BRITISH COLUMBIA

Patient Care Quality Review Boards

Annual Report 2017/2018

Table of Contents

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, 2017 to March 31, 2018. This report has been prepared in accordance with sections 15(1) and 16(1) of the *Patient Care Quality Review Board Act*.

For ten years, the Patient Care Quality Review Boards have provided British Columbians with the confidential means to access a fair and independent review process to voice concerns about their experiences within our health-care system. The Patient Care Quality Review Boards work to resolve patient complaints and bring opportunities for care quality improvement to the attention of the health authorities and the Ministry of Health. In order to best serve the public, 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.

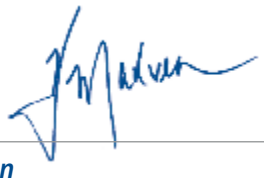
The chairs of the six Patient Care Quality Review Boards would like to take this opportunity to acknowledge the hard work and dedication of staff in the Patient Care Quality Offices and the Review Boards Secretariat. Their expertise and commitment have been critical to the success of this program over the last decade. We would also like to thank the patients, clients, residents and their loved ones who have brought forward their experiences. Their stories have driven change in our health-care system, and initiated improvements that have helped our health authorities deliver more effective, efficient and safer patient-centred care.

Finally, we wish to recognize the contributions of Dr. Craig Beattie, who passed away in August of 2017. Dr. Beattie served on both the Fraser and Vancouver Island Patient Care Quality Review Boards during his time with us, and he quickly became an invaluable member for his professional knowledge and commitment to care quality improvement. He has left behind an admirable legacy of work, and he continues to be missed.

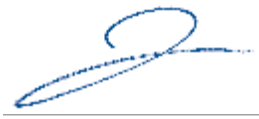
Respectfully submitted,

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

Lorraine Grant
Chair, Northern Patient Care Quality Review Board

Patient Care Quality Office

Introduction

The Patient Care Quality Review Boards were established by the *Patient Care Quality Review Board Act* in 2008 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. However, the boards stand independent from the health authorities and are accountable directly to the Minister of Health.

The health-care system in B.C. is complex and deals with hundreds of thousands of interventions each year. In addition to providing patient care, the people involved in this system engage in an ongoing process of reflection, learning and change in an effort to improve their services and products. The Patient Care Quality Offices and the Patient Care Quality Review Boards play a crucial role in this improvement process by reviewing and addressing the concerns raised by those who use the health-care system.

In the event a person has a complaint about the quality of a health-care service received under the purview of a health authority (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 their concerns are not resolved, they can make a formal complaint to the health authority's Patient Care Quality Office. Should they remain dissatisfied with how their complaint was handled, they can then bring their complaint to the Patient Care Quality Review Boards for review.

In order to facilitate an effective review of a complaint, the Patient Care Quality Review Boards Secretariat aims to provide the board members with a comprehensive understanding of a patient's experiences. This may include but is not limited to: an overview of the complaint and the complainant's concerns, medical records, applicable guidelines and policies, and documentation of the investigation and response by the Patient Care Quality Office. This allows the relevant 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 recommendations are intended to both resolve individual concerns and improve health-care processes, policies and services for all involved. The boards view each complaint as an opportunity to improve the quality of 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 the resulting recommendations have improved our health-care system for the benefit of all British Columbians.

Executive Summary

Since the program's inception in 2008, the Patient Care Quality Review Boards have completed 733 reviews, and made 832 recommendations to the health authorities and 19 recommendations to the Minister of Health. The boards may make multiple recommendations in one case.

In 2017/18, the boards accepted 125 review requests. The boards completed 80 reviews and made 54 recommendations to the health authorities in 36 of those cases. The boards did not make recommendations in 44 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 collect data about the types and number of enquiries they receive. In total, the boards received 609 enquiries in 2017/18, 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.

The health authorities' Patient Care Quality Offices also collect data on the number and types of enquiries they receive and report it quarterly to the boards. This year, the offices received 7,878 complaints concerning care quality, which represents approximately a six per cent increase from the 7,435 received last year. Of the 7,878 complaints received by the health authorities in 2017/18, 125 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

About the Patient Care Quality Review Boards

"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

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 of Health 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 can request a review by submitting a review request form by mail, email, web form 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.

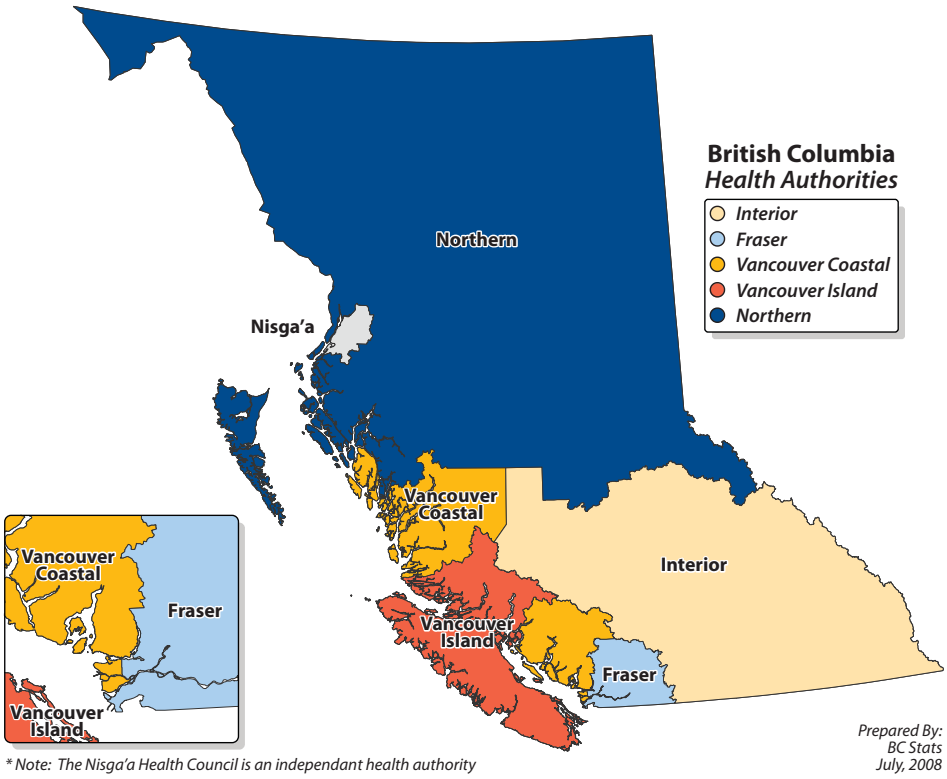
Once the review is complete, the board will send the complainant and the health authority a decision letter indicating whether any recommendations have been made. The board will explain its findings and the reasoning for decisions in the letter. A copy of the letter will also be sent to the Minister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

If a recommendation is made, the health authority is required to respond to the board and the complainant about what actions will be taken to address them.

2017/2018 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. Randall Fairey (Interior Health), William Norton (Northern Health), Allison Read (Northern Health), Dr. Amrik Tung (Vancouver Coastal Health), and Dr. Naznin Virji-Babul (Vancouver Coastal Health).



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

> *"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*

Fraser Patient Care Quality Review Board

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

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

Interior Patient Care Quality Review Board

Thomas Humphries, chair
Pauline Blais
Donna Horning
Roy Kahle
Steven Puhallo
Dr. Robert Ross

Northern Patient Care Quality Review Board

Lorraine Grant, chair
Dr. David Bowering
Elizabeth MacRitchie

Vancouver Island Patient Care Quality Review Board

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

The Patient Care Quality Review Board –

"Improving public confidence in the quality of the health-care system should be a goal of government each and every day. Through this new legislation, we'll be able to examine concerns, address them at the local level where they occurred, and also take those lessons and apply them across the province where necessary."

– **GEORGE ABBOTT, APRIL 30, 2008**

"We need to come together — patients, health-care workers, nurses, doctors. People across British Columbia believe in public health care. They want our system to be more accountable."

– **ADRIAN DIX, APRIL 30, 2008**

"Our boards provide an independent avenue for patients, clients, residents and their loved ones to share concerns about the quality of their care. Each complaint represents an opportunity to understand health-care issues from the unique perspective of patients, and every review is an opportunity to build a more positive patient experience. The Patient Care Quality Review process allows all those people who experience our health-care system to spark quality improvement, supporting a more accessible, transparent, patient-centred health-care system."

– **DR. JACK CHRITCHLEY,** *Board Chair for the Fraser, Vancouver Coastal and Provincial Health Services Patient Care Quality Review Boards, 2011*

"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, 2017*

"Thank you for getting to the truth." – **COMPLAINANT, 2015**

A Ten-Year Retrospective

On April 30, 2008, the government of British Columbia introduced the *Patient Care Quality Review Board Act* with the aim of establishing a clear, consistent, timely and transparent provincewide process for members of the public to bring forward their concerns about the quality of their health care. Met with support throughout the Legislative Assembly of B.C., the act came into force on Oct. 15, 2008.

Prior to 2008, each health authority in B.C. had developed their own unique client relations protocols, with differing degrees of robustness. The complaints process was not always clear to patients and their families, and the outcome was not always communicated back to the complainants. In addition, there was no straightforward mechanism for patients and families to escalate their complaints beyond the health authority level. Complaints were not tracked or reported on a provincial basis, and there was no provincially co-ordinated means for identifying opportunities for quality improvement and sharing the lessons learned across the health authorities.

In addition to requiring each health authority to create a central Patient Care Quality Office to receive and respond to patient complaints, the act established six independent Patient Care Quality Review Boards to review complaints that were not resolved at the health authority level. The boards were designed to be independent from the health authority and accountable to the Minister of Health, with members appointed from the public by ministerial order. Under the act, the boards were given the freedom and responsibility to make recommendations to the health authorities and the Ministry of Health to improve both the quality of patient care in the province and the quality of the complaints process itself.

