Ombudsman Saskatchewan

Promoting Fairness

Executive Summary

Communicating With Care: An Ombudsman Investigation into the care, incident review and concern-handling practices of the Regina Qu'Appelle Regional Health Authority and Extendicare (Canada) Inc. at Extendicare Sunset

OVERVIEW

Mrs. Sellwood was a resident of Extendicare Sunset (Sunset) from February 14, 2013, until her death on December 27, 2013. On admission to Sunset, her fall risk was assessed and incorporated into her care plan. She fell on December 23, 2013 while being assisted by one care aide. We found that before her fall, her fall risk had not been properly reassessed as required. Sunset staff did not follow the fall prevention policies of Extendicare (Canada) Inc. (Extendicare) and Extendicare did not provide us with any information about whether it knew Sunset was not complying with its corporate-wide policies. As well, the Regina Qu'Appelle Regional Health Authority (RQHA) did not monitor Extendicare to ensure that it was following RQHA policies and Ministry of Health (Ministry) standards.

Mrs. Sellwood was taken by ambulance to the Pasqua Hospital emergency room (ER), and given pain medication and sutures. As required after a resident is injured, Sunset completed a Confidential Occurrence Report.

On return to Sunset, Mrs. Sellwood complained of leg pain, leg swelling, and nausea. On December 25, 2013, she was taken again by ambulance to the emergency room. This time, she was diagnosed with a fractured leg, given pain medication and an anti-nauseant, and returned to Sunset. She died in the early morning of December 27, 2013. Her physician completed the Medical Certificate of Death, indicating that her immediate cause of death was "? P.E. post leg injury/congestive heart failure" and noted her manner of death as "accident." According to *The Coroner's Act, 1999,* the Coroner is to be notified of any death that occurs as a result of an accident. Sunset staff did not notify the Coroner and did not appear to be aware of the circumstances under which a coroner must be notified.

After Mrs. Sellwood's death, Sunset wrote "deceased" on the top of the Confidential Occurrence Report; however, the report was not updated with further information about her December 23, 2013 fall, such as that she fractured her leg, nor was the report updated to indicate whether or not her death was possibly related to the fall. We found no evidence that Sunset further investigated her fall at this time. Because Mrs. Sellwood's death was associated with a fall in a long-term care facility, Sunset should have deemed it a critical incident within three business days or as soon as possible, and reported it and reviewed it under *The Critical Incident Regulations*. The RQHA deemed it a critical incident on May 27, 2014, five months after Mrs. Sellwood's death. At this time, the Coroner was contacted. RQHA also requested further information from Sunset, including an internal quality review. While Sunset told the RQHA that it completed a review of the incident and interviewed all the parties involved, we found that this was

not a thorough review. We also found that there were various reviews conducted by RQHA and Extendicare which involved multiple information requests that led to confusion, as well as issues about the timeliness of the response and the quantity and quality of the information provided.

Mrs. Sellwood's family had difficulty obtaining information about their mother's care. When they asked for her entire chart and her transfer, lift and repositioning (TLR) status, Sunset was unsure what information it could provide. The family eventually received a copy of the entire chart on May 29, 2014. Because of the multiple processes underway at one time, which involved RQHA (a regional health authority) and Sunset (an affiliated long-term care facility), the family endured a lengthy, disjointed and unsatisfactory review process and did not get timely, satisfactory answers to their questions. These entities did not work well together to coordinate an effective response to the concerns raised by this family.

Eventually, the family met with then Minister of Health, the Honourable Dustin Duncan, who in turn requested that the Ombudsman review the case. While the request was made during our investigation into the care provided to Margaret Warholm while a resident of Santa Maria Senior Citizens Home, we determined that the issues raised in Mrs. Sellwood's case required a separate investigation.

We thank Mrs. Sellwood's family, the RQHA, and Extendicare for their cooperation during this investigation.

FINDINGS AND RECOMMENDATIONS

Failing to Meet Standards

We found several instances of care and staff action that failed to meet the standards established by the Ministry's Guidelines, and by the RQHA's and Extendicare's own policies - and managers did not seem to be aware of these breaches.

As a result of a previous investigation conducted by our Office and a recommendation we issued in May 2015, the RQHA is working to ensure its long-term care facilities (region-run and contracted) are providing care that meets the Ministry's standards. We have requested an update on their progress in implementing this recommendation.

For its part, Extendicare has taken steps to remedy some of the gaps between its policies and Sunset's practices identified in this case, including, for example, establishing a fall committee, monitoring TLR training for staff, and ensuring resident TLR reviews are completed.

However, neither Extendicare's regional nor local staff seemed to have been aware that Sunset was not meeting the policies and standards of Extendicare, the RQHA and the Ministry. Nor did the RQHA appear to be aware. We note that Extendicare is also contracted to run long-term care facilities in other health regions.

We recommend:

RECOMMENDATION #1

Extendicare (Canada) Inc. take immediate steps to ensure that policies for its Saskatchewan facilities meet all the requirements of Saskatchewan statutes and regulations, including the *Program Guidelines for Special-care Homes*, plus all applicable regional health authority policies and protocols.

