Public Report

Ombudsman Saskatchewan
Promoting Fairness

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

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Executive Summary

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 ER care.
- 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* for 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 Extendicare's 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.

Introduction

The complainants are the family of Mrs. Jessie Sellwood, a former resident of Extendicare Sunset (Sunset) in Regina, Saskatchewan. Sunset, a 152-bed, long-term care home (also known as a special-care home), is operated by Extendicare (Canada) Inc. (Extendicare). Extendicare is under contract with the Regina Qu'Appelle Regional Health Authority (RQHA) to provide long-term care for residents the RQHA has placed in Sunset.

On the night of December 23, 2013, Mrs. Sellwood fell while being assisted by a care aide. She cut her leg and was sent by ambulance to the Pasqua Hospital emergency room (ER). She returned to Sunset a few hours later, but her pain worsened. She was taken back to the ER by ambulance on December 25, 2013. It was then discovered that her other leg was broken. She returned to Sunset again and died in the early morning of December 27, 2013. She was 87 years old.

After ten months of working with Extendicare and the RQHA to address their concerns about their mother's care, the family was dissatisfied with the progress and approached the Minister of Health. The Minister of Health requested that the Ombudsman investigate the matter.

Mrs. Sellwood's family told us they are concerned that Extendicare and the RQHA did not take her care seriously and failed to learn from any mistakes that may have been related to her fall and her death. They questioned the quality of Extendicare's investigation into the fall, believing it was a cursory review that left important questions unanswered. How did their mother fall when she was being helped by staff? Were proper protocols followed? Why did the ER miss her broken leg the first time she was sent for treatment? Why was she billed for two ambulance trips when it seemed like the ER's error necessitated the second trip? How could their mother go from being active (she had been out with her family in the days just prior to her fall) to dead so quickly? Delays, confusing processes, inaccurate information, and general misunderstandings contributed to the family's unresolved concerns. They wanted to better understand what happened to their mother, but also to ensure Extendicare and the RQHA learned from what happened and were held accountable for the decisions they made and the care they provided.

Ombudsman's Mandate

The Ombudsman is an independent officer of the Legislative Assembly of Saskatchewan. Under *The Ombudsman Act, 2012*, we investigate complaints about administrative actions and decisions of provincial ministries, agencies of the government, publicly-funded health entities, and municipal entities, including their council members, board members, officers and employees. After an investigation, we can make recommendations to a government entity when the Ombudsman is of the opinion that the government entity or a public official:

- has made a decision, an omission or a recommendation to a minister, or has acted in a way that appears to be: contrary to law; wrong, unreasonable, unjust, oppressive, improperly discriminatory, based on a mistake of law or fact; or was made or done in

accordance with a law or a practice that is unreasonable, unjust, oppressive or improperly discriminatory.

- has exercised a power, duty or function conferred or imposed on them by any Act for an improper purpose, on irrelevant grounds, or by taking into account irrelevant considerations.

- should have given reasons for a decision, action, omission or recommendation that was the subject matter of the investigation.

Ombudsman Saskatchewan does not advocate for the people who complain to us or for the government entities and public officials we investigate. We are neutral, impartial, and independent from the government entities and public officials we oversee. Our mission is to promote and protect fairness and integrity in the design and delivery of provincial and municipal government services.

Our mandate does not give us the authority to investigate clinical decisions made by health professionals regarding an individual's care. As well, *The Ombudsman Act, 2012,* limits our authority to request any information, report, statement, recommendation, or other record used to prepare a critical incident notice or report under *The Regional Health Services Act*.

Overview of the Investigative Process

Interviews

We interviewed the resident's family and conducted 30 interviews with over 20 staff from Extendicare, the RQHA, eHealth Saskatchewan, and the Office of the Chief Coroner.

Statutes and Regulations

The Coroners Act, 1999

The Regional Health Services Act
The Facility Designation Regulations
The Critical Incident Regulations (repealed)
The Critical Incident Regulations, 2016

The Vital Statistics Act, 2009
The Vital Statistics Regulations, 2010

The Occupational Health and Safety Regulations, 1996

Standards, Policies, and Procedures

Ministry of Health

Program Guidelines for Special-care Homes, 2013

Saskatchewan Critical Incident Reporting Guideline, 2004

Regina Qu'Appelle Regional Health Authority

Client Representative/PSO Joint File Management, 08-Jul-2014

Critical Incident Procedure: Confirmation of Actual & Potential Critical Incidents, 23-Jun-2014

Critical Incident Reviews with Affiliates & Rural Facilities, 22-Oct-2014

Decision Item, Designation of Quality Improvement Committees with the RQHR, 14-Dec-2007

Disclosure of Adverse Events Policy, Ref. No. 603, 14-May-2008

Falls Follow-up Checklist, undated

LTC Facility Falls Prevention and Injury Reduction Program, 14-Feb-2011

Management of Client/Patient Concerns Policy, Ref No. 801, 13-Jun-2008

Management of Patients/Residents/Clients/Family Concerns procedures, Ref No. 801-1, Draft 07-May-2015

Request for Medical Quality Review for Identification of Critical Incident (Form)

Risk Management Critical Incident Procedure, 05-Feb-2013

Extendicare (Canada) Inc. (including Extendicare Sunset)

Administration Manual

Complaints, (09-04-06) June 2010

Health Care Records Manual

Collection, Use and Disclosure of Health Information, (03-04-03) May 2007

Nursing Administration Manual

Pronouncing Resident Death (NURS 02-03-07), December 2002

Resident Death (NURS 02-03-06), December 2002

Extendicare Operations

Fall Prevention and Management Committee (OPER 02-05-09), December 2011

Resident Care Manual

Resident Care: Palliative Care and Death (RESI 04-04-02), December 2002

Resident Care: Lifts and Transfers (RESI 05-06-05), December 2002

Resident Care: Falls (RESI 09-02-01), November 2011

Resident Care: Post Fall Analysis (RESI 09-02-02), September 2010

Other Documents

We also reviewed charts and care records kept by Extendicare (at Sunset), the ER, and the ambulance service; death and Coroner reports; concern-handling files; meeting minutes; emails with the Ministry of Health (the Ministry), the RQHA and Extendicare; and correspondence to and from the family.

Events Leading up to the Complaint

Before the Incident

Mrs. Sellwood moved into Sunset on February 14, 2013. She was 86 years old. On admission, Sunset staff assessed her need for transfer, lift, and repositioning (TLR) assistance and determined she needed one staff member to help her from her bed to a chair and back again. She was also identified as having some risk of falling.

By December 2013, although her overall condition had deteriorated – for example, she had begun using a wheelchair instead of a walker and was complaining of leg pain more often – she was still recorded as a one-person assist. On December 16, 2013, tests showed that she had elevated INR levels (her blood's clotting time had slowed). Her physician was notified and changes were made to her medications. On December 20, 2013, care logs indicate one staff person transferred her, but she was "hard to transfer from chair to bed." During the day on December 21, 2013, two people transferred her and then, that evening, one person did it alone. She was noted as having very swollen legs with redness on her outer left leg, which Sunset's nursing staff were monitoring. During the day on December 22, 2013, she was transferred by one person. During the day and evening on December 23, 2013, she was transferred by two people. Also on that day, the lab notified Extendicare that she had critically high potassium levels. The physician was notified and changes were made to her medications.

Sunset staff did not reassess or change her TLR status or her care plan in response to these events and changes.