Since 2008, the boards have completed a total of 733 reviews that have resulted in 832 recommendations — 869 to the health authorities and 19 to the Ministry of Health. Each of these reviews represent a unique patient story, and the recommendations have initiated change in the way health care is delivered, and the way health-care professionals communicate with patients and their families in hospitals and home and community care setting across the province.

Over the last ten years, those involved with the Patient Care Quality Review Board program have seen meaningful improvements and prompted productive conversations throughout the health-care system. In addition to the direct effect of case-specific recommendations, the boards' reviews have facilitated the sharing of improvement opportunities between health authorities, helped provide health-care professionals with the clear standards needed to care confidently for their patients, and – most importantly – positioned patients and their families at the centre of health care where they belong.

Moving forward, the members of the boards and their secretariat welcome the opportunity to continue their work in the changing world of B.C.'s growing population and expanding health-care system.

Statistical Overview
Patient Care Quality Offices

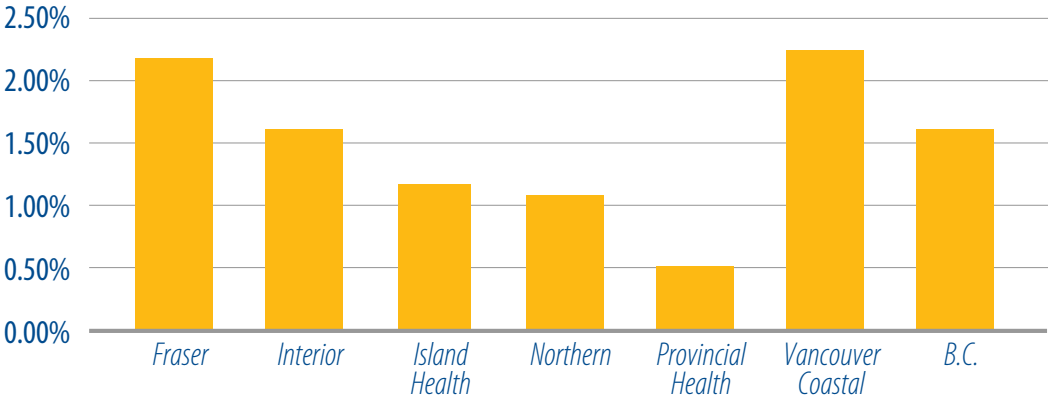
The boards collect data from the Patient Care Quality Offices regarding the number and type of complaints they receive for each quarter throughout the fiscal year. In 2017/18, there were 7,878 care quality complaints brought forward, which constituted an increase of 443 – or approximately six per cent – from the 7,435 complaints received in 2017/18. This included 326 external complaints[1] and 1289 inquiries (see Appendix A for details). The table below presents the volume of care quality complaints received by each office between April 1, 2017 and March 31, 2018.

TABLE 1: *Volume of Care Quality Complaints by Health Authority and B.C. 2017/18*

HEALTH AUTHORITY	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total 2017/18
Fraser Health	473	495	482	597	2047
Interior Health	327	302	322	415	1366
Island Health	499	425	495	575	1994
Northern Health	69	65	72	86	292
Provincial Health Services Authority	169	177	291	297	934
Vancouver Coastal Health	330	311	258	346	1245
BRITISH COLUMBIA	**1867**	**1775**	**1920**	**2316**	**7878**

The boards accepted 125 reviews or approximately 1.59 per cent of the total 7,878 care quality complaints. Chart 1 shows the percentage of care quality complaints that escalated to the boards from each office over the 2017/18 period. This is subject to fluctuations year-over-year and is not an indicator of individual office performance.

CHART 1: *Percentage of Care Quality Complaints that became Patient Care Quality Review Board Accepted Reviews in 2017/18*



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

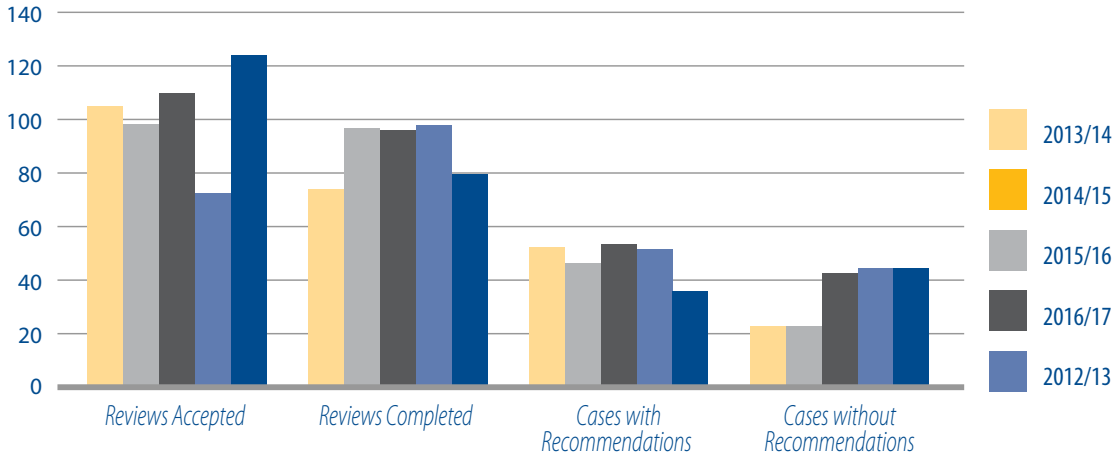
In 2017/18, the boards saw a 71 per cent increase in accepted review requests: 125 compared to 73 last year. The boards completed 80 reviews, down from 98 last year. The table below presents an overview of the boards' volumes.

The boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself in 36 of the completed reviews (45%). In 44 of the completed reviews (55%), the boards did not make recommendations, having concluded that either the quality of care provided was appropriate or that the circumstances of the complaint did not present an opportunity for care quality improvement. The boards made a total of 54 recommendations to the health authorities in 2017/18.

TABLE 2: *Overview of Patient Care Quality Review Board Volume 2017/18*

HEALTH AUTHORITY	Reviews Accepted	Reviews Completed	Cases with Recommendation(s)	Cases without Recommendation(s)
Fraser Health	44	23	8	15
Interior Health	33	14	9	5
Island Health	23	18	6	12
Northern Health	3	1	1	0
Provincial Health Services Authority	5	5	1	4
Vancouver Coastal Health	28	19	11	8
TOTAL	**125**	**80**	**36**	**44**

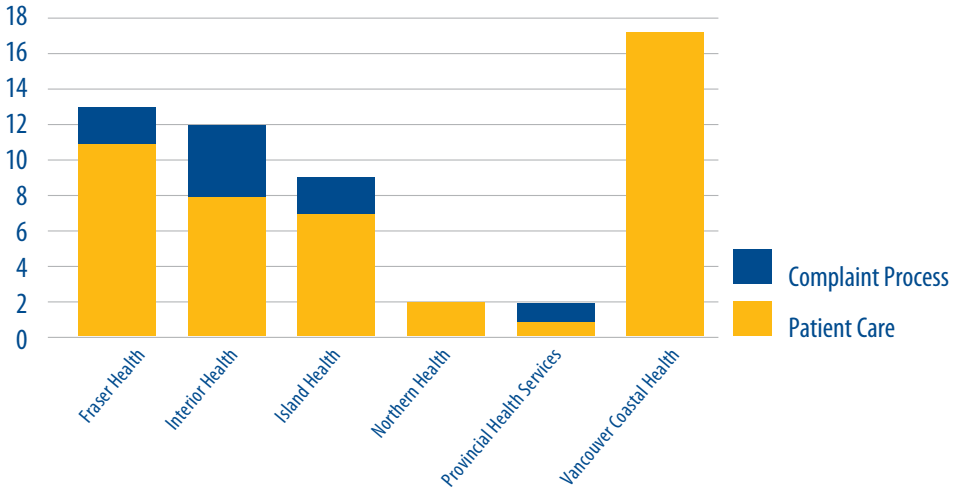
CHART 2: *Volume Comparison for Recommendations and Reviews*



Statistical Overview
Patient Care Quality Review Boards

Of the 54 recommendations to health authorities, 46 were to improve the quality of patient care and eight were to improve the complaints process (see Chart 3).

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 28 of the 36 reviews that resulted in recommendations (78%).

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 2017/18, the average time to complete a review and respond to the complainant was 148 business days. The median time was 141 days. On average, the board took just over eight 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 2017/18. 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 – cancer	Communication	1
Acute care – cardiac	Care	5
Acute care – mental health	Accessibility	1
	Administrative fairness	2
	Attitude and conduct	1
	Care	6
	Challenging patient or family	1
	Discharge arrangements	1
Acute care – renal	Accessibility	1
	Care	1
Acute care – other	Accessibility	1
	Accommodation	1
	Administrative fairness	1
	Attitude and conduct	1
	Care	43
	Communication	4
	Coordination	1
	Discharge arrangements	1
	Environmental	1
	Over capacity for demand	1

Sector	Subject	#
Administration	Accessibility	3
	Administrative fairness	2
	Attitude and conduct	2
	Financial	1
Ambulance – critical care transfer	Care	1
	Coordination	1
Ambulatory care – other	Accessibility	1
	Care	7
Emergency	Accessibility	1
	Attitude and conduct	1
	Care	17
Home and community care	Accessibility	2
	Administrative fairness	3
	Attitude and conduct	1
	Care	17
	Communication	1
	Environmental	1
	Residents' Bill of Rights	2
	Safety	1
Mental health – community, substance use and housing	Accommodation	1
	Attitude and conduct	1
	Care	1
TOTAL		**143**

Recommendations and Responses

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

When making their recommendations, the boards consider:

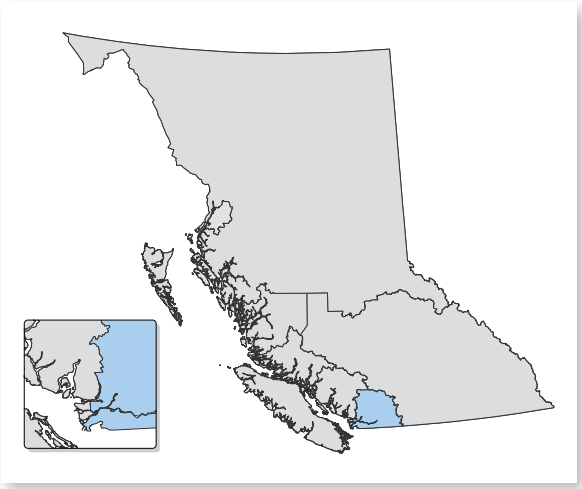
- The context of the complaint from both the health authority and the patient's perspective;
- The policies, procedures and guidelines that are applicable to the complaint;
- The evidence base for the recommendation;
- The potential impact of the recommendation; and
- The feasibility of implementing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

The health authorities consider each recommendation and are required to respond to both the board and the complainant to indicate what actions will be taken to address them.

