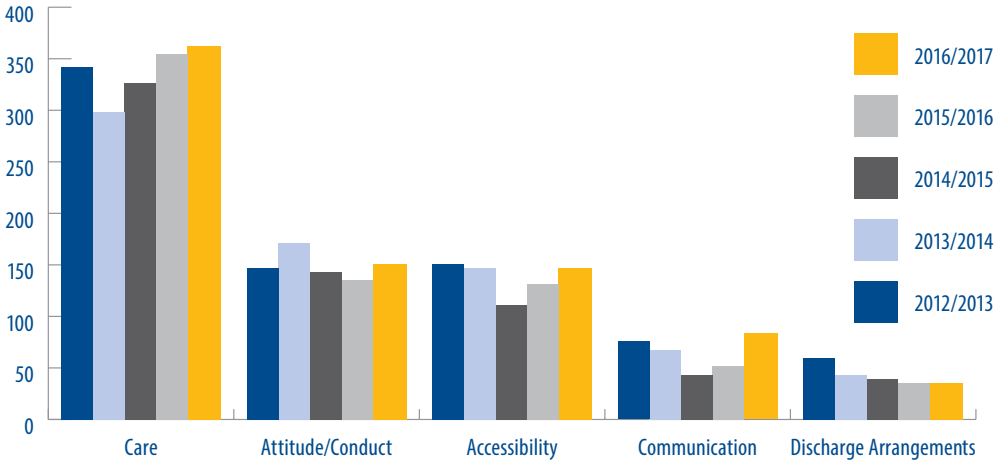
Interior Health

TABLE 5: *Patient Care Quality Office Volume, Interior Health, 2016/17*

INTERIOR HEALTH	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	3	5	3	2	13
Care Quality Complaints	284	276	259	344	1163
Inquiries	16	29	30	27	102
TOTAL VOLUME	**303**	**310**	**292**	**373**	**1278**

The most frequently reported concerns brought forward to Interior Health in 2016/2017 were about care with this subject category being logged 364 times, followed by attitude and conduct at 153, accessibility at 150, communication at 85, and discharge arrangements at 37.

CHART 6: *Patient Care Quality Office Top Five Subjects of Concern, Interior Health, 2016/17*



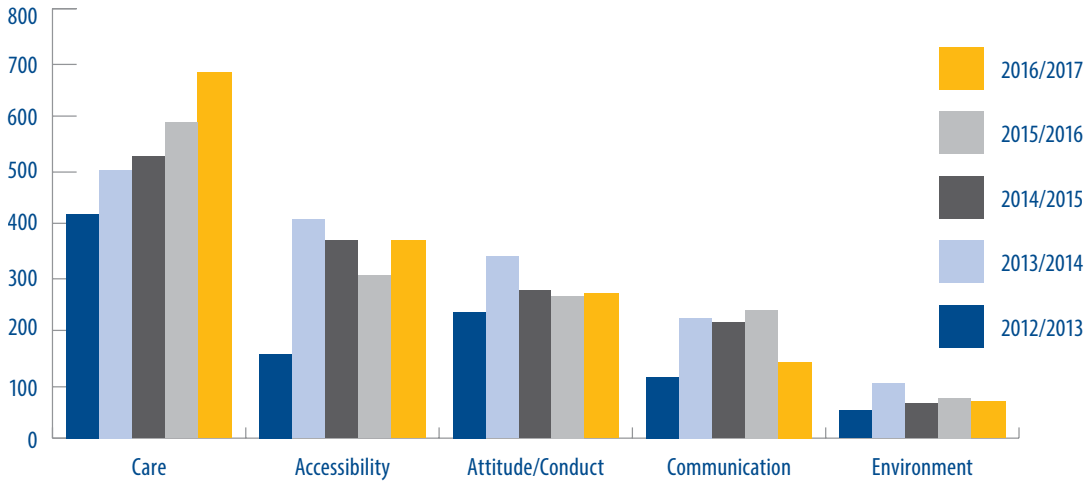
Island Health

TABLE 6: *Patient Care Quality Office Volume, Island Health, 2016/17*

ISLAND HEALTH	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	11	8	15	16	50
Care Quality Complaints	433	438	390	505	1766
Inquiries	71	70	59	54	254
TOTAL VOLUME	**515**	**516**	**464**	**575**	**2070**

The most frequently reported concerns brought forward to Island Health in 2016/2017 were about care with this subject category being logged 681 times, followed by accessibility at 368, attitude and conduct at 269, communication at 142, and discharge arrangements at 68.