The Incident

Just before midnight on December 23, 2013, Mrs. Sellwood fell while being helped by a care aide (who knew her and had worked with her in the past). During our interviews, the care aide recalled that she assessed Mrs. Sellwood as okay to stand, then helped her to the

commode. The care aide then asked her if she could again stand on her own. She said yes. She stood. As the care aide stood behind her helping her with her clothing, Mrs. Sellwood's knees buckled and her weight shifted backward. She began to fall. The back of her body slid down the front of the care aide's body. The care aide did her best to help guide her to the floor. The care aide told us that one of her legs bent at the knee and angled off to the side (it was later found to be fractured) and the other went out front and slightly off to the other side (where it would be cut, possibly on her walker). The care aide immediately saw what she thought was a significant amount of blood.

The other residents in the room were sleeping and the care aide could not reach the call bell, so she shouted for help. Her shift partner came in and immediately went to get the nurse in charge. After the nurse assessed Mrs. Sellwood, she was lifted to her bed. The physician on call was consulted and the ambulance was called (it was now in the early hours of December 24) to take her to the ER.

The ambulance attendants recorded that she had a guided fall to the floor with a loss of consciousness – this report of a loss of consciousness contradicts all other reports. She was alert, but weak to stand, so she was assisted from her bed to the stretcher. The information from Sunset that accompanied her to the ER included her current medications and reference to some of her recent lab results. The Referral Information form stated under the reason for referral "Guided Assisted Fall [large] skin tear to [right] leg" and under comments stated "… please assess for need for stitches."

Afterwards, the nurse who responded to her fall completed post-fall assessments and a Confidential Occurrence Report. This report (a one-page form) must be completed when an incident occurs that harmed or could have harmed a resident. The incident is coded 1 to 4 indicating increasing severity and any follow up required to resolve the event must be indicated. Level 3 and 4 incidents are to be reported to the regional health authority. According to Sunset, at this time Mrs. Sellwood's fall was coded as a Level 2.

In the ER, she was noted as having a large skin tear to her right leg and to have complaints of left knee pain and chronic leg pain. She was alert. After clinical assessment, she was given pain medication and sutures, and then returned to Sunset. On her return trip, the ambulance attendants recorded that she expressed no complaints, slept en route and was stable.

Mrs. Sellwood was gone from Sunset less than three hours. On her return to Sunset, the nurse who responded to her fall charted that she was complaining of left leg pain, had some nausea and vomited.

Her family visited her during the day on December 24, 2013. She continued to suffer from leg swelling, pain and nausea. Her chart indicates that this was discussed with staff, as were her high potassium levels, and that she might be nauseous from the pain medications the hospital gave her. Given that she was also suffering from arthritis-related pain, Extendicare advised her family that she would be given her regular pain medication. Mrs. Sellwood remained in bed all day, which was not normal for her.

The Resident Care Coordinator received and reviewed the Confidential Occurrence Report from the nurse. She then gave it to the Director of Care. Although the Resident Care Coordinator was not certain of the date, she thought this happened on December 24, 2013.

At 2:50 a.m. on December 25, 2013, the same nurse who had responded to her fall found Mrs. Sellwood complaining of "extreme pain to left ankle and shin." She gave her arthritis pain medication. About an hour and a half later, she reassessed her as being "in severe pain … unsettled … shaky and disoriented[.]" The nurse phoned the physician, the ambulance was called, and she was returned to the ER.

This time, after clinical assessment, she was diagnosed with a fractured left fibula. She had low blood pressure and the ER nurse alerted the doctor. She was given pain medication and then an anti-nauseant. She was not admitted to the hospital and her leg was not put in a cast. She was referred to an orthopedic surgeon and returned to Sunset at 9:50 a.m. with a prescription for pain and nausea medication. According to the Department Head of Emergency Medicine who we later interviewed, this care and treatment plan was within expected protocols.

Upon her return, Sunset staff changed Mrs. Sellwood's TLR rating from a one-person lift to full lift and updated her care plan. According to her chart, she was given pain and nausea medication at 5:00 p.m. (Sunset's medication reconciliation records, which track all dispensed medications, indicate this occurred at 7:00 p.m.).

On December 26, 2013, her family was concerned about her nausea and asked for her pain medication to be adjusted, which a physician did. She remained in bed, eating and drinking little. Shortly after midnight on December 27, 2013, the Director of Care (who was working a nursing shift) found Mrs. Sellwood unresponsive in her bed. She was pronounced dead and her son was notified. In the morning, Sunset staff notified her family physician. On the Medical Certificate of Death, her family physician recorded her immediate cause of death as "? P.E. post leg injury / congestive heart failure," with check marks indicating "no autopsy" and her manner of death as "accident." He noted that she "had a fall from her bed and sustained injuries to both legs[…]" The physician did not contact the Coroner.

The Director of Care wrote "Deceased Dec 27/2013" on the top of the Confidential Occurrence Report prepared by the nurse after Mrs. Sellwood's December 23, 2013 fall and updated the coding from a 2 to a 3. However, this change was not dated and signed so it was difficult for our Office to be certain exactly when in the process it got changed and by whom. The report was not updated to include information about her fractured leg, nor did it indicate whether her death was possibly related to the fall. Although post-fall assessments of Mrs. Sellwood were completed by nursing staff at the time of the original fall, we found no evidence that her fall was further investigated by Sunset management at this time (e.g. no questions of staff directly involved, no review of protocols to see if changes were warranted, etc.).

After the Incident

On February 21, 2014, her family spoke with a Client Representative (now called a Patient Advocate) with the RQHA. The role of a Client Representative is to help people find answers

to concerns they have about their own or a family member's care or a service provided within the health region. The family had many questions and concerns about their mother's care. In particular, they wanted to know what her TLR status was at the time she fell and whether it was followed, and how her fractured leg was missed on the first visit to the ER. They thought it was unfair to charge her for a second ambulance trip that seemed to have been the result of staff not assessing her injuries properly the first time. They also wanted to know how to access their mother's records from Extendicare. Out of respect for the family's wish to pursue their concerns directly with Extendicare, the Client Representative initiated the RQHA's concern-handling process and only contacted Sunset's Administrator to ask how the family could access their mother's records; she did not raise their other concerns or questions with Extendicare or the RQHA.

Uncertain about whether she could simply provide the family with a copy of their mother's chart, Sunset's Administrator waited for direction from Extendicare's Regional Director before responding to the Client Representative. On March 11, 2014, she told the Client Representative that a resident's substitute decision-maker needed to complete a form and make an appointment to meet with the Administrator and the Director of Care to review the chart and have their questions answered. The Client Representative informed the family, who arranged to meet with Sunset staff.

There is no record to indicate when Extendicare submitted the Confidential Occurrence Report to the RQHA. Although it may have been submitted in late December or early January, shortly after it was completed and reviewed by Sunset's Director of Care, RQHA's Executive Director of Continuing Care, Programming & Utilization told us that she only reviewed it on March 17, 2014. She advised us that there had been changes in her portfolio and she was working through a backlog of paperwork when she came upon the report. She wrote a memo to Sunset's Director of Care asking questions about the report and whether Mrs. Sellwood had died at Sunset or the hospital and whether her fall had anything to do with her death. On March 18, 2014, this memo, along with a copy of the report was emailed to the Patient Safety Unit at the RQHA and on March 21, 2014 it was faxed to Sunset's Administrator and Director of Care.

On March 18, 2014, the family met with Sunset's Administrator and Director of Care. The family wanted to know their mother's TLR status at the time of her fall and whether it was followed. The managers could not answer these questions and offered to look into the issue and report to the Client Representative by March 31, 2014. Extendicare told us this meeting went well. The family told us, however, that they were disappointed and felt "brushed off." For example, the Sunset managers suggested that she might have fallen while trying to get out of bed on her own without calling for help. The family wondered if they had even reviewed their mother's chart or talked with any of the staff involved, since it was clear that she fell while being helped by a staff member.

