



Taking Care

An Ombudsman investigation into the care provided to Margaret Warholm while a resident of the Santa Maria Senior Citizens Home

May 2015

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**Ombudsman
Saskatchewan**

Promoting Fairness

May 2015

The Honourable Dan D'Autremont
Speaker of the Legislative Assembly
Province of Saskatchewan
Room 129 Legislative Building
2405 Legislative Drive
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Dear Mr. Speaker:

In accordance with section 38 of *The Ombudsman Act, 2012*, it is my honour and privilege to submit to you a report titled *Taking Care: An Ombudsman investigation into the care provided to Margaret Warholm while a resident of the Santa Maria Senior Citizens Home*.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Mary McFadyen", written over a light grey rectangular background.

Mary McFadyen
OMBUDSMAN

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INTRODUCTION

THE MINISTER'S REQUEST FOR AN INVESTIGATION

On November 20, 2014, the Minister of Health wrote the Ombudsman to request an investigation into the care being provided at the Santa Maria Senior Citizens Home (Santa Maria) in the Regina Qu'Appelle Health Region (Region). Specifically, the Minister asked us to investigate the circumstances surrounding the care of Margaret Warholm, whose children had questioned the adequacy of the care she received while a resident of Santa Maria. We accepted the Minister's request and, on November 27, 2014, notified Santa Maria, the Region and the Ministry of Health (Ministry) of our intention to conduct an independent investigation.

When we investigate what happened to one person, our role is to also look for ways to prevent others from encountering the same problems. In this case, our goal was to see if there were system-wide factors that affected Margaret's care.

Anonymous Examples

Throughout the report, we have used boxes like this one to highlight examples of other families who shared concerns with us about the quality of care their loved ones were receiving in long-term care facilities throughout the province. We have used fictitious names to protect their privacy.

The public's response to Margaret's case has been significant. Between November 20, 2014 and April 30, 2015, we received 89 new complaints about the quality of long-term care from all over the province. Some of the issues others brought forward are very similar to the concerns Margaret's family raised. We have highlighted examples of some of these cases throughout this report. Others contacted us about important issues that fell outside the scope of this

investigation, such as long-term care admission and placement processes, and the prices charged for non-prescription drugs in long-term care homes. While we could not address all these issues in this report, we intend to address many of them in separate investigations. We thank all the families who have contacted us and shared their concerns. We want to acknowledge Margaret's family's openness and frankness in publicly sharing their private story. We hope that they find some solace in the fact that by sharing their concerns, they have contributed to a much-needed public conversation about what we want and expect from our long-term care system in Saskatchewan.

OUR ROLE

The Ombudsman is an officer of the Legislative Assembly of Saskatchewan. Ombudsman Saskatchewan receives, informally resolves, and investigates approximately 2,500 complaints each year from citizens concerned about their treatment by provincial government institutions – including ministries,

Crown corporations, most provincial agencies, boards and commissions, and publicly-funded health entities. In the health sector, we have jurisdiction over the Ministry of Health, regional health authorities, the Saskatchewan Cancer Agency, eHealth, 38 “affiliates” as defined in *The Regional Health Services Act*, and 69 other health care organizations listed in *The Regional Health Services Administration Regulations*.

We are not advocates for citizens who bring complaints to our office, or for the government. We are neutral, impartial and independent from the government institutions we oversee. If we determine that an administrative decision, action or omission was unreasonable, unjust, oppressive, improperly discriminatory, unlawful, based on a mistake of law or fact, or just plain wrong, we can make recommendations to government aimed at fixing the issues we uncover. The Ombudsman may also issue public reports of our investigations, if it is in the public interest to do so.

SASKATCHEWAN’S LONG-TERM CARE SYSTEM

What is “long-term care”?

The Facility Designation Regulations (under *The Regional Health Services Act*) define long-term care as “personal care or nursing care provided to individuals who are unable to care fully for themselves and require prolonged care on a residential basis, whether temporary or permanent.” Nursing care is the care provided or co-ordinated by licensed nurses. Personal care is direct assistance to, or supervision of, an individual’s activities of daily living, such as eating, bathing and dressing, and is typically provided by care aides.

The Ministry of Health

The Ministry establishes the strategic direction of Saskatchewan’s health care system, including setting goals for the provision of health services, establishing performance measures to promote effective health services, and developing, implementing and evaluating provincial health care policies. It can prescribe standards for health services and facilities to which regional health authorities and health care organizations must adhere. The Ministry is also responsible for funding the health regions.

The annual funding that the Ministry gives the health regions is based on many factors, such as how much the Ministry itself is allocated in the provincial budget, health regions’ prior funding levels, new initiatives, and details about specific health service areas such as long-term care that are submitted by the health regions during the budgeting process. Every year, the Minister

issues an accountability document to each health region advising it of its annual funding and the assumptions (service volumes and costs) upon which the funding is based. The Region is expected to comply with all legislation, regulations, contracts, policies and directives, and ensure operations remain within budget. In the 2014-15 fiscal year, the Ministry gave the Regina Qu'Appelle Health Region \$928.1 million. The Region then allocated \$151.7 million of its \$1.001 billion total budget to long-term care.

The Ministry has the authority to cease providing funds if the Minister believes that *The Regional Health Services Act* is being breached.

The Health Regions

Saskatchewan is divided into health regions, each of which is governed by a regional health authority responsible for delivering health services within the region. Health regions provide services either directly or through health care organizations under contracts.

Long-term care is provided in three types of designated facilities or homes: homes run directly by a health region, private not-for-profit homes (usually affiliated with a religious or community group), and private for-profit homes. In the latter two, the health region does not directly provide care. Instead, it contracts with long-term care homes who receive funds from the health region in return for providing a specified number of long-term care spaces.

The Regional Health Services Act requires the agreements that health regions enter into with long-term care homes to include certain provisions. For example, they must include performance measures and targets, and provisions requiring the parties to comply with legislation and regulations. They also typically specify what types of care a long-term care home must provide, usually with reference to a number of beds and how much funding it will receive. These agreements also give health regions the authority to decide who will be admitted into long-term care and which homes they will live in.