Responding to and Investigating the Unexpected Death of a Resident in Care

There were at least five review processes (some informal) looking into various aspects of Mrs. Sellwood's fall and subsequent death, including:

- Immediately after the fall, a nurse completed a Confidential Occurrence Report and submitted it to Extendicare management for review.
- The RQHA led a Critical Incident Review looking into the fall (which started 5 months after her fall and death).
- As part of the Critical Incident review process, Extendicare completed an *Integrated Health Services/Occurrence Follow Up Report* for the RQHA.
- The RQHA's Department Head of Emergency Medicine reviewed the care provided by the ER.
- The Coroner considered the circumstances of her death.

These reviews appear to have been completed in isolation, and none reviewed her care in its entirety, across all three sites (Sunset, the ambulance, and the ER). Further, this review process did not ensure that all the various statutory, regulatory and policy requirements were met.

We recommend:

RECOMMENDATION #2

The Regina Qu'Appelle Regional Health Authority develop and implement a process to ensure all unexplained and unexpected deaths in all long-term care facilities in the region are investigated in a coordinated and timely manner.

RECOMMENDATION #3

Extendicare (Canada) Inc. collaborate with the Regina Qu'Appelle Regional Health Authority to ensure the process implemented by the Regina Qu'Appelle Regional Health Authority to investigate all unexplained and unexpected resident deaths is implemented at all Extendicare facilities in the Regina Qu'Appelle Health Region.

Despite *The Coroners Act, 1999* requiring accidental deaths to be reported to the Coroner, in this case, this only happened months later, after the RQHA began considering it as a possible critical incident.

We recommend:

RECOMMENDATION #4

The Regina Qu'Appelle Regional Health Authority immediately implement procedures to ensure all staff and physicians providing care in all long-term care facilities in the region comply with the provisions of *The Coroner's Act, 1999* about when the Coroner is to be notified of a death.

Better Communication

During our investigation, questions were raised as to whether the information shared between the staff at Sunset and the emergency room and then back again was as complete and detailed as it could have been. For example, during our interviews, staff shared different interpretations of the written information provided on the Referral Information form sent to the emergency room after Mrs. Sellwood's fall and what was being conveyed and requested. Similarly, the Department Head of Emergency Medicine, in his letter of response to the family, commented on the accuracy of information shared and how important this information is for accurate diagnosis. We agree that it is critical that complete and accurate information be shared back and forth when transferring a resident from one care team and care site to the next.

We recommend:

RECOMMENDATION #5

The Regina Qu'Appelle Regional Health Authority work with its long-term care homes, both region-run and affiliated, and its acute care facilities (i.e. emergency rooms and hospitals) to develop a process to ensure complete and accurate information is communicated when transferring residents between facilities.

A Meaningful Concern-handling Process

In this case, Mrs. Sellwood's family did not get meaningful and timely answers to their questions.

For example, when Sunset managers first met with the family to initially discuss the fall and death, they left the family with the impression that they were not familiar with the facts of the fall, because they were unable to provide them with answers to seemingly simple questions.

Similarly, when the family asked for a copy of their mother's chart, Sunset staff did not realize that Extendicare's Collection, Use and Disclosure of Health Information (03-04-03) policy and *The Health Information Protection Act* permitted them to share the full chart in these circumstances. Even after taking time to consult internally about how to handle the request for the chart, they mistakenly believed that they had to review the file with the family in person to answer their questions. Later, they provided only a summary of the chart (and this summary contained errors). Although they eventually provided a copy of the full chart, this drawn-out process added unnecessary time to the concern-handling process and to the family's frustration and mistrust.

Meeting with families after an incident is a critical and necessary step in an effective concern-handling process. Extendicare must ensure its managers are aware of all relevant legislation, regulations, policies and procedures, so that they are well informed and able to have these crucial conversations.

We recommend:

RECOMMENDATION #6

Extendicare (Canada) Inc. ensure all managers in its Saskatchewan facilities understand the purpose of *The Health Information Protection Act* and its Collection, Use and Disclosure of Health Information (03-04-03) policy, including the circumstances under which the personal health information of a deceased resident may be released to the immediate family or personal representative of the deceased resident.

RECOMMENDATION #7

Senior officials with Regina Qu'Appelle Regional Health Authority and Extendicare (Canada) Inc. provide the family with an apology, and an explanation of the changes they have made or will make as a result of this case to improve resident care, incident reviews, and processes for responding to concerns raised by families.

CONCLUSION

After completing this investigation, we provided both the RQHA and Extendicare with an opportunity to review and make representations with respect to our findings and recommendations before finalizing this report. We also met with Mrs. Sellwood's family to discuss our findings and recommendations. We then finalized this report. We wish to acknowledge that both the RQHA and Extendicare have accepted our recommendations in this case and have told us that they are already in the process of implementing them. We thank them for their cooperation during this investigation.

We would also like to acknowledge that initiatives are underway at RQHA and the Ministry of Health to improve care and oversight in long-term care, including initiatives that result from the recommendations we made in our May 2015 report, *Taking Care: An Ombudsman investigation into the care provided to Margaret Warholm while a resident of the Santa Maria Senior Citizens Home*. We are hopeful that these initiatives will improve long-term care in the province. We are also hopeful that these initiatives will prevent or at least reduce the chances of an incident like what happened to Mrs. Sellwood and her family from happening again to another resident and family.

This case was raised publicly during question period in the Legislative Assembly, and then the Minister of Health met with the family and asked us to review it. Given that there is public interest in this case and the important issues it raises, we decided that it was in the public interest to issue a public report about this investigation.