On March 19, 2014, the family told the Client Representative about the meeting with Extendicare, including that Sunset's managers said they would send information to her for the family. They also reiterated their concerns with the emergency care and the double ambulance bill.

This same day, the RQHA's Executive Director of Continuing Care, Programming & Utilization emailed the Confidential Occurrence Report to the RQHA's Patient Safety Unit to alert that a possible critical incident occurred. Under *The Critical Incident Regulations,* a critical incident is any event that resulted in, or could have resulted in, serious harm to a patient. Under the Regulations in force at the time, Extendicare was required to review the incident and report to the RQHA, which in turn was to submit the report to the Ministry of Health.

On March 20, 2014, Sunset's Director of Care responded to the March 17, 2014 questions of the RQHA's Executive Director of Continuing Care, Programming & Utilization, indicating that Extendicare was "currently investigating" the fall and noted that "the concerns regarding the ER assessment…[are] in the hands of the Client Representative." On March 24, 2014, the RQHA's Patient Safety Unit emailed other RQHA staff, copying the Executive Director of Continuing Care, Programming & Utilization, asking whether the death was a possible critical incident.

On April 2, 2014, the family met with the Client Representative to pick up the information provided by Extendicare. On April 14, 2014, they contacted the Client Representative and expressed their disappointment in the information from Extendicare. Instead of receiving their mother's full chart, it was only a summary of her chart and TLR ratings. Extendicare did not give them the specific TLR details they expected, and some of the summary information was wrong. For example, the date of the fall was incorrect and Extendicare confused which leg had been cut and which had been broken. The family continued to believe their concerns were not being taken seriously. Sunset managers advised us during our investigation that, in the midst of all the requests for information they were receiving from multiple people within the RQHA, they misunderstood what they were being asked to provide and thought they were to provide the summary.

On April 23, 2014, the Client Representative contacted the RQHA's Privacy Officer to clarify what information the family could access and was advised that according to the law and RQHA policy, the family had a right to the full chart. The next day, on behalf of the family, the Client Representative asked Extendicare for a full copy of the chart. Sunset staff said it needed clarification from Extendicare leadership about what information could be provided. Extendicare believed it could not simply hand over the chart, and needed to also meet with the family to review the information with them so that their questions could be answered.

On May 2, 2014, in response to a suggestion from the Client Representative, the family wrote to the RQHA with concerns about their mother's care, including their disappointment with Extendicare's summary report, their inability to get full TLR information, their continued wait for her full chart, the double ambulance bill, and their overall frustration with trying to get information and meaningful answers. Concerned with whether the incident might be a critical incident (and therefore subject to confidentiality requirements in *The Regional Health Services Act*) the Client Representative asked the RQHA's Patient Safety Unit for advice as to whether she should change her typical concern-handling process.

On May 6, 2014, the Patient Safety Unit told the Client Representative that she should proceed normally, as they were still assessing whether the Patient Safety Unit would have a role. The Client Representative emailed the RQHA's Department Head of Emergency Medicine and an official responsible for ambulance services to share the family's concerns

with their services and to ask for their written responses. She also emailed Extendicare and the RQHA's Executive Director of Continuing Care, Programming & Utilization to advise of the family's complaint letter. She asked Extendicare for its written response to the concerns. In response, the Executive Director emailed the Client Representative asking whether the incident had been raised to the Patient Safety Unit as a critical incident and "What is being done to review the care that occurred in the ER, e.g: no X-rays, etc." The Client Representative advised the Executive Director that the Patient Safety Unit was assessing it.

On May 8, 2014, the Department Head of Emergency Medicine submitted a Level 4 Confidential Occurrence Report to the Patient Safety Unit with respect to her care in the ER. He indicated that Mrs. Sellwood was seen for the cut, readmitted for the fracture, discharged and then died. He did not include details about the cause of death or her injuries, but noted that the incident required review. The next day, he advised the Client Representative that he had reported the incident to the Patient Safety Unit.

On May 12, 2014, the Department Head of Emergency Medicine shared some of his clinical concerns (for example, the elevated lab levels preceding the fall) with the Patient Safety Unit and asked it to request a Coroner's review. The Patient Safety Unit advised him that a physician would normally report a death to the Coroner. They considered whether the Patient Safety Unit or the Coroner would be best to investigate and the Patient Safety Unit then asked the RQHA's Executive Director of Continuing Care, Programming & Utilization to get more information from Extendicare, including whether there was a written report from the care aide who was helping Mrs. Sellwood when she fell, her medication administration records from December 16-27, 2013, and any documentation indicating whether the swelling and redness to her legs reported on December 21, 2013 had been followed up.

The Executive Director faxed a memo (dated May 13, 2014) to Sunset's Director of Care, informing her that the Patient Safety Unit was assessing the event to determine whether it would meet the criteria for being reported as a critical incident, and asked for the additional information requested by the Patient Safety Unit. Later that day, Sunset's Director of Care replied to the Executive Director, informing her that the requested information had been sent to the Patient Safety Unit.

On May 14, 2014, the RQHA advised the family that it had waived the second ambulance bill. On May 22, 2014, the family picked up a letter from Extendicare, which expressed sympathy for the family's loss, and expressed regret "as to the unfortunate experience you and your family expressed that you had," and a copy of their mother's entire chart.

On May 27, 2014, five months after Mrs. Sellwood died, the RQHA deemed the incident at Sunset a critical incident and, therefore, notified the Ministry of Health. Two days later, the RQHA's Department Head of Emergency Medicine contacted the Coroner's office. We were told that this was the first time the Coroner was made aware of the death.

On June 11, 2014, the Patient Safety Unit met with the family and the Client Representative to explain the critical incident review process and hear the family's perspective. The family wanted to understand how the RQHA held Extendicare accountable for the care it provided, and how it made sure Extendicare met its standards and expectations. This same day, the Coroner concluded the death was "accidental" (not natural, suicide, homicide or

undetermined) and listed the Medical Cause of Death as "atherosclerotic cardiovascular disease with leg fracture a significant contributing factor." In the accompanying report, the Coroner called on "nursing home documentation" to describe some of Mrs. Sellwood's medical history, as well as the incidents in and around her fall, fracture and death. She concluded:

> In my opinion, after investigating I feel the decedent's health had been deteriorating slowing (sic) but the fall and fracturing of her fibula most likely hastened her death. The analgesics and decrease in her mobility would further add to her stress. I find that [she] died … of unnatural causes; atherosclerotic cardiovascular disease with a fractured left fibula a significant contributing factor. The manner of death is accidental.

Also on June 11, 2014, the Coroner's Office advised the RQHA that no recommendations were likely to result from its review. On June 17, 2014, the Coroner's Office gave the family a copy of its report.

On June 18, 2014, Extendicare sent the family an outstanding bill of $25.21 for supplies their mother used while she was a resident at Sunset.

On July 10, 2014, the family called the Client Representative for an update on the critical incident review. They wondered whether Extendicare's head office was aware of the incident at Sunset and what the RQHA was doing to hold it accountable for what happened. The Client Representative noted that the family appeared to be interpreting the Coroner's conclusion that the death was accidental "to mean that someone is at fault." She tried to correct this interpretation and encouraged the family to call the Coroner for help in understanding the report. In response to their question of whether Extendicare's head office was aware of the incident, the RQHA's Executive Director of Integrated Health Services redirected the Client Representative to contact Extendicare's Regional Director.