The original agreement between the Regina Qu'Appelle Health Region and Santa Maria, an affiliation agreement signed in 1994, acknowledged that Santa Maria is responsible for the quality of the care it delivers and that the Region is responsible to satisfy itself with the quality of the services. Santa Maria signed a new *Principles and Services Agreement* with the Region on February 27, 2015. This new agreement, based on a template developed in collaboration with the Ministry and other health regions, is more comprehensive than the 1994 agreement. Among other details, it states that Santa Maria is accountable to the Region for delivering services to the standards required under applicable laws.

Santa Maria

Santa Maria Senior Citizens Home Inc. is a private, long-term care home (designated by the Ministry as a special-care home) located in Regina. Since 2012, it has been owned by The Saskatchewan Catholic Health Corporation (better known as the Catholic Health Ministry of Saskatchewan). Santa Maria is overseen by a local board of directors, which hires an executive director responsible for its day-to-day operations and management. It has approximately 270 employees, including care aides, nurses and administrative staff. In 2014-15, the Region paid Santa Maria base funding of \$9.63 million to provide long-term care. Santa Maria also collected \$2.38 million in additional fees directly from its 147 residents.

The Program Guidelines for Special-care Homes

Under the authority of *The Facility Designation Regulations*, the Ministry has established *Program Guidelines for Special-care Homes* (Guidelines) setting out standards that all designated special-care homes (long-term care homes) like Santa Maria must meet, whether they are publicly or privately operated. The Guidelines specifically state that “While the Ministry of Health provides global funding to the regional health authorities, the day-to-day delivery of programs and services, including facility based care...is the responsibility of the regional health authorities.” The Guidelines include over 100 individual standards dealing with topics such as standards of care, resident rights and responsibilities, special care-home rights and responsibilities, resident abuse, staffing requirements, special care aides, incident investigations and reporting, and quality of care concerns.

Who pays for long-term care?

Long-term care is not a publicly-insured health service under Canada’s universal health care system (governed by the federal *Canada Health Act* under which provinces and territories structure their publicly-funded health services in return for federal health dollars). Therefore, provinces and territories may require people receiving long-term care to pay for things such as lodging, meals, personal and nursing care, and the use of equipment. In Saskatchewan, as in other provinces and territories, long-term care is publicly subsidized.

The public money allocated by the Ministry to the health regions, who in turn allocate funds to long-term care, subsidizes, but does not completely cover, the actual costs of caring for residents in long-term care homes. Residents pay fees based on their annual income at rates set out in *The Special-care Homes Rates Regulations, 2011*. In 2014, the minimum resident charge under these regulations was \$1,049 per month and the maximum was

\$1,995 per month. Residents pay these charges directly to the long-term care homes in which they reside. Residents also pay for any personal items and medication they need, though they may have private insurance that offsets some of these costs. Further, for those who qualify, the provincial government offers financial support to help offset the costs of prescription medicines.

How are long-term care spaces assigned?

An application for long-term care in Saskatchewan begins with health region staff evaluating applicants' abilities and care needs, including factors such as their physical and mental health, ability to safely function and perform daily tasks (eating, bathing, dressing, etc.), and the community supports, if any, available to them. Health region staff assign an applicant to a level of need ranging from 1 to 4. The Ministry told us that long-term care residents typically require Level 3 (intensive personal or nursing care) or Level 4 (specialized supervisory care) care. Applicants assessed at Levels 1 or 2 are not usually admitted into a long-term care home, though the admission threshold varies among health regions depending on resources and the number of applicants needing beds.

How many long-term care spaces are available?

The Ministry reported that, as of October 31, 2014, there were 8,528 long-term care beds available in designated long-term care homes and an additional 337 long-term care beds in other facilities not designated, for a total of 8,865 beds across the province. Of those, the Region has 1,674 long-term care beds in 22 designated facilities and an additional 251 long-term care beds in non-designated facilities. Santa Maria, a designated facility, has 147 beds.

TYPES OF CARE OTHER THAN LONG-TERM CARE

This report deals with the care provided in long-term care homes. Long-term care homes are distinct from personal care homes and assisted living homes.

Personal Care Homes

Personal care homes are privately owned and operated. They are licensed under *The Personal Care Homes Act* and inspected by the Ministry of Health, whose inspection reports are available on its website. They are staffed 24 hours a day. Personal care homes generally provide a less intensive level of care than long-term care homes. Section 24 of *The Personal Care Homes Regulations, 1996* sets a minimum number of staff required in a personal

care home. The *Licensees' Handbook: Personal Care Homes* published by the Ministry describes the minimum care hours that each resident must be provided each week. The fees that personal care homes charge are not regulated or controlled by the province. However, beginning in the summer of 2012, a new Seniors' Personal Care Home Benefit was created to help defray the cost for qualifying seniors. It is managed by the Ministry of Social Services.

Assisted Living Homes

Assisted living homes (sometimes called enriched housing or retirement living homes), are unlicensed and their rates are unregulated and unsubsidized. The rents charged at an assisted living home might include some light housekeeping and meals, but assisted living homes typically provide less support than personal care homes or long-term care homes. The Ministry places no licensing or inspection requirements on assisted living homes.

OUR INVESTIGATIVE METHODOLOGY

Our Team

Three investigators worked on this investigation full time. One concentrated on the initial assessment and triage of all the complaints about long-term care we received after the Minister's request. Two others focused on gathering information and conducting interviews about Margaret's case. These investigators were supported by the rest of Ombudsman Saskatchewan's dedicated team of employees.

Our Timeline

Some of the highlights of our investigative process include:

November 2014

We developed an investigation plan and timetable.

November 2014 – January 2015

We hosted 10 sessions at Santa Maria for over 100 people (board members, staff, residents and families) to explain our role and our investigative process.