In 2017/18, the boards made 54 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.

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.

Fraser Health
Recommendations and Responses



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 2017/18, resulting in 13 recommendations across eight cases. Of the 13 recommendations, 11 were to improve care quality and two were to improve the complaints process.

COMMUNICATION WITH SUBSTITUTE DECISION MAKERS

Recommendation

That Fraser Health develop clear policy and training for clinical staff to keep temporary substitute health decision makers informed of any changes in a patient's health condition, particularly in the case of significant change.

Response

The manager of Clinical Operations for the emergency department involved in this case verbally reminded staff to inform family members of changes in a patient's status, and reinforced the importance of communication with families to the patient care co-ordinators who are available 24/7 on the unit. Fraser Health committed to sending out a memo to all department staff on this subject and developing a learning summary in partnership with leads from Clinical Quality and Patient Safety, Professional Practice and the Emergency Network to be shared throughout the Fraser Health Emergency Network.

Recommendation

That Fraser Health remind clinical staff there are legislated timelines for responding to requests for information.

Response

Information about the Patient Care Quality Offices' legislated timelines was shared with staff through an article posted in the Fraser Health Management Centre, and by the Patient Care Quality Office with clinical staff from their primary sites and programs. The director and executive director responsible for the Patient Care Quality Office shared the information on the Fraser Health directors and executive directors email lists, and the executive medical director of Quality and Safety shared the information with Fraser Health medical directors, department heads and physicians through their relevant email lists.

Recommendation

That Fraser Health have a specialist review this case in order to answer the complainant's questions about the quality of care their loved one received.

Response

The regional medical director of Hospitalist Services requested a specialist review of this patient's case, with a response letter sent to the complainant upon completion.

EMERGENCY DEPARTMENT DISCHARGE

Recommendation

That Fraser Health undertake an independent review and determine whether the discharge in this case was appropriate, specifically with regard to the patient's cardiac history and the diagnostics, hematology and chemistry results that indicated possible cardiac rhythm instability during the emergency department visit.

Response

The regional medical director for Emergency Medicine and the vice-president of Medicine at the site involved in this case asked a department head of Emergency Medicine to conduct an independent review of the patient's care. The review found that the patient had received thorough monitoring and appropriate physician and nursing assessments, and that the patient's discharge from the emergency department was a reasonable decision by the treating physician based on test results and non-specific symptoms. The review also stated that it was not advisable to alter the referral patterns of patients with a cardiac history presenting to an emergency department based on the outcome of this case. Emergency physicians will continue to work alongside their cardiology colleagues to identify patients at higher risk of poor cardiac outcomes. However, even with the most appropriate investigation and treatment, not all adverse outcomes can be avoided, regardless of whether patients are managed on an inpatient or outpatient basis.

RESIDENTIAL CARE ASSESSMENT AND CHARTING

Recommendation

That Fraser Health ensure nurses and care staff at residential care homes undertake additional training in recognizing health changes and the proper techniques in charting a resident's care and history, and ensure there is an audit trail of all training.

Response

Fraser Health did not feel there was enough evidence to support the recommendation of additional training for nurses and care staff in recognizing health changes and proper techniques in charting a resident's care and history. They found that current practices of charting and assessment met the standard. As an alternative action, Fraser Health appointed a quality assurance co-ordinator from the Residential Contracts & Services care team to conduct a review of the practices at the residential care home involved in this case to determine if this complaint was an isolated incident or part of a systemic issue. The findings and details of any required action to be undertaken by the residential care home will be forwarded to the review board.

VITAL SIGN RESPONSE, CLINICAL DOCUMENTATION AND PATIENT SAFETY CHECKS

Recommendation

That Fraser Health remind nursing staff at the hospital involved in this case of the importance of taking appropriate action when vital signs recorded on the Vital Signs Trend and Trigger Record – Adult form fall outside of normally expected ranges.

Response

The director of Clinical Operations collaborated with a clinical nurse specialist to improve the Vital Signs Trend and Trigger Record to more clearly define the areas that trigger action when vital signs are not within range. Clinical nurse educators will also hold training sessions on the importance of taking action when vital signs fall outside of expected ranges.

Recommendation

That Fraser Health conduct a review of clinical documentation practices at the hospital where the complaint occurred, and take any action necessary to ensure that clinical documentation is meeting appropriate standards as outlined in the nursing Acute Care Standards.

Response

Clinical nurse educators performed an audit of documentation practices to establish a baseline before conducting education sessions reminding staff of the Documentation Clinical Policy. Following the sessions, follow-up audits will be conducted to measure improvement.

Recommendation

That Fraser Health conduct a review of current practices regarding patient safety checks at the hospital involved in this case. This review should include the following:

1. Are safety checks being performed often enough?
2. Are safety checks thorough enough?
3. Are safety checks being appropriately documented?
4. Are senior staff monitoring to ensure that checks are being performed thoroughly and often enough, and being completely documented?

Response

The 24-Hour Patient Care Record for Surgical Services was updated and implemented, including an assessment of safety equipment, falls risk, specific precautions and focused hourly rounds. Staff are responsible for recording twice per shift. Clinical nurse educators will oversee an education refresh on safety checks, documentation and the changes in the 24-Hour Patient Care Record, followed by an audit of documentation practices.

FAMILY AND PRACTITIONER COMMUNICATION

Recommendation

That Fraser Health ensure patients and their families are clearly advised that all communication and inquiries should be directed to the patient's most responsible physician or social worker, and that the most responsible physician or social worker liaise with all the other health practitioners who are treating the patient to provide continuity of care and navigation through the health-care system.

Response

Fraser Health will continue to increase awareness about the key contact for patients and families if they have questions or concerns through:

1. A compliments or concerns information sheet, available to each unit, advising patients and families how they can share compliments or raise questions or concerns;
2. Names and contact information of the patient care co-ordinator(s) and manager displayed at the entrance of the unit; and
3. Revision of the patient care co-ordinator's job description to clearly include statements regarding their role as point person for patients and families to connect with when they have questions about their care, and their responsibility to co-ordinate with the most appropriate party to ensure those questions are answered.

REPRESENTATION AGREEMENTS

Recommendation

That Fraser Health organize an educational seminar for all Patient Care Quality Office staff regarding representation agreements.

Response

Patient Care Quality Office staff committed to participating in an education seminar regarding representation agreements as well as information related to advance care planning options, consent and temporary substitute decision makers.

MEDICATION RECONCILIATION POLICIES AND PROTOCOLS

Recommendation

That Fraser Health review and reassess their current medication reconciliation policies and protocols to ensure:

1. Patient medications are appropriately reconciled within 48 hours of being received into care;
2. A member of the interdisciplinary care team is designated to take leadership and accountability for accuracy of the medication reconciliation process, including the resolution of discrepancies; and
3. Family members and caregivers have the opportunity to review and comment on the medication reconciliation for accuracy upon admission.

Response

Fraser Health committed to updating Medication Reconciliation at Transitions of Care and adding it to the MedRec policy by October 2018.

1. According to the Clinical Practice Guideline, admission MedRec is the responsibility of the most responsible physician upon admission. At the residential care home involved in this case, the admitting registered nurse took the initial responsibility for initiating MedRec and is responsible for following up with the physician. The residential care home nurses continue to promote and provide ongoing education about the importance of MedRec.

   Actions for Improvement at the residential care home:

   a. Medication reconciliation has been added as a standing agenda item for the quarterly meeting with all residential physicians.
   b. To provide additional support for MedRec, a process is in development to have the pharmacist review each resident after admission to ensure medications are complete. It is anticipated this process will be fully implemented by October 2018.
   c. The residential care co-ordinator will conduct random chart audits of new residents to monitor if a MedRec is being completed within 24 hours of transitions, with a plan to review 4-5 charts a month from May to October 2018.
   d. Under "Residential Care" in Medication Reconciliation at Transitions in Care, it is noted "the multi-disciplinary team will verify and document the Best Possible Medication History in consultation with the resident and/or caregiver." This is further supported in Appendix A, which notes one of the Top 10 Tips for obtaining this history is to "verify information by using two sources" (e.g., patient and/or family/caregiver, and Pharmanet). At the residential care facility involved in this case, the expectation has been set within the department that the admitting registered nurse goes over all medications with the resident (if able) and their family upon admission. Education around this expectation is now part of the clinical nurse educator's orientation for new nurses.

FALLS PREVENTION

Recommendation

That Fraser Health review its approach to falls prevention and develop and/or more fully implement a procedure for a personalized safety plan for patients with both cognitive and physical risk factors for falls. This should include a mechanism to ensure that personalized safety plans are prominently displayed and routinely reviewed by the entire care team.