On July 16, 2014, Extendicare's Regional Director explained its organizational structure and incident reporting process to the Client Representative. She said she reviews all incident reports and then she and other western directors meet to review them, but head office does not. Head office gets performance summaries about, for example, the number of falls, how many residents have worsening bedsores, and other quality-of-care issue indicators. She also told the Client Representative that the family should disregard Extendicare's invoice for $25.21. However, as the printed invoice was already in process, the family did receive another bill for the outstanding $25.21 on July 23, 2014.

By August 6, 2014, the Patient Safety Unit was still waiting for a detailed internal quality review from Extendicare. The RQHA's Executive Director of Continuing Care, Programming & Utilization intervened to get Extendicare to provide the information the Patient Safety Unit wanted. The Executive Director contacted Sunset's Administrator to ask for its "internal quality review and actions taken to prevent the occurrence in the future" and sent the Administrator an Integrated Health Services/Occurrence Follow Up Report template to complete. In response, Sunset's Administrator submitted the follow-up report two days later, completing most of the sections of the report with "please refer to information previously sent" and indicated that, "At Sunset we completed a full review of this situation. We interviewed all of the parties involved."

On August 19, 2014, the Patient Safety Unit provided Extendicare and the RQHA's Executive Director of Continuing Care, Programming & Utilization with a draft critical incident report for comment. Extendicare replied on August 25, 2014. It was shared with the Ministry of Health and the RQHA's senior leadership on September 24, 2014.

On September 26, 2014, the RQHA and Extendicare met to prepare for a meeting with the family. We were told that because the critical incident review was the focus of the meeting with the family and because it had been focused on the events surrounding the fall in the home, not the care provided in the emergency room (that had been reviewed separately), no one from the ER or the ambulance service was invited.

On October 3, 2014, before the scheduled incident review meeting with the family, and as part of the RQHA concern-handling process being managed by the Client Representative, the Department Head of Emergency Medicine wrote the family to share the results of his review of Mrs. Sellwood's emergency care. He expressed his condolences to the family, his belief that the death required further review by the Coroner, and his understanding that, after such a review, the Coroner had changed her cause of death to accidental. (Our investigation has found no evidence that the Coroner changed his conclusions as to the cause of death. Instead, after being alerted to her death in late May, the Coroner reviewed the circumstances of her death and concluded it was accidental. This was not a change in conclusion but rather a first and only conclusion; later Coroner reports would be issued but they only altered minor details not the conclusion as to manner of death.) The Department Head of Emergency Medicine then explained in the letter the standard practices and decision paths a physician would follow when assessing a patient after a guided fall like this one and shared his conclusion that, based on his review of the ER charts, the ambulance records and the nursing home transfer information, he was confident that her emergency room care was appropriate. He proceeded to comment on how the accuracy of information shared can be a problem and can contribute to a misdiagnosis and that based on the information he had access to, he could not conclude whether the ER missed the break or that the break occurred after her first visit.

The family met with Extendicare and the RQHA on October 17, 2014. According to the minutes, Sunset's Administrator apologized to the family and Sunset's Director of Care verbally shared the results of her inquiries into the fall. She acknowledged that Extendicare erred by not reassessing their mother's TLR rating before she fell. The Administrator said Sunset's TLR assessment processes were being changed and its staff were told to ensure they update TLR ratings.

Although the family had previously told the Client Representative that they had no further questions about the ER care, doubts arose again in this meeting and the family again asked how her broken leg could be missed at the ER. They wanted to know if processes could be changed so an elderly person would be assessed more thoroughly after a fall. They also questioned the Coroner's role in reviewing deaths. Neither Extendicare nor the RQHA representatives in attendance could answer these questions and they had not invited representatives from emergency services. The Client Representative offered to arrange a meeting with the Department Head of Emergency Medicine and the family was advised to contact the Office of the Chief Coroner directly with questions about its investigation and report, as RQHA could not answer questions or comment on that independent process. The

RQHA gave the family a summary of its review. The summary included corrective actions for Extendicare – that it educate its front line staff at Sunset about appropriate indicators and processes for changing TLR ratings and that it develop standards to ensure Sunset's supervisory staff are aware of potential changes to residents' TLR ratings and that the changes be made in a timely fashion.

Some officials who were at the meeting told us, in hindsight, they were disappointed that representatives from the hospital's emergency services had not been invited to attend the meeting in order to answer the family's questions. To them, the meeting felt unbalanced, and to them the critical incident review and concern-handling process were incomplete and disjointed. Several staff described the meeting as very emotional, with the family pushing for answers. Despite this, the family told us they were pleased that Extendicare had finally acknowledged its part in the incident and accepted its role in not updating their mother's TLR rating.

On October 22, 2014, the Coroner's Office resent its June 11, 2014 report to the family.

On November 21, 2014, the family arranged to pick up a draft copy of minutes from the October 17th meeting, but the RQHA's Executive Director of Continuing Care, Programming & Utilization, had not approved them yet. The family insisted on getting the draft minutes and told the Client Representative that they may be taking their concerns to the politicians.

On November 26, 2014, the family was in the Legislature while the Leader of the Opposition questioned the Premier and the Minister of Health about the Ministry's handling of their mother's care and its response to her fall and death.

This same day, the Coroner's office sent another copy of their report to the family. The report had been changed as the assistant Coroner made adjustments to some details (e.g. dates), but the conclusions remain unchanged from the original June 11, 2014 report.

As arranged by the Client Representative (after the October 17, 2014 meeting), the family met with the Department Head of Emergency Medicine on December 12, 2014.

After further meetings between the family, the RQHA and the Ministry, on December 24, 2014, the Minister of Health requested that the Ombudsman review the case.

Issues Raised by this Complaint

1. Did the care provided to Mrs. Sellwood at Sunset meet Ministry, RQHA and Extendicare standards?

2. Did Extendicare and the RQHA address and investigate Mrs. Sellwood's death reasonably and in accordance with established rules and policies?

3. Did Extendicare and the RQHA respond to and address the family's concerns reasonably and in accordance with relevant policies and procedures?

Findings

Issue 1: Did the care provided to Mrs. Sellwood at Sunset meet Ministry, RQHA and Extendicare standards?

Ministry Standards

The *Program Guidelines for Special-care Homes* made under the authority of *The Facility Designation Regulations* set out the minimum standards for long-term care homes. Under the *Guidelines*, "the day-to-day delivery of programs and services, including facility based care…is the responsibility of the regional health authorities."

At the time of Mrs. Sellwood's fall, Standard 15.2 of the *Guidelines – Falls Prevention* required all homes to implement and maintain a falls prevention program to reduce the number and severity of falls, which had to include "a commitment to review all falls regardless of injury."

RQHA Policies

The RQHA's LTC Facility Falls Prevention and Injury Reduction Program dated February 14, 2011, requires each long-term care home to complete:

- a "Falls Matrix" for each resident on admission. Strategies to reduce the identified risks must be written into the resident's care plan. Clinical information needs to be regularly reviewed and changes made to the matrix as needed. The fall reduction strategies must be communicated to the entire team, implemented, evaluated and revised as necessary.
- a "Post Fall Huddle Meeting Document" as soon as possible after a fall. On-duty staff must attend the huddle. Any changes to fall prevention strategies must be made in the care plan and communicated to the team. This form is to be attached to the Confidential Occurrence Report and sent to the manager after the initial investigation and follow up.
- a "Falls Alert" to be posted in the room of any resident who falls. The Falls Matrix and a Falls Minimization Planning Document must be completed and placed on the resident's chart. A head-to-toe nursing assessment must be completed before the resident is moved.