December 2014 – February 2015

Our investigators interviewed 41 people (including Margaret's family, and management and staff of Santa Maria, the Region and the Ministry, plus officials from unions representing employees of long-term care facilities). We reviewed documents from Santa Maria and the Region about Margaret's care, including her resident chart, hospital chart, and client file. We also reviewed legislation and regulations relating to long-term care, the Guidelines, the Region and Santa Maria's service agreements, relevant Santa Maria, Region and Ministry policies and procedures, and the training and qualifications for continuing care aides.

March 2015 – April 2015

We analyzed all the information we collected and prepared our tentative findings and recommendations. As required by section 24 of *The Ombudsman Act, 2012*, we provided the Ministry, the Region and Santa Maria with an opportunity to make representations with respect to our tentative findings and recommendations. We briefed the Minister of Health.

May 2015

We met with Margaret's family to discuss our findings and recommendations, finalized our report, briefed the Leader of the Opposition, and then issued this report publicly.

OTHER INITIATIVES CONCERNING SANTA MARIA

During our investigation:

- Santa Maria announced that it hired an independent consultant to look into the non-criminal aspects of an alleged assault on a resident that was captured on a hidden camera.
- The Ministry announced the creation of a new quality oversight committee of senior officials from the Ministry, the Region, Santa Maria and Santa Maria's owner, the Catholic Health Ministry of Saskatchewan. This oversight committee is to examine care processes and key quality indicators at Santa Maria, direct the development of appropriate corrective action plans and additional quality indicators, and may review other aspects of Santa Maria's operations that affect resident care.
- The Ministry also announced that Santa Maria's board of directors and the Catholic Health Ministry of Saskatchewan appointed a care consultant to lead specific care and concern reviews and recommend improvements to care procedures.

These initiatives did not interfere with our investigation. We are not in a position to discuss their effectiveness, the work they have accomplished, or how they have or will improve long-term care at Santa Maria.

THE ISSUES WE INVESTIGATED

We investigated the quality of care standards that were in place while Margaret was a resident at Santa Maria and considered whether they were followed in her case. We also investigated how the Ministry's, the Region's and Santa Maria's responsibilities are established and whether they are effectively enforced through sound accountability measures in the long-term care system. We did not, nor do we have the authority to, investigate the clinical decisions made by health care professionals regarding Margaret's care. Our role is to examine whether there were reasonable administrative processes in place to provide Margaret with high quality care, and if so, whether they were followed in her case. Specifically, this report addresses the following issues:

1. Did Margaret's care meet the standards in the Ministry's Guidelines and Santa Maria's own policies and procedures?
2. Are there clear roles, responsibilities and accountabilities in the long-term care system to ensure appropriate standards of care are met?
3. Are there effective processes in place for addressing the concerns of residents and their families?
4. Are there other factors that could affect the quality of long-term care?

Before we discuss our findings, it is important to tell the story of Margaret's experiences at Santa Maria.

MARGARET'S STORY

HER ARRIVAL AT SANTA MARIA

After suffering a fall in 2009 that made it impossible for her to return home, Margaret Warholm was admitted to long-term care. She moved into Santa Maria, her facility of choice, on September 21, 2011. She was 72 years of age. Shortly after she was admitted, Santa Maria staff began assessing her care needs, including her nutritional needs. She weighed 144 pounds.

After her first month as a resident, staff noted that Margaret had issues with chronic pain and was quite dependent on them to help her with the activities of daily living. The summary care plan posted on the wall of her room indicated she: (a) needed help with grooming, dressing and moving about, (b) was to receive bed baths on Friday nights, and (c) independently ate a regular diet. It also indicated that two people were needed to transfer, lift, or reposition her.

HER EATING HABITS AND BEDSORES

On November 10, 2011, three of Margaret's family members attended a care-planning meeting at Santa Maria. The notes of this meeting indicate that, given her Spartan eating habits and a few other minor concerns, she was at moderate nutritional risk. She had no noted bedsores, but had the potential for developing skin issues because she was "refusing to get up." There were concerns about her pain and her increased use of pain medication.

Staff continued to monitor her diet. By July 2012, she had gained weight and the minor concerns had subsided. Santa Maria reduced her nutritional risk to low. However, chart notes made a few weeks later indicated that she may have suffered a possible stroke and that her condition had generally deteriorated. She was also having difficulty swallowing. Staff asked that Margaret's diet be changed to pureed foods and thickened fluids. Santa Maria's dietary staff reassessed her nutritional needs, switched her to a pureed diet, and raised her to high nutritional risk status. Her family recalls that, around this time, she became unable to reach out for her own drinks or food. The summary care plan on her wall was not changed to indicate that she needed more help with eating and drinking.

On July 25, 2012, Margaret's family signed a form authorizing Santa Maria to move her from a Level III Advanced Care Directive (if acute symptoms developed, she would be transferred to the hospital, but not given CPR or intensive care) to a Level I (she would be given supportive, comfort care, but not be transferred to the hospital or given CPR). One of her daughters recalled a brief conversation she had with a nurse around August 2012:

One time when I went ... to visit mom, I sat down with [a nurse] and she told me mom was getting worse and the doctor wanted to know if we should be providing her compassionate care. I said "Are you saying mom is dying?" and she said "Oh no" and so we said "We don't want to change her medication or anything then."

There are frequent entries in Margaret's chart noting that staff had difficulty encouraging her to eat. One care aide described a typical process in which she would start by offering her the main course. If she declined, the care aide would then offer her a meal supplement, then juice, then water. If Margaret refused all of it, then the care aide would return in five or ten minutes and try again. As she recalled it, Margaret often refused food, but would sometimes change her mind and then eat her whole meal. In this care aide's opinion, she could not just put the food on a spoon and force Margaret to eat if she was refusing to eat, because that would have been disrespectful.

One of Margaret's daughters recalled frequent visits when she found her alone with her tray, with no visible signs that her food had been touched or the utensils had been used to attempt to feed her. She would then help her to eat. She also recalled regular visits where she would find Margaret extremely thirsty, with visibly dry lips and mouth, so she would clean and moisten her lips. To her family, these occasions indicated Santa Maria was not doing enough to feed or hydrate their mom.