CHART 7: *Patient Care Quality Office Top Five Subjects of Concern, Island Health, 2016/17*



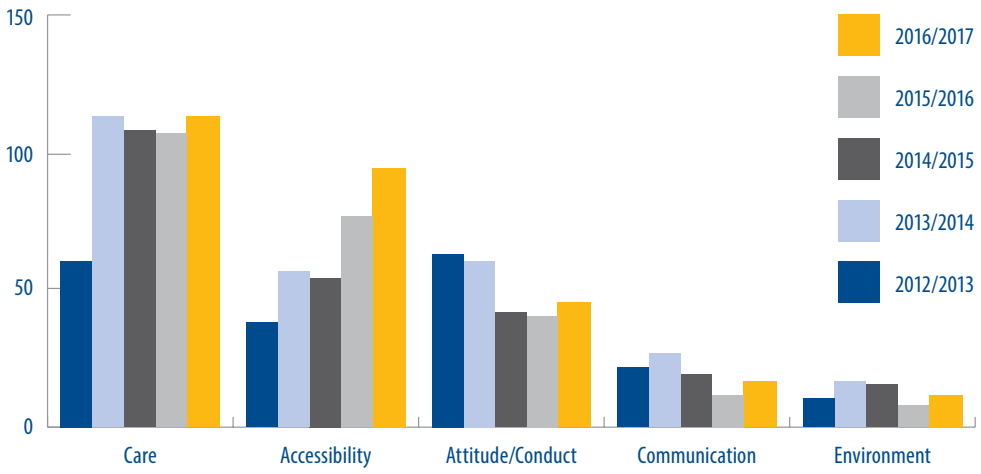
Northern Health

TABLE 7: *Patient Care Quality Office Volume, Northern Health, 2016/17*

NORTHERN HEALTH	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	12	3	7	6	28
Care Quality Complaints	84	110	82	85	361
Inquiries	16	19	32	34	101
TOTAL VOLUME	**112**	**132**	**121**	**125**	**490**

The most frequently reported concerns brought forward to Northern Health in 2016/2017 were about care with this subject category being logged 114 times, followed by accessibility at 94, attitude and conduct at 46, communication at 17, and environment at 12. (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 of Concern, Northern Health, 2016/17*



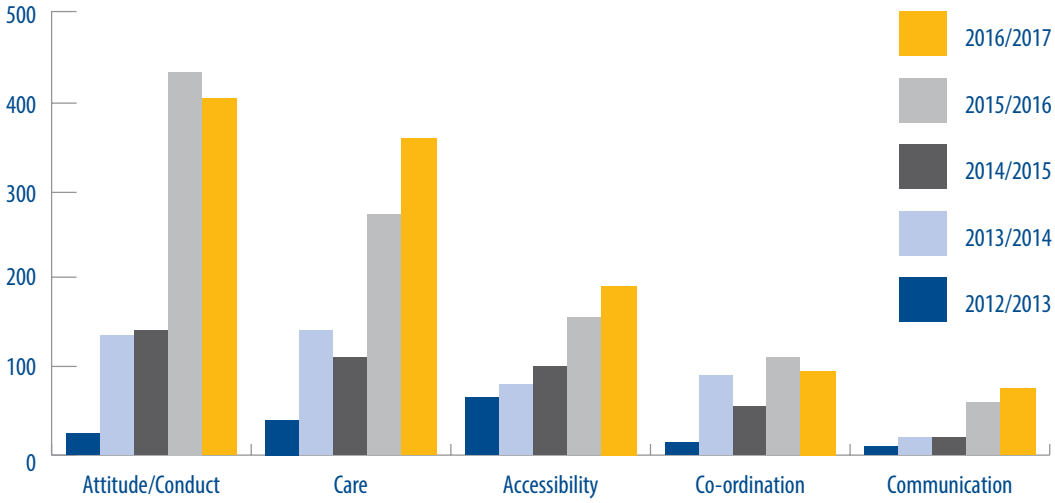
Provincial Health Services Authority

TABLE 8: *Patient Care Quality Office Volume, Provincial Health Services Authority, 2016/17*

PHSA	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	16	9	3	16	44
Care Quality Complaints	195	213	145	217	770
Inquiries	80	63	72	89	304
TOTAL VOLUME	**291**	**285**	**220**	**322**	**1118**

The most frequently reported concerns brought forward to the Provincial Health Services Authority in 2016/2017 were about attitude and conduct with this subject category being logged 405 times, followed by care at 360, accessibility at 191, co-ordination at 95, and communication at 77.