Extendicare (Canada) Inc.'s Policies

Extendicare's Fall Prevention and Management Committee Policy (OPER 02-05-09) was applicable to all its long-term care homes in Canada at the time of Mrs. Sellwood's fall. It required Sunset to establish a committee to govern its required fall prevention and management program that was to meet at least quarterly to review performance on fall indicators and the status of any improvement initiatives.

Sunset's Resident Care: Falls (RESI 09-02-01*)* policy has 19 procedures that, among other things, prescribe immediate post-fall assessments, 24-hour monitoring, physician and family

notifications, and completion of incident and post-fall analysis reports. It also requires staff to:

- assess each resident's risk of falling, using a standardized assessment tool.
- use a multidisciplinary approach to minimize the risk of falling, including assessing at-risk residents' vitals, blood sugars, 6-month history of falls, gait and balance, pain, cognition, visual and spatial abilities, continence, and medications.
- discourage residents from having trip/fall hazards (cords and rugs) in their rooms.
- establish a committee to oversee the Fall Prevention and Management Program, analyze fall data, make recommendations for training, and report annually on falls.

Sunset's Resident Care: Post Fall Analysis (RESI 09-02-02) policy requires staff to do a post-fall analysis for each resident who falls and integrate the information into the resident's care plan. The analysis is to be done by an interdisciplinary team within 48 hours of the fall and the completed form is then to be sent to the Fall Prevention and Management Committee for review.

Analysis

In this case, Sunset staff did consider Mrs. Sellwood's fall risk when she was admitted and incorporated it into her care plan. However, it is not clear that Sunset properly reassessed her risk of falling in light of later events – for example, after her difficult transfer on December 20, 2013, or after her critically high potassium results on December 23, 2013. Staff only reassessed her fall risk after she returned from the ER the second time with a diagnosed fracture.

The RQHA's policies provide direction to facilities within the health region about what is expected of them in order to be in compliance with the Ministry's standards. However, in this case, we found no evidence that the RQHA took any steps to ensure Extendicare was following the policies at Sunset. There is also no evidence that it monitored or enforced them. In our view, it is important for the RQHA to ensure that its policies and directions for all facilities providing health services on their behalf are widely understood by RQHA officials and long-term care homes, and are properly and consistently followed.

As for Extendicare's policies, at the time of Mrs. Sellwood's fall, Sunset management and staff did not follow all the required steps of Extendicare's fall prevention policies (such as updating her fall risk and providing details of the fall to the Falls and Restraints Committee for review). As well, Extendicare did not provide any indication to us that they knew its Sunset facility was not in compliance with corporate-wide policies on fall prevention. Further, despite it being an RQHA requirement, Extendicare did not have specific processes in place at Sunset for ensuring that fall risk information was updated and communicated to its staff at the time of her fall.

We acknowledge that since this incident, Sunset staff has taken steps towards meeting Extendicare's and the RQHA's policy requirements. It has now established a Fall Prevention and Management Committee. It now has its "Falling Stars" program in place to alert staff to

residents who fall, as well as its "fall package" – a bundle of all the protocols and forms that staff must follow and complete after a resident falls.

When Extendicare reviewed Mrs. Sellwood's fall (after the RQHA deemed it a critical incident), it identified shortcomings in its TLR practices and advised us that it made several changes to correct them. For example, we have been advised that staff must now have TLR certification before starting work, track current TLR certifications in a database, complete resident care audits to ensure TLR requirements are being followed, and immediately bring violations to the attention of the Director of Care and the Administrator. Further, only nurses can do TLR assessments (care aides can no longer informally change a TLR), all residents will be assessed within 24 hours of admission, and regularly reassessed on a quarterly schedule, regardless of any changes in their status or health. All TLR changes are discussed at shift report for the following two weeks and documented on the census, which is checked daily by the Director or Assistant Director of Care. The quarterly reassessment schedule is monitored by the Resident Care Coordinator nurse and audited by the Director of Care.

These changes, if followed consistently, should help ensure that what happened to this resident will not happen to anyone else. However, these measures were not put forward until after this family came forward with their concerns, even though the RQHA's and Extendicare's fall protocols and policies in place at the time already required these measures to be in place as part of a routine staff review of a fall.

In summary, we find that although Extendicare had policies in place to meet the standards set out in 15.2 of the *Guidelines* at the time of this resident's fall, Sunset did not follow all of them. We also find that although the RQHA had set policy direction on what was expected of all of its long-term care facilities in order to meet standard 15.2 of the *Guidelines,* it did not take any steps to ensure that the Sunset facility was meeting the standards.

Therefore, we find that the care provided to Mrs. Sellwood at Sunset did not fully meet the Ministry's standards, the RQHA's policies nor Extendicare's own standards.

Issue 2: Did Extendicare and the RQHA address and investigate Mrs. Sellwood's death reasonably and in accordance with established rules and policies?

Provincial Legislation

The purpose of *The Vital Statistics Act, 2009* is to ensure events such as births and deaths are properly recorded. It requires an adult who was present or with knowledge of the personal particulars of a death to complete a statement of death. It also requires a medical certificate of death to be completed by a physician.

The Coroners Act, 1999 requires a person to "immediately notify a coroner or a peace officer of any death that the person knows or has reason to believe…occurred as a result of an accident;… from a cause other than disease or sickness;… as a result of negligence… or malpractice;… [or] suddenly and unexpectedly when the deceased appeared to be in good health." If a person's death meets any of these criteria, the body cannot be moved until the Coroner directs it.

The Critical Incident Regulations in force at the time of Mrs. Sellwood's death had two separate investigation processes, depending on whether the incident occurred at a facility run by a regional health authority, or at a facility run by contracted health care organizations like Extendicare. Section 5 required health care organizations to notify the regional health authority of any critical incident that occurred in its facility within three business days or as soon as possible after becoming aware of the critical incident. Once the regional health authority was notified, it was required to notify the Ministry of Health within three business days. Section 9 required health care organizations to investigate and prepare a report for each critical incident occurring in their facilities. The report was to include:

> (a) a description of the circumstances leading up to and culminating in the critical incident;
>
> (b) a statement identifying any current practice, procedure or factor involved in the provision of the health service or the operation of the program that:
>
> > (i) contributed to the occurrence of the critical incident; and
> >
> > (ii) if corrected or modified, may prevent the occurrence of a similar critical incident in the future;
>
> (c) a description of the actions taken and the actions intended to be taken by the health care organization as a result of the investigation; and
>
> (d) any recommendations arising from the investigation.

If the health care organization could not submit this report to the regional health authority within 60 days of being aware of the incident, it was required to notify the authority. In any event, the report was to be completed within 180 days of the health care organization being aware of the incident.

Ministry Standards

Under the *Saskatchewan Critical Incident Reporting Guideline, 2004*, a critical incident is a serious adverse health event, such as an actual or potential loss of life, limb or function

related to a health service provided by a health care facility or a special-care home. Among the events it lists as critical incidents, the following seem applicable to Mrs. Sellwood's fall and death:

> Error in diagnosis, where the treatment provided or not provided leads to patient death or serious disability….
>
> Patient death associated with a fall while being cared for by an RHA or HCO

In the Guidelines, the phrase "associated with" means:

> …that it is reasonable to initially assume that the critical incident was due to the referenced course of care; further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, but should not delay notification to Saskatchewan Health.