Margaret's family told us that they also raised concerns with staff about whether they were remembering to accommodate Margaret's food preferences. They described talking to several staff members about their mother being given food and drinks that were not her preference and about making sure staff offered her food and fluids regularly. They also raised concerns about whether Margaret's pain was being suitably managed. The family told us things would improve for a couple of days after they raised these sorts of concerns, but would then revert back, so they would have to raise them again. Several staff members told us that information specific to a resident would be passed on fairly well from one shift to the next, and from one day to the next, but would not necessarily be passed on very well after that.

By September 2012, Margaret had lost over 30 pounds and bedsores (or pressure sores) had appeared on her back. Many staff told us that proper nutrition is a critical factor in healing bedsores. By mid-December 2012, Margaret had lost more weight. Her dietary records indicate that she had lost a total of 41% of her body weight in six months.

Starting His Day

Anne is 87 and her husband is in a long-term care facility. She told us that she often arrives at 9:20 a.m. to visit and always finds him sitting in bed with his uneaten breakfast, which was served at 8:00 a.m. She helps him eat, brushes his hair and gets him ready for his day. Anne said that staff are busy and express their appreciation, but she worries about what will happen if she can no longer be there.

Santa Maria's records suggest that a care conference planned for December 13, 2012 never occurred. Information was prepared, but there are no records of the meeting. The family did not receive an invitation to this meeting. A note on Margaret's dietary record has the abbreviation for the conference struck out, suggesting it was scheduled but did not go forward. A Santa Maria official informed us that any records of this meeting, if it had happened, would have been in her chart.

A handwritten note added to the summary care plan on Margaret's wall in February 2013, indicated that she should be turned every two hours, have lotion applied to her back with a slight massage to support circulation, and should be offered fluids regularly. Nothing else on the care plan was changed. Margaret's family told us that she was usually lying in the same position in bed when they visited, so they did not think she was being repositioned every two hours. Some staff told us that Margaret did not always like to be repositioned and sometimes refused. By the end of February 2013, Margaret had continued to lose weight and still had multiple bedsores. Dietary records note that she was counseled about the importance of eating.

Throughout 2013, physician orders were regularly entered on her chart for a variety of complaints, mostly about managing her pain and treating her bedsores, which improved and then worsened again. By March 2013, the bedsore on her shoulder had progressed to stage 3 and 4, meaning it was serious enough that it warranted being reported to the Region as a critical incident. On occasion, a staff member with wound care expertise was consulted for advice about treating her bedsores. Overall, Margaret had some good days – when she was relatively pain-free and in good spirits, but mostly she had bad days – with chart notes indicating she was in pain. Her March 2013 chart notes describe a conversation with one of Margaret's daughters about her general condition, her deterioration, her bedsores and her poor diet, and that her daughter stated that she was aware of these issues.

By the mid-May 2013 care conference, Margaret weighed 93 pounds. Notes indicate that two of her family members attended this conference and the issues discussed with them included that her appetite remained "poor," and she was at most eating just half of the food being offered to her. It was noted that she needed "total assistance" to eat the pureed diet she was being given. Notes from the meeting also indicate that the bedsore on her shoulder was still at stage 3, but was "slowly healing" and being treated with pharmacy samples. Her regular mattress was changed to a special air mattress, which staff told us was to help her bedsores. Her family raised concerns with staff about the side rails on her bed being left down, scissors being left on her bedside, and staff leaving her too long without pain medication. The summary care plan posted on her wall was not updated, but a memo was

posted in her room reminding staff to ensure the side rails were kept up, to offer her fluids often, and that she liked orange juice.

Margaret's last nutritional assessment was in May 2013. The dietician noted that her weight loss had slowed and, because her treatment plan was "status quo," there was no need to see her monthly – only at her next required 6-month assessment.

HER FALL

On August 16, 2013, a care aide found Margaret heavily soiled. The care aide was concerned that she would not be able to clean Margaret's bedsores well enough by giving her a bed bath, so she decided to give her a tub bath instead. Although Margaret's care plan indicated she was only to be bed bathed, the care aide told us that it was within her authority to decide to give her a tub bath. Both the Director of Care and the Nurse Manager told us care aides have the discretion to choose to give a tub bath even when the resident's care plan says otherwise. Other staff told us, however, that the care aide should have consulted with the supervising nurse before straying from the care plan.

The care aide asked a second care aide to help her move Margaret from the bed to the wheelchair. The second care aide told us she would have preferred to give Margaret a bed bath because it was safer given Margaret's condition. However, because she was only there to assist the first care aide, she deferred to the first care aide's decision. They lifted Margaret from her bed to her wheelchair using a mechanical lift. The first care aide told us that once they lowered her to the wheelchair, but before she was secured into it, Margaret "stiffened" and began sliding to the floor. The second care aide had turned away to begin changing the sheets on the bed. The first care aide said she was reaching to grab the required safety belt at the time, but managed to catch Margaret "around the middle" and used her arm to somewhat slow her fall to the floor. The care aide told us that Margaret's head got caught and she "bumped it on the chair." Then she slid to the floor. She cried out in pain. The second care aide ran to get the nurse in charge.

The nurse entered the room and saw Margaret on the floor. The nurse tried to calm her while doing a clinical assessment. Margaret had swelling and a small cut on the back of her head that was bleeding "a tiny bit." The nurse found no other bruising or signs of fractures or dislocations. She took Margaret's vital signs, and then she and one of the care aides transferred Margaret back to bed using the lift. Ice was brought in for her head. The nurse left a message for the doctor and called Margaret's daughter.

According to the nurse, she told Margaret's daughter that while she only found a head bump and a small cut, the family might want to send Margaret to the hospital for further assessment. The nurse said that Margaret's daughter told her that she wanted to get the doctor's opinion and see her mom for herself before deciding. The nurse said she then gave Margaret some pain medication, cleaned her head and applied a cold compress to it. She spoke with the doctor. The nurse told us that the doctor advised Margaret could be sent to the hospital for assessment, if the family agreed. The nurse called Margaret's daughter back. She told us that the daughter said she did not want to put Margaret through the stress of going to the emergency room in an ambulance. She said the daughter decided first to come to see Margaret for herself. When the daughter arrived, Margaret was upset. The nurse said that after seeing Margaret, her daughter decided to not have Margaret sent to the hospital, but to have Santa Maria continue to assess her. The nurse told us she felt Margaret should have gone to the hospital and though she could not recall, she believed she would have given the daughter this advice.