CHART 9: *Patient Care Quality Office Top Five Subjects of Concern, Provincial Health Services Authority, 2016/17*



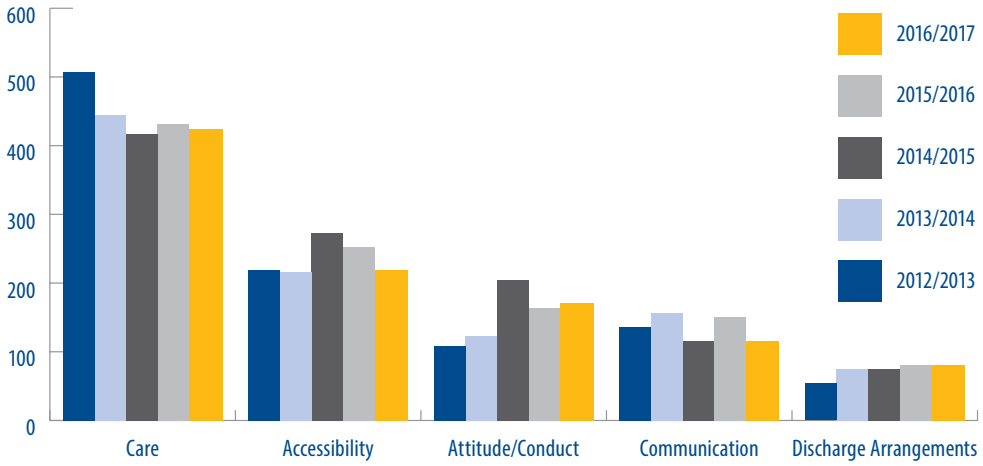
Vancouver Coastal Health

TABLE 9: *Patient Care Quality Office Volume, Vancouver Coastal Health, 2016/17*

Vancouver Coastal Health	APR-JUNE 2016	JULY-SEPT 2016	OCT-DEC 2016	JAN-MAR 2017	TOTAL
External Complaints	2	12	9	7	30
Care Quality Complaints	457	375	333	368	1533
Inquiries	57	62	60	70	249
TOTAL VOLUME	**516**	**449**	**402**	**445**	**1812**

The most frequently reported concerns brought forward to Vancouver Coastal Health in 2016/2017 were about care with this subject category being logged 427times, followed by attitude and conduct at 222, accessibility at 171, communication at 114, and discharge arrangements at 84.

CHART 10: *Patient Care Quality Office Top Five Subjects of Concern, Vancouver Coastal Health, 2016/17*



Appendix B | *Financial Information*

(Source: Corporate Accounting Services Financial Reports)

EXPENDITURES	ACTUAL $ 2016/17
Board Members	
Board Member meeting fees and expenses	$148,123.05
TOTAL	**$148,123.05**
Board Support	
Board Support Personnel	$1,080,333.78
Board Support Travel	$24,949.51
Legal Expenses and Professional Services	$7,931.70
Office Business and Info Systems	$29,899.97
TOTAL	**$1,143,114.96**
TOTAL EXPENDITURES	**$1,291,238.01**

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 1 800 663-6105.

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:

Vancouver Coastal Health

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

Interior Health

505 Doyle Ave, Kelowna, BC V1Y 0C5
Phone: 1-877-442-2001 (toll-free)
Fax: 250-870-4670
Email: *patient.concerns@interiorhealth.ca*
Website: *www.interiorhealth.ca*

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*

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 BC Ambulance Service, 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 Society, BC Women's Hospital & Health Centre, and Cardiac Services BC.)

Suite 202, 601 West Broadway Street,
Vancouver BC V4Z 4C2
Phone: 1 888 875-3256 (toll-free)
Fax: 604 829-2631
Email: *pcqo@phsa.ca*
Website: *www.phsa.ca*


MAIN ENTRANCE

BRITISH COLUMBIA

Patient Care Quality Review Boards