Response

Fraser Health committed to raising awareness about falls and injury reduction as well as dementia care among health care aides through the following steps:

1. Health care aides will be asked to complete the Falls and Injury Reduction online module. The goals of this module are to review the principles of universal fall precautions, engage in risk reduction skills through the application of these principles, provide staff with the knowledge to identify a person's individualized fall and injury risk factors, and identify additional risk reduction interventions to promote safe and client-centred care.
2. The clinical nurse educator supporting the care and discharge planning will provide education to patient care co-ordinators to reinforce the importance of discussing and documenting personalized safety plans (including cognition and mobility status) during daily care and discharge planning rounds, as well as ensuring the plans are communicated to health care aides.
3. The clinical nurse educator for Patient Safety will conduct random chart audits of patients identified with cognitive impairment to monitor if personalized safety plans are being documented and communicated. Two to three charts from each of the Fraser Health medical units will be reviewed.

Recommendation

That Fraser Health conduct a thorough review of the care received by the patient in this complaint and provide the complainant with a detailed explanation of the events that led to the patient's fall. The review should include transparent information regarding which elements of the patient's care met or fell short of existing falls prevention policies, as well as information on any opportunities identified to improve existing policies as a result of the review.

Response

A detailed review was conducted of the events, which determined that the health care aide assigned to the patient escorted the patient to the bathroom. The health care aide was called by the registered nurse to assist in the next room and left the patient alone with instructions to call when finished. The patient, due to level of cognition, was unable to follow the instructions to call for help and subsequently fell. When reviewed in the context of the Falls and Injury Reduction Practice Guideline and the nursing care standards for medical units, the following areas were noted to need improvement: mobility status and cognition is to be assessed every shift; the handover record, as noted above, is to include information about mobility status and cognition; and a post fall risk assessment form is to be fully completed.

The following is a list of falls prevention strategies that have been reinforced in the unit:

1. Falls and injury reduction begins on admission to the unit.
2. Intentional hourly rounding is to occur on all patients.
3. Patients most at risk are to be located close to the care station.
4. Patients with a history of falls and/or mobility impairment will have the following in place starting on admission:
5. 48/6 and behaviour care plan established and revised daily;
6. Bed alarm turned on;
7. Hip protectors applied;
8. Non-skid footwear or non-skid socks applied;
9. Consistent documentation in Nursing Notes, handover record and care plan; and
10. White Board updated per shift.
11. Injury prevention strategies are to be communicated during morning huddle.
12. If a fall should occur, staff are to complete:
13. A Post Fall Assessment (followed, completed and documented, with the patient care co-ordinator, in-charge registered nurse and most responsible physician informed); and
14. A Post Fall Huddle (this is a good time to debrief what happened and update the patient's care plan).

Interior Health
Recommendations and Responses

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 approximately 740,000.

The Interior board completed 14 case reviews in 2017/18, resulting in 12 recommendations across nine cases. Of the 12 recommendations, eight were to improve care quality and four were to improve the complaints process.

MATURE MINOR CONSENT FOR IMMUNIZATION

Recommendation

That Interior Health ensure immunization medical records reflect that mature minor consent has been addressed and clearly indicates on what basis the decision to provide or not provide treatment was made.

Response

Interior Health has assured the board that it complies with the "Informed Consent for Immunization" section of the BC Centre for Disease Control Manual, Section 1B. When mature minor consent has been taken (in the appropriate circumstances), a drop-down field in the public health record Panorama allows the immunizer to document "mature minor" as the person consenting and include any discussion in the comments field.

Public health nurses use the seven-step decision support tool to guide the consent process for immunization. This is found in the manual referenced above, and the usual practices for minor consent for immunization are outlined in Health Link BC's document, "The Infants Act, Mature Consent and Immunization."

VALUABLES AND PERSONAL EFFECTS

Recommendation

That Interior Health ensure all hospital staff are familiar with – and follow policy regarding – client valuables and personal effects, and that the appropriate forms are completed by hospital staff and signed off by the patient on both admission and discharge.

Response

Interior Health has assured the board that the safekeeping of valuables and personal effects is important to the organization. Improvements to the processes involved in the safekeeping of client valuables and personal effects have occurred at the hospital where the complaint took place, and there has been a downward trend in the numbers of complaints received by the Patient Care Quality Office concerning patient valuables.

Recommendation

That Interior Health update its policy to require that a staff member be designated to ensure the safekeeping of an incapacitated patient's belongings and that all appropriate forms are completed.

Response

Interior Health had recently updated their Client Valuables and Personal Effects Policy at the time of this recommendation. They had previously committed to providing education to clinical management staff, with emphasis placed on the appropriate documentation of patient valuables and personal effects, and clarity around the processes when a patient may be incapacitated for a variety of reasons. The Patient Care Quality Office affirmed an offer of $500 compensation to the client in this case.

PROFESSIONALISM AND CONFIDENTIALITY

Recommendation

That Interior Health ensure in-service learning sessions about professionalism at work be held regularly (i.e., every six months) at the hospital involved in this case. These sessions should be focused on communication and confidentiality. The in-service ses–sion should review the following health authority policies:

1. AR0400 – Privacy and Management of Confidential Information
2. AR0450 – Managing Privacy and Security Breaches/Violations
3. AU0100 – Standards of Conduct for Interior Health Employees

Response

Interior Health requires mandatory annual training in the areas of Information Privacy and Security. This training consists of an iLearn module that staff complete independently. Interior Health committed to sending out policy AU0100 – Standards of Conduct for Interior Health Employees to all staff at the site involved in this case.

Recommendation

That Interior Health require the registration supervisor responsible for the site of the complaint to provide a letter to the complainant apologizing for the inappropriate sharing of the complainant's confidential information.

Response

The registration supervisor in question was no longer in this position at the time of the recommendation and response. The regional manager for Registration Services committed to providing a letter to the complainant as suggested by the board.

DOCUMENTATION OF ADVERSE EVENTS

Recommendation

That Interior Health ensure the Disclosure of Adverse Events Policy is reviewed with all hospital staff, with emphasis on required documentation.

Response

The events involving the care of the patient who is the subject of this complaint indicate that the patient did not suffer an adverse event requiring disclosure under the Disclosure of Adverse Event Policy. It was not required per Interior Health policy to document a disclosure conversation in this case as there had been no adverse event identified as intended in the policy.

DISCHARGE OF VULNERABLE PATIENTS

Recommendation

That Interior Health require the chief of staff of the hospital involved in this case to write a letter of apology to the complainant and complainant's family outlining the steps the hospital has taken to ensure that the error of discharging vulnerable and elderly patients does not occur again.

Response

Interior Health committed to writing to the complainant as recommended by the board. The letter was co-authored by the health services administrator and chief of staff for the hospital.

CATHETERIZATION TRAINING

Recommendation

That Interior Health confirm management at the hospital involved in this case is providing in-service training on catheterization procedures to all registered nurses.

Response

Catheterization is an entry-level skill for registered nurses. Interior Health and the hospital involved in this case do not routinely provide training on catheterization procedures to all registered nurses. In circumstances where a knowledge gap may be identified due to infrequency of practice of catheterization, education and training will be provided on an as-needed basis.

Recommendation

That Interior Health ensure the hospital manager offer to hold a face-to-face meeting with the complainant to discuss any concerns, and confirm that the importance of proper catheter insertion protocols have been reviewed and discussed with the nurse involved.

Response

The health service director and manager of the hospital's Emergency Department agreed to offer a face-to-face meeting to provide the complainant with an opportunity to share experiences directly with the Emergency Department's management team.

POST-SURGICAL CARE (PATIENT DECEASED)

Recommendation

That Interior Health provide to the family:

1. The recommendations stemming from the quality assurance review;
2. An explanation of how the recommendations will impact the day-to-day operation at the hospital where the event occurred; and
3. The implementation status of the recommendations.

Response

Interior Health has written to the complainant with an update on actions taken at the hospital, impact on day-to-day operations, and implementation status since the events involved in this case.

SAME-GENDER CARE FOR RESIDENT'S PERSONAL HYGIENE

Recommendation

That Interior Health develop a policy for the provision of same-gender care for a resident's personal hygiene and related matters that is consistent with a resident's right to protection and promotion of their health, safety and dignity. The policy should be consistent with the "bona fide occupational requirement" principles set out in the common law and the BC Human Rights Code.

Response

A standardized process and procedure has been developed by Home Health for "Do Not Send Requests" and communicated to staff. As well, Interior Health will develop a communication strategy for patients and families.

EMERGENCY DEPARTMENT TREATMENT OF BRAIN ANEURYSM

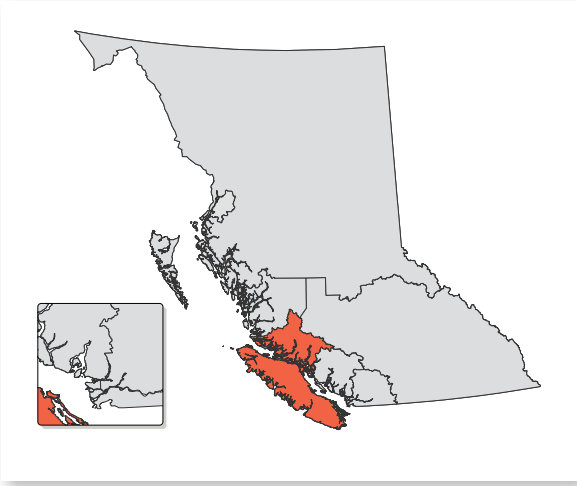
Recommendation

That Interior Health conduct a review under section 51 of the Evidence Act to determine whether an appropriate assessment of the patient's presenting symptoms was completed, and whether the care provided reflected best practices and patient-centred care. Any recommendations stemming from the Section 51 review should be shared with the complainant in a timely manner.

Response

Interior Health committed to engaging a physician and nurse reviewer external to the hospital involved in this case to conduct a quality review under Section 51 of the Evidence Act, and to inform the complainant of any actions that were undertaken following the review.