Margaret's daughter's recollection of the nurse's advice, however, is different. She said the nurse first called to tell her Margaret had fallen, but did not yet know how it had happened. She said the nurse told her Margaret appeared okay except for a bump on her head. When the nurse called her back, she said that the nurse told her that Margaret was upset and wanted the family to come. She said the nurse told her that the doctor had left it up to the family to decide whether to send Margaret to the hospital. The daughter told us that when she asked for the nurse's opinion, the nurse said something like "she has a bump on her head, she is in pain and is scared, but she seems okay." As the daughter put it, "I trusted her to know." About an hour later, when she came to see her mom for herself, Margaret began to cry saying she had been dropped, was afraid, and did not want the staff coming into her room.

"I trusted her to know."

- Margaret Warholm's daughter, speaking about her conversation with a nurse about Margaret's condition after falling and whether she should be taken to the hospital.

AFTER HER FALL

There were various entries and deletions made to her chart later in the evening after Margaret had fallen. The first care aide entered a note at 9:49 p.m. She indicated that at 6:15 p.m., two staff were transferring Margaret for a bath when she slid from her chair, had a small cut on her head, was put back to bed, and given a sponge bath. An hour and 20 minutes later, this entry was deleted as "incorrect" and another note was entered indicating that the incident happened at 5:55 p.m., Margaret was put back to bed at 6:15 p.m. and given a sponge bath 10:00 p.m. The nurse also entered a progress note to the chart that evening, which is consistent with how she described her conversations with the doctor and Margaret's daughter to us.

On August 17, 2013, the nurse completed a Confidential Occurrence Report coding the incident as a Level 2 (minor self-limiting injury requiring basic first aid or short-term monitoring) on a Level 1-4 scale, and indicating that care aides must “always transfer with care and get all equipment within reach before transferring residents... [and] ask for clarification of care from RN when not sure...”

The nurse also changed the summary care plan on Margaret’s wall to indicate that Margaret grooms and dresses herself, is to receive a “bed bath only” on Friday nights, and eats a regular diet on her own. We note that these changes seem to contradict earlier care decisions made about Margaret’s inability to feed, groom or dress herself.

Handwritten notes were also added to the care plan reiterating the February 2013 instructions to turn Margaret every 2 hours, apply lotion with a massage for circulation, and offer fluids regularly. Notes state that Margaret was on total bed rest and that the nurse must be notified when the lift will be used for transfer. Further unsigned, undated handwritten instructions indicate “no sheepskin, soaker and sliding sheets on the top of the bed.”

On August 18, 2013, the first care aide entered another progress note, adding a few more details, such as their use of a “full lift,” that as she fell, Margaret’s “head was caught in the chair” and modifying some of the times reported in an earlier note.

On August 19, 2013, Santa Maria management received the nurse’s Confidential Occurrence Report. Because of the Level 2 rating, Santa Maria did not provide the Confidential Occurrence Report to the Region’s Patient Safety unit as is required for Level 3 or 4 incidents. No further action or follow up occurred.

One of Margaret’s daughters filled out a “merit-gram” for the nurse who called about the fall when it happened. Merit-grams acknowledge staff and thank them for a job well done. She also left a telephone message asking that the care aides involved in Margaret’s fall no longer provide her with care. This family member does not recall ever hearing back from Santa Maria, and staff did not recall receiving this message. A family member remembered making this request to another staff member, but could not remember whether it was ever followed up.

From August to October 2013, Santa Maria’s progress notes focused on Margaret’s limited eating, the regular assessment and care of her wounds, and her pain. By September 2013, her back was “red and scaly.” Her skin was “breaking down,” “fragile” and had torn during a routine dressing change. This pattern of deterioration continued until the morning of October 3, 2013, when she was found acutely ill and taken to the hospital by ambulance. The Transfer Referral Report prepared by Santa Maria staff

indicated a bedsore on her tailbone, but not the one on her shoulder or the tear or the general condition of her skin. The Patient Care Report form completed by the ambulance attendant does not refer to her skin or the bedsores. After her diagnoses and presenting complaints, this form noted “no other head to toe findings.”

Later that evening, emergency room staff noted a large open wound on Margaret’s back. In addition, they noted that the rest of the skin on her back appeared “extremely red,” “fragile” and “thin.” To them, she appeared to have “friction burns.” Margaret’s family thought that, as of May 2013, her only bedsore was about the size of a quarter. They did not understand that she also had an open wound twice that size, and that almost her entire back was fragile and compromised. A family member took a picture of her back while she was in the hospital.

After consulting the family, care for Margaret in the hospital shifted from active treatment to compassionate care. Three days after being admitted to hospital, on October 6, 2013, Margaret died. She was 74.

AFTER HER DEATH

A few months after Margaret passed away, one of her daughters, troubled by the photos of her back taken while she was in the hospital, asked for a copy of her hospital chart. The chart described her as “emaciated” and “malnourished.” This made her family question how often Santa Maria staff had been helping her eat. Her family knew she had a poor appetite and had been losing weight, but told us that only seeing her in bed wrapped in blankets, they had not realized it was so serious. The hospital chart also referred to “recent” compression fractures in her spine. The family wondered whether her fall had been more serious than Santa Maria staff had led them to believe.

On February 20, 2014, Margaret’s family wrote Santa Maria’s Director of Care to detail their concerns. They wrote that while there were good people working at Santa Maria, they had too many examples of poor care. They attached pictures of Margaret’s back wound, and told him that they would not be paying Margaret’s outstanding bill (\$657).

The Director of Care thanked the family for sharing their concerns, and offered to meet with them, which he did, along with the Nurse Manager on March 21, 2014. The Director of Care told the family that he had begun investigating Margaret’s fall. He offered an apology, but it fell flat. The family wanted financial restitution. Santa Maria could not agree to compensation, but agreed to investigate further, to comment on the care provided and to

ensure, if there were shortcomings, that they were corrected. The Director of Care agreed to contact them within three weeks.