Under its *Program Guidelines for Special-care Homes*, Standard 15.1 – Death of a Resident requires all homes to ensure a consistent procedure is followed in the event of a resident's death. The standard confirms that there is no legal requirement for a death to be pronounced by a physician (the act of assessing and then expressing the opinion that a person has died), but that there is a legal requirement for a death to be certified by a physician or by a Coroner (completing a Medical Certificate of Death for use in registering the death with Vital Statistics). The *Guidelines* require the home's policy to identify who is responsible for pronouncing the death, notifying the physician responsible for certifying the death, notifying the family, and ensuring all documentation is completed. The *Guidelines* also state that, if the death is one that falls under *The Coroners Act, 1999,* the body is not to be moved without the Coroner's authorization.

Ministry Standard 17.1 – Incident Review Investigation and Reporting requires all incidents that affect or have the potential to affect the health and safety of a resident to be reviewed to prevent any reoccurrence. Special-care homes (also known as long-term-care homes) must have a process "for the review, investigation and reporting of incidents" that meet "the threshold for a critical incident as per *Saskatchewan Critical Incident Reporting Guideline, 2004*.

RQHA Policies

The RQHA advised us that it does not have policies providing further direction to health care organizations on how to handle resident deaths. However, its Affiliation Agreement with Extendicare requires Sunset to follow all applicable legislation and regulations.

The RQHA does have a Risk Management Critical Incident Procedure dated February, 5, 2013. During its review of Mrs. Sellwood's fall and death, it also approved a Critical Incident Procedure: Confirmation of Actual & Potential Critical Incidents, dated June 23, 2014, which describes in detail the tasks that the RQHA's Patient Safety Unit must take when completing a critical incident review, which would include the death of a resident after a fall.

Extendicare Policies

Extendicare's nursing policy, Pronouncing Resident Death (NURS 02-03-07) states that a nurse may pronounce a resident's death only when the resident had been diagnosed terminally ill by a physician, the care team (including the physician) and the family agrees, and, among other things, the resident's advance care directive includes a do-not-resuscitate order. Otherwise, the attending physician must pronounce the death. The physician must notify the Coroner of the death in required cases. This policy refers to the Standards of Practice of the College of Nurses of Ontario. When we asked about this and the application of this policy to its facilities in Saskatchewan, Extendicare's Regional Manager told us:

> Saskatchewan does not have as tight guidelines as Ontario with the death protocols… The policies, as you noted, are Ontario based. Attached is the [Palliative Care and Death] policy we have in place in Saskatchewan and that Sunset uses… In Regina, if there were to be an "unexpected" death – bearing in mind the age and health condition of a resident - the physician and family would be notified. It would be determined at that time if the coroner should be contacted. In the event the police are involved (e.g. suicide, resident beat another resident. etc.) then the coroner would definitely be contacted … Sunset is in the process of contacting the coroner's office for additional information as to their expectations of when they would be notified to a death in a long term care facility.

We understood this to mean that the Regional Manager believed Extendicare's nursing policy (NURS 02-03-07) did not apply in Saskatchewan, but that its Palliative Care and Death (RESI 04-04-02) policy did. This policy states that "…legal requirements according to province, determine the approach to care of the body after death." Specifically, it states that Sunset's registered nurses are to record "…the time when respirations ceased and when death pronounced, if RN pronouncement implemented. See *Nursing Administration Manual,* Pronouncing Resident Death (NURS 02-03-07)." To us, this indicates that Extendicare expected nursing policy (NURS 02-03-07) to govern the circumstances under which a nurse could pronounce a death in Saskatchewan.

According to the *Critical Incident Reporting Guideline, 2004*, a critical incident report is to be completed if a patient death is associated with a fall that occurred while the patient was being cared for by a regional health authority or a health care organization. Although Extendicare did not provide us with any incident review protocols of its own, Sunset care staff, including the nurse who initially responded to the fall, recognized that the nurse needed to complete a Confidential Occurrence Report for the Resident Care Coordinator's approval who then had to submit it to the Director of Care. According to RQHA and Extendicare representatives, if it was a level 3 or 4 incident, the Director of Care was to submit it to Extendicare's Regional Director and to the RQHA's Executive Director, Continuing Care, Programming & Utilization. This Executive Director would review the information and, if it appeared a possible critical incident, would forward the information to the Patient Safety Unit for their determination and then alert the facility that this determination is pending.

Analysis

Pronouncing the Death and Notifying the Coroner

Mrs. Sellwood's death was unexpected – several staff told us they were surprised to hear that she had died. She was elderly, increasingly frail and had just had a serious fall with a fracture and cut, but she was not palliative. She had been out in the community with family a few days before her fall. Therefore, while most of Extendicare's Palliative Care and Death (RESI 04-04-02) policy did not apply to her, the provisions on how to deal with a body after death were applicable. Also, since Extendicare's *Nursing Administration Manual,* Pronouncing Resident Death (NURS 02-03-07) was specifically referred to in the relevant provisions of its Palliative Care and Death (RESI 04-04-02) policy, it was also applicable to her death. This is in keeping with the Ministry standard, which allows facilities to determine who can pronounce deaths in the facility.

Sunset's Director of Care (a nurse) pronounced her death, but according to Extendicare's Pronouncing Resident Death (NURS 02-03-07) policy a nurse can only pronounce death when a resident is terminally ill, the family agrees, and there is an advanced care directive which includes a do-not-resuscitate order. None of these factors were present in this case. Therefore, according to its own policies, a physician was required to pronounce the death.

It further appears that neither the physician who certified the death nor Sunset's Administrator considered whether these policies were to be followed. Nor did the Director of Care complete the required Confidential Occurrence Report for a resident death so soon after a fall; instead, she simply added a handwritten note to the top of the Confidential Occurrence Report form that had been prepared by the nurse shortly after the fall.

As well, the physician who completed the Medical Certificate of Death coded it as accidental (not natural, suicide, homicide, or undetermined). *The Coroners Act, 1999* states that the Coroner shall be immediately notified if it is believed that the death occurred as a result of an accident. When we asked, Sunset staff seemed uncertain about when the Coroner should be called, suggesting that the Coroner would be required only for an unexpected or suspicious death. Despite being surprised that she had died, no one at Sunset, including the physician, appears to have considered that her unexpected death, which was certified to have occurred due to an accident, required the Coroner to be notified. It was not until five months later that the Coroner was contacted about the death, and then, it was the RQHA who contacted the Coroner, not Extendicare.

Therefore, we find that Extendicare neither followed its own policies for pronouncing the death of a resident, nor notified the Coroner of the death as it was required to do by legislation. We understand that Sunset staff are now working with the Coroner to clarify when the Coroner must be notified of a resident's death.

Incident Review

The nurse who responded to Mrs. Sellwood's fall prepared a Confidential Occurrence Report (a pre-printed one-page form) almost immediately after she fell and before her leg fracture was diagnosed. This form was not, however, updated after learning that her leg was broken

as a result of the fall. After her death, the Director of Care did not complete another Confidential Occurrence Report to indicate a death shortly after a fall. Instead, she simply added a handwritten note to the top of the previous Confidential Occurrence Report form, noting that Mrs. Sellwood had died; she did not include information about the fractured leg, indicate that it had been missed on an earlier assessment at the ER, or indicate whether the death had occurred in the home or at the hospital.

The Director of Care also did not address whether this resident's death was possibly related to her fall, which would have then required reporting and review as a critical incident. However, the Medical Certificate of Death completed by the physician, stated that the leg injuries from the fall were among the immediate causes of death. As well, the Coroner would later conclude that her broken leg was a significant contributing factor leading to her death, noting that the analgesics and her decrease in mobility added to her stress.