Island Health
Recommendations and Responses



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

The Island board completed 18 cases in 2017/18, resulting in nine recommendations across six cases. Of the nine recommendations, seven were to improve care quality and two were to improve the complaints process.

DEMENTIA CARE UNIT SECURITY AND VISITOR ACCESS

Recommendation

That Island Health amend and implement their existing policy and procedures related to security and visitor access, particularly ensuring a second level of security is observed in dementia units across all residential care facilities under its jurisdiction.

Response

Island Health Residential Services committed to a two-step process:

1. Communicating to staff the importance of being vigilant, and their responsibility for the security and safety of residents; and
2. Developing and implementing a program-wide guideline regarding safety and security specific to unwanted or unknown visitors.

EMERGENCY DEPARTMENT WAIT TIMES AND ASSAULT ALLEGATIONS

Recommendation

That Island Health develop and promote a policy or protocol to ensure that patients in emergency departments are seen by physicians and assessed by nurses within appropriate timelines based on patients' triage acuity and Canadian Triage Acuity Scale Guidelines.

Response

Island Health acknowledged that the patient in this case did not receive a standard of care that would be reasonably expected during their emergency department visit or subsequent stay. Health authority staff expressed regrets for the distress and pain the patient experienced, and committed to drawing from this experience in order to do better in the future.

With respect to this recommendation, Island Health respectfully submitted that the Canadian Triage Acuity Scale (CTAS) Guidelines are a protocol. They stated that every effort is made to ensure that Emergency Department patients throughout the health authority are seen within the recommended timelines, but acknowledged that the wait the patient in this case endured without assessment was well outside the CTAS Guidelines. Island Health suggested that creating a policy or protocol requiring that the CTAS Guidelines must be met in each case may not be feasible, given that as the board noted, "the timelines for treatment in the CTAS Guidelines are recommended targets that cannot always be met precisely." As well, once a patient has been triaged and arrives at a care area, their actual medical needs may be higher or lower than the initial CTAS assignment suggested at triage.

Island Health prides itself on being a learning organization and asked that, with the patient's permission, the Patient Care Quality Review Board allow Island Health to use this case as a teaching tool to improve care for patients, and to act as a reminder that the CTAS Guidelines are in place to ensure patient safety and quality care.

Recommendation

That Island Health develop a comprehensive policy detailing the actions to be taken when a complaint is received that a staff member has assaulted a patient. This policy should include (but not be limited to) the following:

1. Timelines for actions;
2. Who is responsible for investigating an alleged incident and taking actions to ensure patient safety;
3. What actions should be taken to investigate an alleged incident and ensure patient safety; and
4. In what circumstances outside agencies (e.g., regulatory colleges or police) should be notified.

Response

Island Health committed to developing a decision support tool that outlines immediate follow-up actions to be taken to initiate an investigation following any allegations of staff misconduct, which will include the items noted above.

PATIENT ALLERGIES

Recommendation

That Island Health develop and implement a system to electronically flag patient allergies and require staff to check for a medical alert bracelet or necklace when a patient arrives in the emergency department to ensure that there are no medication errors.

Response

The Island Health Electronic Medical Record currently has patient allergies flagged, and this information is to be reviewed at every admission. The health authority committed to reminding staff in writing and at staff meetings of the importance of reviewing the medical record for allergies, and of checking for allergy bracelets or necklaces to confirm patient allergies. They also committed to requesting that the next upgrade to the electronic medical record include a feature to prompt staff to check for an allergy bracelet or necklace to confirm patient allergies.

PATIENT FEEDBACK AND INPATIENT CARE PLANS

Recommendation

That Island Health develop exit survey forms for all patients admitted for inpatient care at the hospital involved in this case to gather feedback on the quality of care, and staff communication with patients and their families. Hard copies of the forms should be given to patients on discharge and online copies sent where possible. The results of the survey should be shared with leadership at the hospital and steps should be taken to address any issues identified.

Response

Island Health committed to developing an exit survey form or survey process for contacting patients admitted for inpatient care at all of their hospitals. In the interim, they committed to continuing to participate in patient surveying led by the Ministry of Health through the Acute Inpatient Survey, which consists of Patient Reported Experience Measures and Patient Reported Outcome Measures surveys. These surveys are provided to a random sample of patients who have received care as inpatients within all Island Health facilities. Results are provided to the health authority on a quarterly basis, to be used by local areas and units for quality improvement. Leadership at the hospital involved in this case are using the most recent results of the survey to help guide the work of their Quality Councils. In addition, the site undertook a one-day point-in-time survey to further support meaningful improvement.

Recommendation

That Island Health ensure there is an up-to-date care plan for each inpatient at the hospital involved in this case, that these care plans are clearly posted in patients' rooms and recorded in patients' charts, and that all staff are reminded of the importance of creating and following care plans.

Response

Patient communication boards have been installed in all rooms at the hospital, and audits of patient care plans and communication boards will occur regularly. Unit-based onboarding and training was held on the use of the communication boards in the patients' room to display care plans, and to reiterate the requirement to generate and maintain appropriate patient-centred care plans.

Recommendation

That Island Health ensures their Patient Care Quality Office's approval process is sufficiently streamlined so that responses to complaints are made within legislated timelines.

Response

Patient Care Quality Office leadership has developed a new process to increase the timely identification of potential delays or barriers to meeting legislative timelines. The team has also reviewed legislative expectations around timelines to ensure all team members are familiar with these expectations. Opportunities for continuous improvement will be identified.

RECORDING HOME AND COMMUNITY CARE STAFF

Recommendation

That Island Health review their policy asking Home and Community Care clients if they possess home surveillance and/or recording devices, and determine whether this question is justified for staff safety.

Response

Island Health reviewed the board's recommendations. After careful consideration, they concluded that the presence of devices used for surveillance do not present a staff safety issue. They recognize the potential relevance in identifying recording equipment in the context of the Freedom of Information and Protection of Privacy Act, staff privacy and work environments, and committed to consulting with internal stakeholders and external counterparts across the province to review.

COMMUNICATION WITH FAMILIES AND CAREGIVERS OF LONG-TERM CARE CLIENTS

Recommendation

That Island Health use this complaint as a learning tool to illustrate the need for clear and frequent communication with caregivers and family to ensure co-ordination and consistency of patient care.

Response

Island Health committed to bringing this case forward to the appropriate Quality Council for review. To ensure improved co-ordination and consistency of patient care, the director of the area proposes the Quality Council supports the following recommendations:

1. Families and caregivers of long-term care patients be offered a monthly interdisciplinary conference;
2. Families and caregivers of long-term care patients with greater acuity and complexity have scheduled weekly check-ins with staff; and
3. An information sheet be prepared for families and caregivers outlining how to connect with the care team.

The health authority also committed to implementing any other suggestions for improving communication supported by the Quality Council as quickly as possible.

Northern Health
Recommendations and Responses

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 board completed one case review in 2017/18, resulting in two recommendations for care quality improvements.

COMMUNICATION FOLLOWING INCORRECT REPROCESSING OF MEDICAL DEVICES

Recommendation

That Northern Health develop a policy for dealing with medical errors such as the one in this case, and that policy should include:

1. A public communication plan for informing the person(s) affected when an error occurs, explaining the error, the risks involved, actions they should take, and the mitigating steps that have been put in place;
2. The appointment of a clinical expert to respond to patient's questions either directly and/or in a town hall type meeting; and
3. Ensuring patients have a family doctor or specialist to follow up with regarding any concerns they may have about their individual health-care needs.

Response

Northern Health has an existing policy in this regard, but committed to reviewing the policy to ensure the processes recommended by the board are clearly outlined.

Recommendation

That Northern Health review and adhere to the guidelines of the Ministry of Health Best Practice Guidelines for Cleaning, Disinfection and Sterilization in Health Authorities – December 2011.

Response

Northern Health is committed to adhering to the best practice guidelines as recommended by the board. They noted that the equipment that was reprocessed incorrectly in this case was used by a private physician who was responsible for their own reprocessing. The regional co-ordinator of Medical Device Reprocessing will include private physician offices in future audits to ensure correct reprocessing of all devices being used in the health authority.

Provincial Health Services
Recommendations and Responses

Instead of a geographic region, the Provincial Health Services Authority is responsible for specific provincial agencies and services including: BC Cancer, 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, Trauma Services BC, and Correctional Health Services.

The Provincial board reviewed five cases in 2017/18, resulting in one recommendation for care quality improvement.

FOLLOW-UP MEETING TO EMERGENCY DEPARTMENT TRIAGE CONCERN

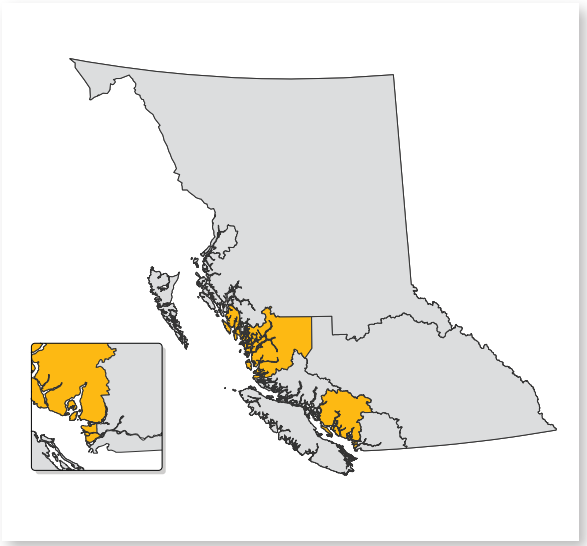
Recommendation

That Provincial Health Services Authority confirm that a meeting took place between the program manager and triage nurse involved in this case and, if so, set out any further information deemed appropriate concerning the outcome of that meeting in writing to the complainant. If a meeting did not take place, the health authority needs to follow through on what was indicated in the response by the program manager to the patient care quality officer, and ensure a meeting between the program manager and the triage nurse takes place. The health authority needs to share with the complainant any appropriate information arising from that meeting.