The Director of Care finished his investigation by mid-April 2014, but did not meet with the family until July 22, 2014. At this meeting, he explained why staff decided to give Margaret a tub bath instead of a bed bath, and told them that the care aides had followed proper lift procedures even though Margaret fell. The Director of Care told the family that though he disagreed with the decision to tub bath Margaret, given the care aides' remorse and positive job records, no formal discipline would result.

Margaret's family told us that the Director of Care gave them inaccurate information about Margaret's fall and care. For example, to them he talked as though she had been taken to the hospital shortly after falling. Further, they were told that Margaret, who could not reach a glass of water on her own, had thrown her food tray when approached by staff to eat. They heard that she had two bedsores on her shoulder, not just the quarter size one they had been told about before. At various times, Santa Maria has told the family that Margaret was found on the floor, that she had stiffened and slid to the floor, that she fell, and that she was dropped. The family heard these accounts as contradictions. They did not believe Santa Maria was being truthful. They got the impression that the Director of Care had not thoroughly reviewed Margaret's chart or their concerns. When they asked to see the investigation report, they were denied. They thought the Director of Care suggested at one point that people do not get better when they come to Santa Maria, but rather "come here to die." According to all accounts, the meeting deteriorated to the point that the family threatened to go to the media and see Santa Maria shut down.

Santa Maria then asked the Region to review Margaret's chart. An executive director with the Region conducted the review. She first met with the family and then reviewed Margaret's chart notes. She uncovered issues with the care Margaret received. For example, she questioned staff's decision to give Margaret a tub bath when her care plan specified a bed bath. Regarding the fall, she concluded that the care aides did not follow proper procedures for lifting her from the bed to the chair. First, they lifted her before ensuring that the safety belt was in place on the chair. Second, one of the care aides turned her back to Margaret before she was safely secured. As a result of its chart review, the Region made 14 recommendations to improve Santa Maria's processes, including, for example, that it establish new protocols for better pain

Lifting Procedures

Louise was in a long-term care facility. She was initially assessed as needing one person to assist her with moving and getting out of bed. When her health deteriorated, this was changed to two, and was documented above her bed. Her family told us that she fell in her bathroom, suffering significant injuries from which she later died. Her family told us that a facility review revealed that only one staff had been assisting her and had been unable to prevent her from falling to the floor.

management, be more transparent with families, increase family involvement in treatment discussions, assist families with the post-death move out of a room, provide them with better information about how to raise concerns, and provide all staff with training on how to manage bedsores. The Region also advised Santa Maria to report the fall to the Region's Patient Safety unit for review. Santa Maria accepted all the recommendations.

On November 10, 2014, Santa Maria's Executive Director and two Region officials (including the one who did the chart review) met with Margaret's family. This meeting had been rescheduled by the Region due to concerns about a letter it received from Margaret's family demanding that the care aides involved with her fall be terminated and that her family be provided financial compensation for her death. At the November 10 meeting, the Executive Director gave them a copy of a letter responding to their concerns and a report about how Santa Maria was specifically addressing the issues they raised and which the Region had flagged during the chart review. He apologized and his letter expressed his regret for their experience. He walked the family through the report describing the various changes Santa Maria was making to improve care, including improving communication with family about conditions and arising issues, working with pain experts to better manage resident pain, and re-educating staff (including the care aides involved) about how to properly transfer and lift residents. Santa Maria had already waived the balance owed on Margaret's account, but offered no further financial restitution.

Some family members were insulted that Santa Maria would pay significantly to retrain staff (which the Executive Director told them would cost about \$90,000) but would not compensate them. To the family, compensation represented accountability. They felt staff were being given perks instead of being held to account for poor judgment and for not following policy. The family felt that they were being blamed for not taking Margaret to the hospital right after she fell, when from their perspective, they followed the nurse's advice that it was not necessary. Margaret's family left the meeting even more angry at Santa Maria and was now also upset with the Region's investigation and response.

The family wrote to the Minister of Health. They contacted a group of local activists fighting for better seniors' care. They were put in touch with the opposition and Margaret's story was shared in the Legislative Assembly. Thereafter, the Minister of Health referred the matter to the Ombudsman.

DID MARGARET’S CARE MEET THE STANDARDS IN THE MINISTRY’S GUIDELINES AND SANTA MARIA’S OWN POLICIES AND PROCEDURES?

CARING FOR MARGARET’S BEDSORES

The Relevant Standards

Standards 1.4(m) and (t) of the Ministry’s Guidelines require long-term care homes to ensure residents have clean and healthy appearing skin and that they are properly positioned for their comfort and the prevention of bedsores.

Standard 17.1 requires homes to have procedures for reviewing, investigating and reporting incidents that have the potential to, or have affected, the health and safety of a resident, including critical incidents under the *Saskatchewan Critical Incident Reporting Guidelines, 2004* adopted in *The Critical Incident Regulations*. According to the *Reporting Guidelines*, stage 3 and 4 bedsores must be reported to the Region as a “Care Management Event.”

Standards 16.1 and 16.2 require homes to ensure resident care records are accurate, up-to-date, meet professional standards, include residents’ responses to care, and are done immediately after any particular care event.

Santa Maria’s *Standards of Nursing Care* policy (NUR 1.7) requires staff to ensure residents have no bedsores. Its *Nursing Procedure on Ostomy & Wound Care Referrals* (W.1) requires nursing staff to follow the treatment prescribed in the Region’s Skin and Wound Care manual for two weeks, and then seek a physician referral to the Wound Care Centre. The procedure also states that, once referred, a wound nurse is to assess the resident’s bedsores and make treatment recommendations. Under its *Quality Assurance* policy (NUR 9.3), nursing staff must complete regular audits of, among other things, residents’ charts and the care being provided.