According to a February 7, 2005 memorandum, "Critical Incidents in Health Care," sent from an RQHA Executive Director to all long-term care facilities in the region, Extendicare was to have submitted the Confidential Occurrence Report to the RQHA within three working days of the incident. In this case, Extendicare could not say whether it did this, it could only say that its practice was to submit these on time. The earliest documented indication that the RQHA was aware of the Confidential Occurrence Report was a March 17, 2014 memo from the RQHA's Executive Director of Continuing Care, Programming & Utilization to Sunset's Director of Care asking questions of the report. The RQHA acknowledged that that the report may have been submitted much earlier, but it did not have a record to indicate the date it was received. Given this, we cannot determine whether Extendicare submitted the report within the three-day deadline. We find, however, that neither the RQHA nor Extendicare followed up on the report until the middle of March 2014 – more than two and half months after Mrs. Sellwood's fall and death.

Because this death was associated with a fall while being cared for at Sunset, it was required to be reported by the RQHA to the Ministry of Health. Under *The Critical Incident Regulations* in force at the time*,* Extendicare was then required to investigate the fall and death and submit a written report to the RQHA. If Extendicare could not submit this report to the RQHA within 60 days after it became aware of the incident, it was required to advise the RQHA, who must then advise the Ministry. In no event is a critical incident investigation report to take longer than 180 days. Neither the RQHA nor Extendicare appear to have been aware that this requirement had not been met until July 17, 2014 – 202 days after Mrs. Sellwood's death – when the Patient Safety Unit asked an RQHA Executive Director to ask Extendicare whether it had done an internal investigation. In response, it submitted a two-page Integrated Health Services/Occurrence Follow Up Report on August 8, 2014 – 224 days after she died, telling the RQHA that it had "completed a full review," including interviewing "all of the parties involved."

Sunset's Director of Care told us in preparing this report for the RQHA, however, that she only had casual follow-up conversations with staff. She could neither tell us the names of the staff that she had spoken to, nor had she written down her questions or their answers. The care aide who had been working with Mrs. Sellwood at the time of her fall could not recall anyone ever having spoken to her about the incident until we interviewed her. The casual nature of Extendicare's review is also reflected in the Integrated Health

Services/Occurrence Follow Up Report it submitted to the RQHA. This report was two pages long, and under each of its section headings entitled, "Background Information," "Occurrence Details/Sequence of Events," "Potential Contributing Factors," "Incidental Findings," and "Involvement of Family/Supporter in Review of the Incident," it only stated "Please refer to information previously sent." We acknowledge that Extendicare was, by this time, concerned with the RQHA's repeated, seemingly uncoordinated requests for what they believed to be the same information that had already been provided the RQHA.

Extendicare reviewed Mrs. Sellwood's chart after she died, and sent the review to the RQHA along with her full chart in May 2014, but it is not clear from the information that Extendicare and the RQHA provided us that it did a full investigation into its role in her fall and death. While the follow-up report indicates its plans to improve its TLR rating assessment processes, Extendicare does not address any other issues, such as its failure to follow its death pronouncement policies, notify the Coroner, or make sure a Confidential Occurrence Report was properly completed and submitted on time.

The critical incident review process the RQHA was to follow is well-documented in its policies. Since we have no authority under our legislation to review the details of the RQHA's critical incident review, we can only make a few limited observations about it and then only about the process. Once the RQHA's Patient Safety Unit was cognizant of the incident – by mid-March 2014 – it appears to have gathered what information was available from Sunset and asked the appropriate officials responsible for emergency services about Mrs. Sellwood's emergency care.

In reviewing her death after the fall, generally, the RQHA seems to have focused mostly on Extendicare's role and less on emergency services' role, even though ER staff did not diagnose her broken leg during her first assessment. Some officials at the RQHA and Sunset told us this signalled to them that the review was too narrowly focused and a broader review that considered the connected work of all three sites (Sunset, the ambulance, and the ER) would have been more useful. When questioned by the family about the quality of care provided by the ER, the ER suggested that Mrs. Sellwood might have broken her leg after her first visit to the ER. However, the ER did not X-ray her leg on her first trip, and there is no evidence of her suffering a second incident while in the care of the ambulance service or Sunset. Also, the RQHA waived the second ambulance bill. While this may have only been a gesture, the fee was waived when the family argued that the second trip was unnecessary because the ER failed to diagnose her fractured leg the first time. Given these circumstances, the RQHA may have missed an opportunity to consider whether improvements could have been made to the ER's processes.

We noticed several issues with the entire review process of this case and various reviews conducted by the RQHA, and Extendicare:

- Extendicare did not actively participate in the incident review: it did not initiate its own internal quality review until asked by the RQHA and it only reacted to requests for information from the RQHA, which led to issues with the timeliness, quantity and quality of the information submitted.

- Some of the staff involved were confused about who was responsible for various aspects of the review process, particularly because the incident occurred at Sunset, which is not an RQHA-run facility.
- The Patient Safety Unit directed its requests for information from Sunset through the Executive Director of Continuing Care, Programming & Utilization because Sunset is not an RQHA-run facility.
- There was some confusion about which forms Extendicare needed to complete so the RQHA could prepare its standard report for the Ministry.
- Some RQHA and Extendicare staff felt the review was not properly focused, as it appeared to them to only consider Sunset's work and not that of emergency services. Other RQHA staff disagreed and said that these services were reviewed, but separately. However, they did agree that the process may have been more effective if representatives from all care sites had been brought together to review the entire incident as a whole, resulting in a more comprehensive review and identification of improvement opportunities.
- The RQHA relied on Extendicare's internal investigation, which was informal and likely incomplete. For its part, Extendicare seems to have over-represented the quality of its investigation.
- At the time of our interview, Extendicare's Vice President of Western Operations told us he was still waiting for the results and recommendations of the critical incident review to be shared with him.
- Throughout the multiple processes all underway at one time (Sunset review, RQHA concern handling process, RQHA Critical Incident review process), there were multiple information requests from different people at various times and this created confusion for many people as to exactly who was reviewing what and who was responsible for sharing what information with whom. As a result, the family endured a lengthy, disjointed, and unsatisfying review process.

Overall, the RQHA appears to have drafted its critical incident report and submitted it to the Ministry of Health in a reasonably timely fashion once it got started, but it is not clear that it considered whether improvements could be made to its process to ensure that critical incidents are reviewed in a timely manner and in accordance with its established rules. More broadly, these issues suggest that neither Extendicare nor the RQHA approached the review with the sense of accountability that might reasonably be expected in the circumstances.

While the Ministry, RQHA and Extendicare together have clear quality-of-care objectives articulated in their collective incident review and related policies, the RQHA and Extendicare do not appear to have monitored and overseen the process in this case in a way that demonstrates a full commitment to following established processes and being accountable for achieving those objectives.

We acknowledge that some of the RQHA's lack of oversight over the Sunset facility appears to be grounded in a broadly held belief that the RQHA has only limited authority over Extendicare's facilities, because it provides long-term care under contract, and is not directly

run by the RQHA. However, this case and others like it that have received public attention, demonstrate that residents, families and the public expect the RQHA (and the Ministry of Health) to be fully accountable for all publicly-funded health facilities into which they place elderly and vulnerable residents, whether they are RQHA-run, or run under contract by profit or not-for-profit corporations.

Subsection 7(1) of *The Critical Incident Regulations, 2016*, which became effective on February 25, 2016, requires heath care organizations such as Extendicare to investigate critical incidents in their facilities in collaboration with the regional health authority. In our view, this change provides the basis for the RQHA and Extendicare to develop processes to streamline the routing of information during the process and to improve the quality of the reviews, by ensuring all reviews follow a consistent approach and the RQHA's expertise will be available to support the reviews completed by Extendicare and other health care organizations in the region.