Response

The Patient Care Quality Office followed up with the program manager for Emergency and Trauma Services on Feb. 26, 2018 to confirm that a meeting with the triage nurse did take place shortly after the complaint was received in June 2017. The triage nurse took the opportunity to learn from the complainant's feedback and received additional coaching and mentorship from the program manager. The Patient Care Quality Office responded to the complainant by email on March 16, 2018.

Vancouver Coastal Health
Recommendations and Responses



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 Vancouver Coastal board completed 19 case reviews in 2017/18, resulting in 17 recommendations to improve care quality across 11 cases.

ADDENDA TO PATIENT MEDICAL CHARTS

Recommendation

That Vancouver Coastal Health ensure addenda making substantive corrections to a patient's medical chart are reflected in a prominent manner that is readily accessible, such as in a face sheet or summary document.

Response

Vancouver Coastal Health agrees that addenda, especially in cases where substantive corrections are made, should be reflected in a sufficiently prominent manner so as to be readily accessible by others and to ensure no confusion occurs. The health authority has explored alternatives and believe that the action taken in this case — involving integrating the information into existing and familiar practices for communicating updates – was in fact the most effective approach to ensuring profile for the update and preferred to attempting to develop and implement a non-standard process. This confirmation of practice within Health Information Management has been communicated across the Lower Mainland to ensure consistency in practice.

COMMUNICATION REGARDING IMAGING DEPARTMENT SERVICES

Recommendation

That Vancouver Coastal Health develop a process to communicate with patients and referring physicians when a service through the imaging department involved in this case cannot be provided within the guidelines' stated timeline.

Response

Vancouver Coastal Health shared this patient's concern regarding wait times for these services and recognized that patients are waiting beyond the Canadian Association of Radiologists' recommended guidelines for many MRI and CT appointments across the region. Lower Mainland Medical Imaging has made significant efforts over the past year to ensure appointments are booked in a timely manner once the imaging requisition is received. Additional temporary clerical resources have been added at the hospital involved in this case to improve the turnaround between the time the requisition is received, and the time the appointment is booked and communicated to the patient and physician.

Lower Mainland Medical Imaging is committed to ensuring patients and referring providers are provided timely information on their imaging appointments, and that they have an opportunity to contact the imaging department and make alternative care plans should they feel the wait is unacceptable. The new standard for advising patients of their appointment time is three business days from the time the requisition is received in the imaging department. Strategies have been put in place to achieve this target, including an operational review and waitlist reduction strategy.

Recommendation

That Vancouver Coastal Health consider engaging an independent consultant to review the hospital's current imaging department communication system (including the phone tree) to develop a more user-friendly, informative and reliable patient-centered system.

Response

Lower Mainland Medical Imaging updated the messaging on the hospital's image department phone tree to ensure all callers can speak to an imaging clerk regarding their CT request or appointment. In addition, they committed to conducting an internal review of the hospital imaging department's communication system, and updating the phone tree navigation for all modalities, as appropriate, to make it a user-friendly, informative and reliable patient-centred system.

CO-ORDINATION OF MENTAL HEALTH CARE

Recommendation

That Vancouver Coastal Health have its president refer this matter to a committee composed of at least one of the health authority's senior operations officers, and the appropriate chiefs of medicine or other managerial officers from the hospitals involved in this case to:

1. Review the circumstances of this case and the availability of care for patients who are not certified under the Mental Health Act but whose mental health condition makes it unlikely they meet existing criteria for acute care, palliative care, residential care or mental health care facilities;
2. Determine the appropriate care setting for such patients and, if none exist, determine how to direct the flexible application of such requirements so they meet the patient's care needs; and
3. Report back to the health authority president on how to ensure that safe and appropriate care can be made available to patients and made known to placement co-ordinators throughout the health authority.

Response

Vancouver Coastal shared the board and the complainant's concern about the need to strike a balance between respecting the autonomy of patients considered capable to manage their own safety, and making the appropriate application of services and supports available in law to protect vulnerable persons from harm. They appreciated that there were further lessons to learn from this patient's experience.

The health authority reviewed the recommendation. While the outcome of that review would be shared with the president/chief executive officer, the review team would be reporting directly to the vice-president of Quality and Safety. The review team included the regional head of Medicine, the leader of the Psychiatry Consult Service at one of the hospitals involved, the vice-president of Community Services, and two members of the Patient Care Quality Office (the regional director and an officer who recently joined the team and whose experience includes nine years as regional lead, Community Acquired Brain Injury Supports). The team was tasked with engaging with the providers at both hospitals involved.

Recommendation

That Vancouver Coastal Health have one of the hospitals involved apply this case as a learning opportunity to ensure important information regarding a patient's complex diagnoses (i.e., mental capacity and functioning) is documented and understood by those offering care, and considered in the development of a care plan or discharge plan that meets the patient's needs.

Response

Vancouver Coastal Health committed to reviewing this case and the outcome of the review within their quality committees across the health authority to consider and explore opportunities for ensuring patient-centred care, including discharge planning that is attentive to each patient's needs. The mandate of the review team includes identification of specific audiences for discussion of the lessons learned.

CESSATION OF CLINIC SERVICES

Recommendation

That the Vancouver Coastal Health clinic involved in this case reconsider their decision to cease providing health-care services to the complainant based upon the BC Health Quality Matrix Handbook factors as published by the BC Patient Safety & Quality Council, with particular reference to the following:

1. Affording full consideration to the patient's input and submissions as to continuing with the clinic's health-care services;
2. Obtaining the patient's physician's advice as to whether continuity of care would be in the patient's best interest, particularly given the patient's age and existing complex care needs;
3. Consulting with the Vancouver Coastal Health Clinical Ethics Committee concerning their administration of this discharge process without notice to patients or apparent reference to a patient-centered concept of health care, and without ensuring that any transition in care was arranged for in a compassionate and seamless manner; and
4. Consulting with Vancouver Coastal Health about potentially expanding the resources available to the clinic to service new and long-term patients.

Response

A new process was developed in consultation with the Office of the Ombudsperson to improve attention to administrative fairness, which included the posting of public notices in community health centres to provide clients with: information about clinical reviews; notice of the results of a clinical review, and an opportunity to provide input and feedback to the reviewer; and providing discharged clients with contact information of the Patient Care Quality Office if they would like a review of the decision.

Recommendation

That Vancouver Coastal Health review the implementation of this abrupt termination of patient services in relation to other patients discharged by the clinic by reference to the same factors, and take appropriate and corrective measures.

Response

Appropriate and corrective measures were identified and implemented as a result of the original complaint for each of the clients who have expressed concern after having received similar notice. The new review model of enhanced engagement, dialogue, and administrative fairness was applied.

EMERGENCY DEPARTMENT SERVICE AND COMMUNICATION

Recommendation

That Vancouver Coastal Health use this case as an example and a teaching tool to reinforce with the hospital emergency department physicians and staff involved:

1. The need to provide care for the patient as a whole;
2. The importance of listening to patients and their family; and
3. The need to not pre-judge patients who appear to be homeless, and suffering from mental health, addiction issues and/or other challenges.

Response

As part of departmental meetings and continuous quality improvement, the health authority will remind staff of the importance of:

1. Clear communication with patients and families, including ensuring that they understand the rationale for the treatment being recommended;
2. The expectation that all staff reflect on their practice with patients who may be suffering from mental health and/or addiction issues; and
3. The need to provide care for the patient as a whole, the importance of listening to patients and their family, and the need to not pre-judge patients on any aspect of their presentation.

SAME-DAY HOSPITAL DISCHARGE POLICIES

Recommendation

That Vancouver Coastal Health's vice-president of Quality Services and vice-president of Medicine, or other senior health authority officials within the health authority as the president may deem appropriate, review the changes made to the same-day discharge protocols at the hospital involved in this case with a view to share them with the other care facilities within the health authority so that, where advisable, similar changes in care protocols may be implemented throughout the health authority.

Response

Vancouver Coastal Health committed to issuing a directive from the vice-president Quality and Safety and the vice-president of Medicine to all medical staff to reinforce the expectation that patients who experience an unusual course when recovering from a surgical or other interventional procedure are to be seen by a medical practitioner to confirm suitability for discharge. They also committed to sharing this directive with clinical and operational leaders across the organization to ensure that expectation is documented within protocols concerning discharge following anesthesia or procedural sedation.

PAIN MANAGEMENT AND FAMILY COMMUNICATION IN PALLIATIVE CASES

Recommendation

That Vancouver Coastal Health provide ongoing training regarding palliative care to all staff in the unit involved in this case, including the provision of pain management for patients, and emotional support and communication with families and caregivers of palliative, cognitively impaired patients.

Response

Unit leadership and the Palliative Care Program have worked on an awareness and education strategy for the unit to raise awareness and expertise concerning symptom control, and communication with families and caregivers. They have provided a number of in-service sessions on those topics. The palliative care co-ordinator (a clinical resource nurse) is available for consultation, coaching and care planning consultation for nursing and the rest of the care team on any unit at the hospital.

Recommendation

That Vancouver Coastal Health designate leaders from the unit and the Palliative Care Program to monitor the impact of ongoing palliative care training to determine whether the actions taken have improved the quality of palliative care. Designates should report their findings to senior hospital leadership within a period of nine months and use the findings to inform further program enhancements.

Response

Unit leadership and Professional Practice committed to collaborating on an approach to evaluate the impact of the strategy. The site was implementing a new clinical information system at the time of the board's review, with many operational changes underway. The health authority affirmed their commitment to improving staff awareness and expertise concerning palliative care.