Our Findings

Margaret had no bedsores when she arrived at Santa Maria in September 2011, but eight weeks later, Santa Maria staff noted that her skin was at risk. By June 2012, her skin was beginning to break down and by September 2012, she had a stage 2 to 3 bedsore. Her bedsore care records show that from March to September 2013, she was being regularly treated for a stage 3 to 4 bedsore. Her chart shows that a Santa Maria staff member with wound care expertise was assessing her bedsores and their treatment. It also included occasional references to her being repositioned.

The Region’s review of Margaret’s chart after her death raised concerns with how Santa Maria cared for her skin, which led to the Region recommending that Santa Maria educate its staff on the techniques and equipment used to support skin integrity and treatment.

It is clear, regardless of their efforts to treat her, Santa Maria staff did not ensure Margaret's skin was healthy as required by the Ministry's Guidelines and its own nursing care standards. It also never referred her to the Wound Care Centre as required in the Guidelines, and we found no evidence that it reported either of her stage 3 or higher bedsores to the Region as required in the Ministry's Guidelines.

We also gathered evidence to suggest instances in which staff felt Margaret's bedsores were not being cared for properly. For example, staff told us that absorbent pads were being placed over Margaret's specialty air mattress, which eliminated any benefit the air mattress was intended to provide her. We also learned that opinions differed as to the best way to deal with Margaret's bedsores – resulting in inconsistencies in how they were being cared for each day.

RECOMMENDATION 1

That Santa Maria Senior Citizens Home implement a process to ensure that its staff:

- a) **Can identify, manage and treat bedsores.**
- b) **Understand that they must pay particular attention to advanced or complicated bedsores and know when to consult external resources about treatment.**
- c) **Follow prescribed care plans when caring for bedsores.**
- d) **Are aware of the duty to report bedsores as required by standard 17.1 of the *Program Guidelines for Special-care Homes*.**

Based on the care records Santa Maria provided us, it is not clear that staff repositioned Margaret every two hours as required in her care plan as of February 2013. Staff told us that they are allowed to “chart by exception” – meaning that they do not have to record planned care events as long as they are done as planned and yield the intended results. Assuming Margaret's caregivers “charted by exception,” she may have been repositioned every 2 hours as required, because if she was not, it should have been noted in her chart. However, many staff told us that Margaret was sometimes difficult to reposition and altogether refused on occasion. As well, Santa Maria staff told us that they often do not chart at all because other work consumes all of their time.

Therefore, if its staff were not charting care events that it should have, Santa Maria was violating standards 16.1 and 16.2 of the Ministry's Guidelines. If Margaret was not being repositioned frequently enough, Santa Maria was violating its own care plan for her, its *Standards of Nursing Care* policy (NUR 1.7) and standard 1.4 of the Ministry's Guidelines. Finally, although nursing

staff were required to conduct chart audits under Santa Maria's *Quality Assurance* policy (NUR 9.3), none of the information Santa Maria provided us, whether in interviews or records, indicate these audits were ever done.

RECOMMENDATION 2

That Santa Maria Senior Citizens Home implement a process to ensure residents' charts are up to date and that staff know when and what to chart, in accordance with standards 16.1 and 16.2 of the *Program Guidelines for Special-care Homes*.

MEETING MARGARET'S NUTRITIONAL AND HYDRATION NEEDS

Relevant Standards

Standards 1.1 to 1.4 and standards 2.1 and 2.2 of the Ministry's Guidelines require long-term care homes to respect residents' choices about the care they are receiving, including their right to refuse care and ensure residents' individuality, privacy, dignity and sense of security are respected. Homes must encourage residents' potential for independence.

Standard 1.4(x) generally requires homes to monitor the nutritional and hydration status of each resident. Standard 13.5 specifically requires homes to ensure all residents have their nutritional and hydration needs assessed and be offered appropriate nutrients and fluid intake based on their assessed needs.

Standard 15.5 requires homes to develop resident care plans and update them at least every three months (or more frequently if a resident's health changes significantly). Santa Maria's nursing *Care Plan* policy (NUR 8.3) requires resident care plans to be reviewed at least monthly and its nursing procedure (C.1) requires the care plan summary (on residents' walls) to indicate what activities they need help with or need to have done for them. These summaries must be reviewed at least weekly, on the resident's bath day.

Santa Maria's *Resident Counselling and Nutritional Assessment* policy (DIE 7.3) requires its dietician to assess each resident shortly after admission. Whether staff assess residents at low, medium or high nutritional risk determines how often they are assessed by the dietician. All residents must be assessed at least once a year, but medium risk residents must be seen every 3 to 6 months and high risk residents every 1 to 3 months.

Santa Maria's *Standards of Nursing Care* policy (NUR 1.7) require staff to ensure residents consume adequate food and fluids (progress notes must reflect this), and to record their fluid intake and output. And the audits done by

nursing staff under its nursing *Quality Assurance* policy (NUR 9.3) must address issues such as whether residents look comfortable when eating, have enough fresh water, are satisfied with their meals, and whether their nutrition plan is being followed.

Our Findings

Santa Maria's dietary staff assessed Margaret's nutritional needs and risks shortly after she arrived. She was ranked as a medium nutritional risk. As she gained weight and no new concerns arose, her risk was changed to low. Then in the summer of 2012, her weight began to decline rapidly. After her significant weight loss, and the development of bedsores, dietary staff considered adding vitamins to her daily diet (but the physician declined), and counseled her about her need to eat. We could not tell from her chart how thoroughly or frequently she was counseled to eat, or how she responded. Dietary staff told us that Margaret was competent and lucid when they talked with her. It is clear, however, from our interviews with staff and family and from her rapid weight loss, that Margaret stopped eating enough.

Records indicate that, over time, Margaret's ability to feed herself diminished. Her family told us that they believed staff did not really try to get her to eat. They often found the utensils on her tray clean and her food untouched. They told us staff should have tried to lift food to her mouth. But staff thought this would have been disrespectful. Staff said they could not force her to eat, only verbally encourage her to eat, and that it was Margaret's choice whether or not to eat.