For Extendicare's part, its management team does not appear to have established clear expectations or taken steps to effectively monitor, evaluate and follow up on its local staff's development and implementation of clear, locally-relevant policies and procedures for dealing with resident deaths and incident reviews that meet its corporate-wide standards as well as the Ministry and RQHA standards it is contractually required to meet.

Focusing only on the administrative aspects of their review processes, we find that neither Extendicare nor the RQHA fully addressed and investigated Mrs. Sellwood's fall and death in a reasonable timeframe or in full accordance with established legislation, regulations and policies.

To be effective, policies and procedures have to be relevant, widely-understood and followed. Their implementation must also be monitored, managed and evaluated.

Issue 3: Did Extendicare and the RQHA respond to and address the family's concerns reasonably and in accordance with relevant policies and procedures?

Ministry Policies

The Ministry's Standard 12.2 – *Resident Information Handbook*, requires each special-care home to include its concern-handling process in its Resident Information Handbook, an information package provided to all residents when they move into the home. Standard 17.3 – *Quality of Care Concerns* requires homes to establish and follow a process to address resident and family concerns related to care.

RQHA Policies

The RQHA's Patient Advocate Services (PAS) division (formerly the Client Representative Office) employs Patient Advocates (formerly Client Representatives) to receive and resolve complaints. Residents, patients and their families may raise their concerns with a Patient Advocate (or with other staff or managers, who may try to resolve them or forward them to the appropriate area, including PAS, to resolve).

The RQHA's Management of Client/Patient Concerns Policy (Ref No. 801) requires all its staff and service providers to follow its procedures to ensure concerns are coordinated and handled consistently. Though it does not specifically state that it is intended to apply to contracted health care organizations such as Extendicare, the RQHA's Client Representative Office did help the family get answers from the RQHA and Extendicare.

Under its policy entitled, Management of Patients/Residents/Clients/Family Concerns (Ref. No. 801-1), Patient Advocates must acknowledge and respond to complaints within specific timeframes. As well, there are detailed procedures for investigating and tracking concerns. For example, concerns about a physician's care must be made in writing. Clause 4.3.6 of these procedures requires Patient Advocates to become involved to ensure that all concerns about multiple areas (such as this family's concerns about Sunset, the ER and the ambulance bills) "are received and that the person initiating the concerns receives one coordinated response."

Extendicare Policies

In a previous investigation, we reviewed Extendicare's complaint handling policy: Complaints (09-04-06). We found that although it established reasonable objectives, timelines and procedures, Sunset's staff and management were generally unaware of it, and the policy did not comply with some of the Ministry's and the RQHA's requirements. For example, it did not address the role of the RQHA's Patient Advocates. As a result, we recommended that Extendicare update the policy to incorporate all provincial and RQHA requirements, and ensure that all staff in its Saskatchewan facilities have been educated on the policy and its procedures. Extendicare accepted this recommendation, and made the changes. However, these changes had not yet been put in place when Mrs. Sellwood's family was raising their concerns about her care.

Under Extendicare's Collection, Use and Disclosure of Health Information (03-04-03) policy, a deceased resident's health information may be disclosed to close family members as long as the disclosure is not against the resident's expressed wishes. A description of what was disclosed when and to whom, and why the disclosure was being sought must be recorded. This policy aligns with the RQHA's Disclosure Policy and *The Health Information Protection Act*.

Analysis

The RQHA and Extendicare did not effectively work together to coordinate an effective response to the concerns raised by this family. For example, when the family first contacted the office, the Client Representative (now called a Patient Advocate) recorded all of their concerns, but initially, in accordance with the family's wishes, only focused on getting the family access to Sunset's records. While this was respectful and helpful, the result was that the RQHA did not start addressing the family's broader issues until after it received the family's written complaint on May 5, 2014. Similarly, when the Patient Safety Unit was alerted to the fall and death and then needed information from Extendicare, it made its requests through the Region's Executive Director of Continuing Care, Programming and Utilization, who then relayed the request to Extendicare who then provided it to the same

Executive Director at the RQHA to relay it back to the Patient Safety Unit. To us, this seems to have been a cumbersome process and not conducive to ensuring the investigation was timely.

When the Department Head of Emergency Medicine was reviewing the emergency care provided to Mrs. Sellwood, he did not have access to all the information about her and her care at Sunset prior to her fall (for example, all of her elevated lab levels and the resulting changes to her medication). Similarly, Extendicare knew very little about what happened while Mrs. Sellwood was being transported to, or cared for in the ER, so when later meeting with the family, Sunset's staff could not adequately answer all of the family's questions about their mother's care along the continuum of care.

Because there was no coordinated and concerted effort by Extendicare and the RQHA to respond to all of the families concerns, the various responses the family eventually received (for example about accessing her chart, specific details about the care provided at Sunset and the ER, the legitimacy of two ambulance bills, Extendicare's accountability to the RQHA and whether Extendicare's national leaders were aware or accountable for the care its Sunset facility had provided), were all delivered in separate, disjointed and ineffectual ways.

In our view, it would have been reasonable to expect all the relevant staff of the RQHA and Sunset to have come together to consider both Extendicare's and the ER's role in handling Mrs. Sellwood's treatment and then provide the family with a single, coordinated response that fully explained what happened. A coordinated response would have better served the family and the various service providers, answering the family's questions at one time and not permitting an unintentional pitting of one team against another. It would have also better served the RQHA and Extendicare, enabling them to more fully consider where they needed to improve processes across the system and not simply in one or each of their isolated parts of it.

For Extendicare's part, it does not appear to have followed its Collection, Use and Disclosure of Health Information (03-04-03) policy. Instead, Sunset's Administrator first sought direction from the Extendicare Regional Manager and then imposed a more onerous process on the family – requiring her substitute decision-maker to complete a form and make an appointment to meet with the Administrator and the Director of Care to review the chart. This process also added to the family's frustration and sense that Extendicare was not being forthcoming. It also added significantly to the delay in responding to their requests for information.

Furthermore, Extendicare's billing reminder for fees that had already been waived by the Regional Director led the family to believe that no official other than Sunset staff were engaged in answering their concerns. This added to their sense that no one was held accountable for what was happening locally.

When the family asked how Extendicare's regional and national organization ensured its accountability for the services provided at Sunset, and also how the RQHA ensured Extendicare's accountability for the services, the RQHA response was not helpful to the family and could suggest that it takes little responsibility for Extendicare's performance. Rather than reaching out to the family, the Executive Director referred the Client

Representative working with the family to the Extendicare's Regional Director. Then, the Regional Director relayed general information to the Client Representative. She was not asked nor did she offer to speak to the family, leaving it to the Client Representative to relay the information back and try to answer the family's questions.

Despite all the time and effort of the RQHA and Extendicare staff trying to respond to the family, as a result of the uncoordinated, and, in some aspects, incomplete response to their concerns, we find that the family did not get timely or meaningful answers. We find that neither Extendicare nor the RQHA responded to nor addressed the family's concerns reasonably or in accordance with relevant policies and procedures.

Conclusion 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 ER care.
- 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 Extendicare's 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

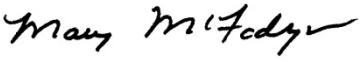
Senior officials with Regina Qu'Appelle Regional Health Authority and Extendicare (Canada) Inc. provide the family with an apology, and an explanation of the changes they have made or will make as a result of this case to improve resident care, incident reviews, and processes for responding to concerns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

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.

Dated this 23rd day of September, 2016



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