HOSPITAL INTERPRETER SERVICES

Recommendation

That Vancouver Coastal Health ensure nursing and medical staff at the hospital in this case are educated and trained on when to contact and how to use interpreter services, focusing on the Provincial Language Services policy requirements that interpreters are to be used when there is a language barrier of any kind. In such situations, professional interpreter services should be engaged, particularly when discussing clinical matters or issues that may be personally sensitive to the patient and when obtaining consent for a clinical procedure.

Response

Vancouver Coastal Health undertook to raise the profile of the Provincial Language Service among nursing and medical staff. They also committed to discussing across the organization the use of professional interpreter support for significant and/or sensitive conversations, and discouraging reliance on the involvement of family members other than in exceptional circumstances. Additional actions included updating their intranet resource page concerning the Provincial Language Service to include additional guidance, including information about accessing the service in the Vancouver Coastal Health newsletter, and directly communicating this to program leaders.

Recommendation

That the consent form for medical or surgical care be revised to include a section to indicate whether the patient understands English and, if not, the manner in which the English version of the consent form was explained prior to the patient signing it.

Response

Vancouver Coastal Health noted that the back of the consent form does currently document the involvement of and declaration by an interpreter involved in the discussion; however, they committed to further action to clarify the importance of completion of this section even if it is a family member relied upon for the discussion.

Recommendation

That the health authority amend its Emergency Case Booking policy to clearly articulate how the priority level of emergency classification is determined for a surgical procedure. If ranges of time are to be used for certain priority levels, ensure these clearly state what time frame is preferable and what time frame is required.

Response

The recommendation was referred to the Regional Surgical Program for consideration of potential improvements to the policy, and if a resource targeted for patients and families to help them better understand the process would be beneficial.

DISCHARGE OF VULNERABLE PATIENTS

Recommendation

That Vancouver Coastal Health ensure management at the hospital involved review this case with staff and stress:

1. The importance of appropriate charting of physicians' instructions and of nurses' assessments in relation to patient discharge; and
2. It is imperative to follow the protocol for the discharge of vulnerable emergency department patients.

Response

Vancouver Coastal Health agreed with the board about the importance of clear and helpful documentation and the fundamental imperative to be mindful in any patient interaction of the patient's ability to manage their own safety. The Patient Care Quality Office confirmed with the program director and the patient care manager for the emergency department that the case had been reviewed with front-line staff (including physicians). This reinforced awareness of, and adherence with, the Protocol for Discharge of Vulnerable Emergency Department Patients, and reminded providers that their documentation speaks to both their assessment of the patient and decisions made.

LAUNDERING OF INFECTED CLOTHING AND BEDDING

Recommendation

That Vancouver Coastal Health reconsider the decision made in this case after the following:

1. Consultation with one of its medical health officers and a review of this case in regard to the use of a publicly available laundry facility to launder C. difficile infected soiled clothing and bedding, and ascertain whether or not this is a matter of public health concern (e.g., its potential to spread communicable disease) and what alternative laundry services would avoid such risks;
2. A review of patient medical care needs, including treating a request for laundry assistance not just as a personal care support but as a medical care need; and
3. If the policy is not deemed to permit such a decision, review the policy to determine if an amendment is needed to allow for an additional exception to address exceptional care needs and maintain public safety.

Response

1. Vancouver Coastal Health leadership consulted with Regional Infection Control and the medical health officer, and received assurance that there was minimal public health risk from the use of publicly available facilities for laundry of patients with C. difficile infection or colonization. There was no evidence that this was a meaningful pathway of transmission in the community.
2. Vancouver Coastal Health agreed with the board and accepted its opportunity and obligation to consider the client's situation broadly, and to consider exceptional services that deviate from provincial or local policy and guidelines when it is indicated for a client-focused solution. With that philosophy in mind, Vancouver Coastal Health undertook a review of the client's current personal and medical care needs.
3. Coincidentally with the review of these recommendations, the provision of those activities that support independent living—including laundry services—were under discussion at the provincial Home and Community Care Committee. The perspective of the board was shared as part of that discussion. With respect to Vancouver Coastal Health policy and its application in practice, they are confident that their policy does support that exceptions can be made. This case illuminated the challenge in considering requests for exceptions with a fiscally responsible yet patient-centred approach, and the health authority trusts that as they move forward they can achieve that balance and resolve these requests closer to the point of service, ideally within the program area.

RESIDENTIAL CARE TEMPORARY RATE REDUCTION

Recommendation

That Vancouver Coastal Health complete a retroactive Financial Profile and Calculation form (HLTH 1.6) to determine if the complainant was eligible for a temporary rate reduction during the period in which their current debt was accumulated. If it is determined that the client would have qualified for a temporary rate reduction due to serious financial hardship, the health authority should consider forgiving the outstanding debt. In the event that the review indicates that the client was ineligible for a temporary rate reduction during this period, the health authority should stand by its good faith offer to reduce the outstanding arrears to half.

Response

Vancouver Coastal Health appreciated and agreed with the board's finding that the health authority had made reasonable efforts to provide this complainant with information about the steps necessary for any client to seek temporary rate reduction. They accepted the recommendation to exercise further discretion to conduct a review to determine whether the temporary rate reduction would have been granted had a timely application been made.

Staff invited the complainant to submit the necessary documents, complete a retroactive Financial Profile and Calculation form (HLTH 1.6) and committed to determining, upon receipt of those documents, whether the client was eligible for a temporary rate reduction during the period in which the current debt was accumulated.

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 2017/18. It also compares the number of times the top five subjects of concern were logged within the province and each health authority for 2013/14, 2014/2015, 2015/2016, 2016/17 and 2017/18.[1]

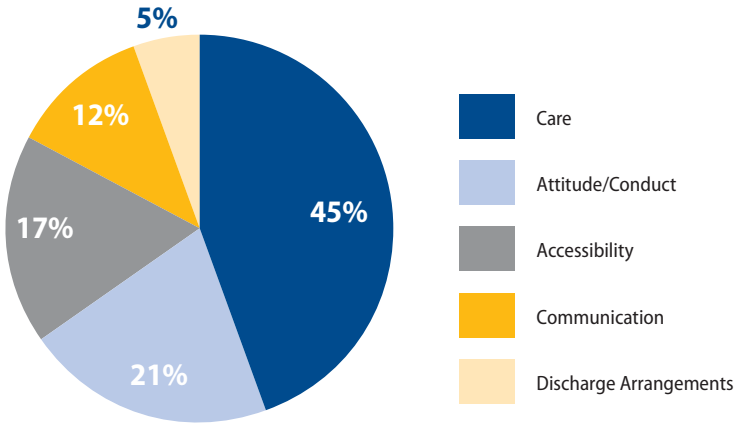
BRITISH COLUMBIA

TABLE 3: *Patient Care Quality Office Volume, B.C., 2017/18*

	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total
External Complaints	75	67	92	92	326
Care Quality Complaints	1,867	1,775	1,920	2,316	7,878
Enquiries	302	274	336	377	1,289
TOTAL VOLUME	**2,244**	**2,116**	**2,348**	**2,785**	**9,493**

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 3,379 times. Attitude and conduct followed, with 1,594 times logged. Accessibility (e.g., wait times for surgery or test results, availability of services) was the third most frequently logged subject at 1,323. Communication was fourth at 880, followed by discharge arrangements at 414.

CHART 4: *Patient Care Quality Office Top Five Categories of Concern, B.C., 2017/18*



1 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, and public health. 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.

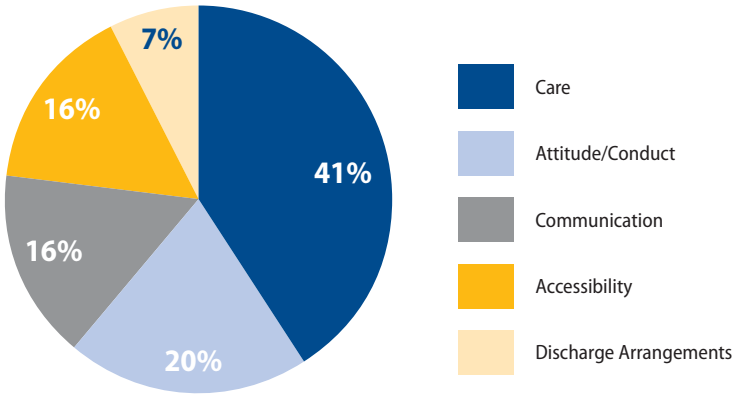
FRASER HEALTH

TABLE 4: *Patient Care Quality Office Volume, Fraser Health, 2017/18*

Fraser Health	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total
External Complaints	39	31	40	45	155
Care Quality Complaints	473	495	482	597	2047
Enquiries	104	87	84	86	361
TOTAL VOLUME	**616**	**613**	**606**	**728**	**2563**

The most frequently reported concerns brought forward to Fraser Health in 2017/2018 were about care, with this subject category being logged 969 times, followed by attitude and conduct at 477, accessibility and communication tied at 372, and discharge arrangements at 171.

CHART 5: *Patient Care Quality Office Top Five Categories of Concern, Fraser Health, 2017/18*



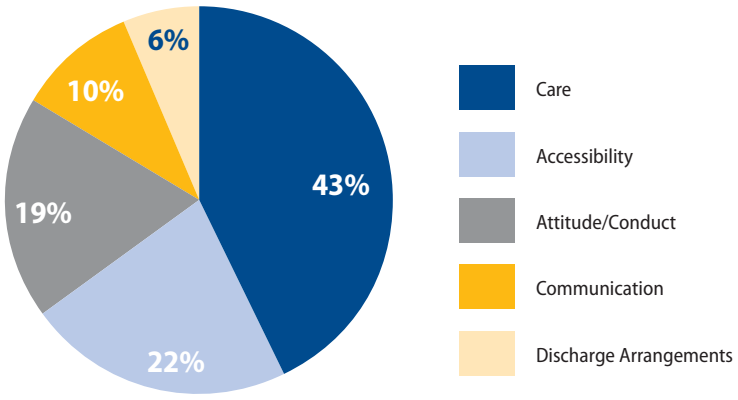
INTERIOR HEALTH

TABLE 5: *Patient Care Quality Office Volume, Interior Health, 2017/18*

Interior Health	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total
External Complaints	1	4	3	3	11
Care Quality Complaints	327	302	322	415	1366
Enquiries	25	22	30	33	110
TOTAL VOLUME	**353**	**328**	**355**	**451**	**1487**

The most frequently eported concerns brought forward to Interior Health in 2017/2018 were about care, with this subject category being logged 496 times, followed by accessibility at 257, attitude and conduct at 215, communication at 116, and discharge arrangements at 71.

CHART 6: *Patient Care Quality Office Top Five Categories of Concern, Interior Health, 2017/18*



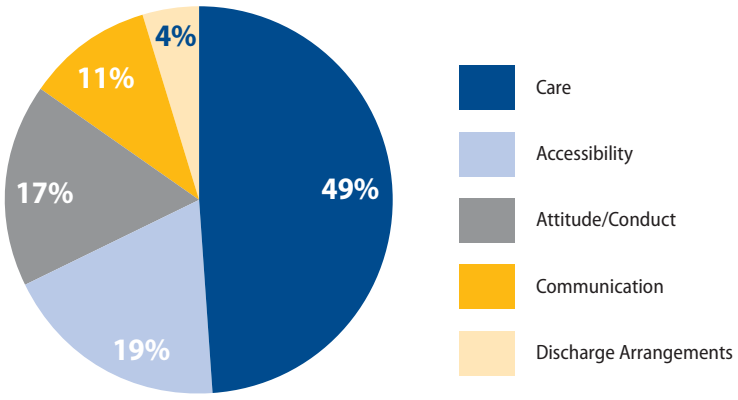
ISLAND HEALTH

TABLE 6: *Patient Care Quality Office Volume, Island Health, 2017/18*

Island Health	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total
External Complaints	16	20	32	14	82
Care Quality Complaints	499	425	495	575	1994
Inquiries	44	41	78	85	248
TOTAL VOLUME	**559**	**486**	**605**	**674**	**2324**

The most frequently reported concerns brought forward to Island Health in 2017/2018 were about care, with this subject category being logged 957 times, followed by accessibility at 370, attitude and conduct at 331, communication at 210, and discharge arrangements at 87.

CHART 7: *Patient Care Quality Office Top Five Categories of Concern, Island Health, 2017/18*



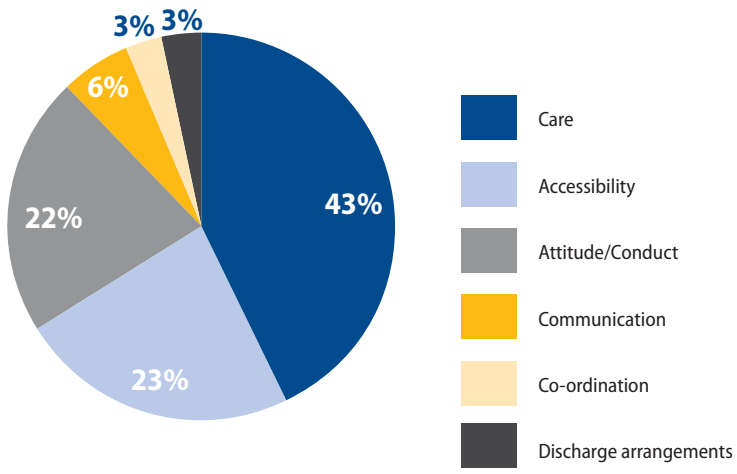
NORTHERN HEALTH

TABLE 7: *Patient Care Quality Office Volume, Northern Health, 2017/18*

Northern Health	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total
External Complaints	1	4	11	13	29
Care Quality Complaints	69	65	72	86	292
Enquiries	17	8	26	27	78
TOTAL VOLUME	**87**	**77**	**109**	**126**	**399**

The most frequently reported concerns brought forward to Northern Health in 2017/2018 were about care, with this subject category being logged 97 times, followed by accessibility at 53, attitude and conduct at 49, communication at 13, and co-ordination and discharge arrangements tied at 7.

CHART 8: *Patient Care Quality Office Top Five Categories of Concern, Northern Health, 2017/18*



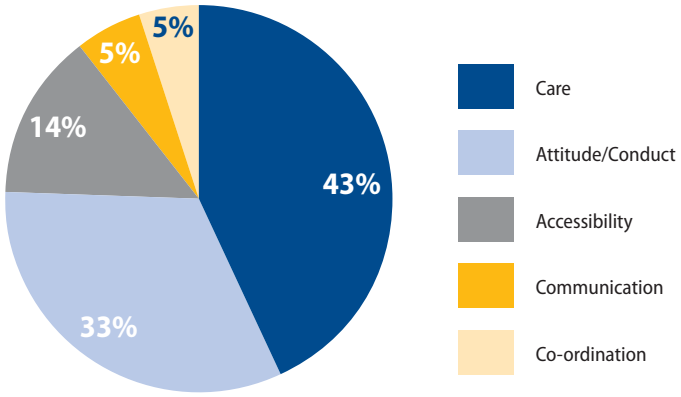
PROVINCIAL HEALTH SERVICES AUTHORITY

TABLE 8: *Patient Care Quality Office Volume, Provincial Health Services Authority, 2017/18*

PHSA	Apr-June 2017	July-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Total
External Complaints	9	3	1	0	13
Care Quality Complaints	169	177	291	297	934
Enquiries	57	63	75	76	271
TOTAL VOLUME	**235**	**243**	**367**	**373**	**1218**

The most frequently reported concerns brought forward to the Provincial Health Services Authority in 2017/2018 were about care, with this subject category being logged 359 times, followed by attitude and conduct at 271, accessibility at 116, communication at 46, and co-ordination at 40.

CHART 9: *Patient Care Quality Office Top Five Categories of Concern, Provincial Health Services Authority, 2017/18*



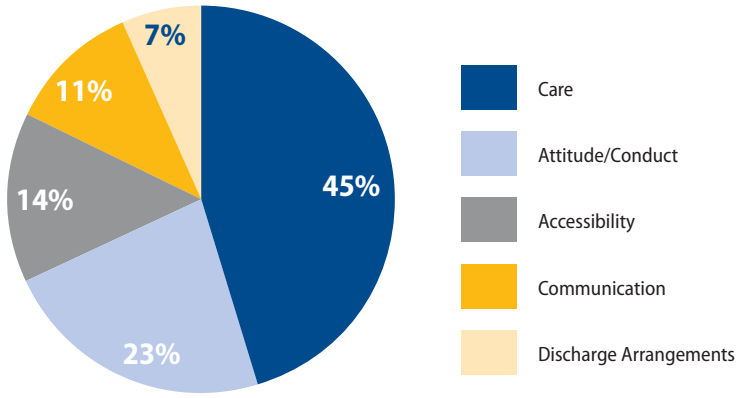
VANCOUVER COASTAL HEALTH

TABLE 9: *Patient Care Quality Office Volume, Vancouver Coastal Health, 2017/18*

Vancouver Coastal Health	Apr-June 2016	July-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Total
External Complaints	9	5	5	17	36
Care Quality Complaints	330	311	258	346	1245
Enquiries	55	53	43	70	221
TOTAL VOLUME	**394**	**369**	**306**	**433**	**1502**

The most frequently reported concerns brought forward to Vancouver Coastal Health in 2017/2018 were about care, with this subject category being logged 501 times, followed by attitude and conduct at 251, accessibility at 155, communication at 123, and discharge arrangements at 72.

CHART 10: *Patient Care Quality Office Top Five Categories of Concern, Vancouver Coastal Health, 2017/18*



Appendix B: Financial Information

(Source: CAS Financial Reports)

Expenditures	Actual $ 2017/18
Board Members	
Board member meeting fees and expenses	$112,540.25
Total	$112,540.25
Board Support	
Board support personnel	$1,103,974.28
Board support travel	$12,933.32
Legal expenses and professional services	$7,435.80
Office business and information systems	$15,529.54
Total	$1,139,872.94
TOTAL EXPENDITURES	**$1,252,413.19**

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 the 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

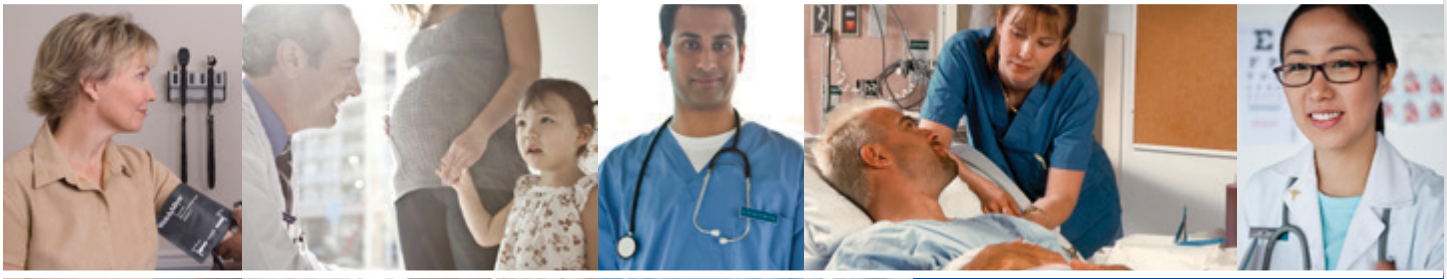
6th floor, 299 Victoria Street, Prince George, BC V2L 5B8
Phone: 1 877 677-7715 (toll-free)
Fax: 250 565-2640
Email: *patientcarequalityoffice@northernhealth.ca*
Website: *www.northernhealth.ca*

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*

Notes



Annual Report 2017/2018

BRITISH COLUMBIA

Patient Care Quality Review Boards