Margaret's family also told us that, while staff ensured water jugs were in her room, she was not able to reach the cup and bring it to her mouth, and that she was largely dependent on others to help her. They recalled finding her extremely thirsty, sometimes to the point of crying out so loudly for a drink that they could hear her even before they entered her room. They told us they sometimes found her mouth so dry that they needed to moisten and clean it out. There are occasional progress notes indicating staff were offering Margaret fluids, and whether she accepted or refused on some occasions. A February 2013 note added to the summary care plan on her wall required staff to regularly offer her fluids.

In general, we found that Santa Maria did not meet the Ministry's Guidelines for ensuring Margaret received adequate nutrients and fluids. Given her significant weight loss, Santa Maria did not provide us with evidence that it was monitoring her food or fluid consumption to the extent that could be expected from its nursing care standards or the Ministry's Guidelines. While we understand residents are to be treated with respect and dignity, and that Margaret to eat when she did not want to was wrong, the issue of Margaret not eating enough should have been monitored better and dealt with accordingly. If staff felt that she was determined to not eat despite their efforts, then we would have expected her

chart or care plan to reflect this concern, include strategies for addressing it, and document their efforts to fully inform her family to seek their ideas and assistance.

RECOMMENDATION 3

That Santa Maria Senior Citizens Home implement a process to ensure that residents receive adequate hydration and nutrition in accordance with standard 13.5 of the *Program Guidelines for Special-care Homes*.

A weight loss as significant as Margaret experienced, while noted in her chart, did not seem to trigger any further action or get reported further.

RECOMMENDATION 4

That Santa Maria Senior Citizens Home implement a process to ensure that when a resident's weight change exceeds a certain threshold (established in consultation with a dietician) that it be reported to the Director of Care (or equivalent), as well as the resident and family, so that any appropriate interventions can be considered and agreed upon.

It is also not clear that Santa Maria staff reviewed and updated Margaret's care plan any more frequently as a result of her significant weight loss, the appearance of her bedsores or her overall deterioration. The care plans on her chart are dated October 2011 and March 2013. The summary versions on her wall are dated September 2011, February 2013 and August 2013. Santa Maria's nursing policies and the Guidelines suggest that they should have been updated much more frequently. We also found no record that any nursing care audits were done.

RECOMMENDATION 5

That Santa Maria Senior Citizens Home audit residents' charts and care plans in accordance with its *Quality Assurance* policy (NUR 9.3).

RECOMMENDATION 6

That Santa Maria Senior Citizens Home implement a process to ensure that care plans are reviewed and updated in accordance with standard 15.5 of the *Program Guidelines for Special-care Homes*.

MANAGING MARGARET'S PAIN

Relevant Standards

Standard 1.4(u) of the Ministry's Guidelines is relevant to how Margaret's pain was managed, which was a regular focus of her care at Santa Maria. It requires long-term care homes to provide evidence that "every effort is made to recognize, assess and appropriately manage pain."

Our Findings

As early as her initial care conference, Santa Maria considered referring Margaret to a pain specialist, but it does not appear to have followed up. Her chart is replete with references to her pain, her requests for pain medication, her hollering out in pain, her family asking about pain medication, nurses asking the doctor to consider her pain medications, and her doctor writing prescriptions for pain medication. The Region's report, following its review of Margaret's chart, expressed concerns about her pain management, commenting that "there was very little effective pain management," and recommended Santa Maria implement a pain management protocol, which Santa Maria began working on during our investigation.

RECOMMENDATION 7

That Santa Maria Senior Citizens Home implement a process to ensure effective recognition, assessment and management of residents' pain in accordance with standard 1.4 of the *Program Guidelines for Special-care Homes*.

MARGARET'S FALL

Relevant Standards

Standard 17.1 of the Ministry's Guidelines requires homes to establish a process for reviewing, investigating and reporting all incidents that have the potential to, or have affected the health and safety of a resident, including critical incidents as described in the *Saskatchewan Critical Incident Reporting Guidelines, 2004*, which the Ministry has adopted in *The Critical Incident Regulations*.

The Region's Patient Safety unit requires incidents to be coded from 1 (no clinically significant or known injury) to 4 (irreversible complications or death). Region-run facilities must report all incidents to the Region's Patient Safety unit for review, but affiliated facilities such as Santa Maria are only

required to submit incidents coded as 3 and 4. Management at the Region told us this protocol is being updated to require all confidential occurrence reports (1-4) to be reported directly to its Patient Safety unit.

Santa Maria's *Occurrence Reporting* policy (GEN 46.1) similarly requires staff who witness or discover an event resulting in an injury to complete a form describing it and coding it from 1 to 4 – levels defined substantially the same as the Region's incident codes. Forms must be promptly submitted to a supervisor. Supervisors must investigate, decide whether further corrective action is required, and forward the forms to Santa Maria's management (within 48 hours for level 1 and 2 events, and immediately for level 3 and 4 events). Management is to submit level 3 and 4 events to the Region.

Santa Maria's *Incident Reports* nursing policy (NUR 8.9) requires staff to complete an incident report after any event that may result in injury to a person or damage to property, send it to management, and then follow it up by completing what is referred to as a "third day" report – though the policy does not describe the purpose of this report.

Santa Maria's *Transfer Lifting and Repositioning (TLR)* policy (GEN 25.10) requires all lifts – moving residents who cannot bear their own weight from one surface to another (for example, from a bed to a wheelchair) – to be done safely by properly trained staff. Its *Total Lift* nursing procedure (T.3) requires staff to identify and remove any risks before moving a resident with a lift, and requires the second person to "ensure that the transfer is completed safely."

Our Findings

The care aides involved in Margaret's lift the evening she fell told us they believed they followed the appropriate procedures. Santa Maria's Director of Care agreed with them. But the executive director from the Region who reviewed Margaret's chart did not. She identified two failings: 1) they had not properly readied the equipment before starting the transfer (a belt was out of reach and a care aide had to move away from Margaret to reach it), and 2) a care aide left the required position before the lift was completed (by turning to change Margaret's bedding before she was secured in the chair).

There appears to be a disagreement between Santa Maria and the Region as to what is required to comply with the TLR procedures and conduct a proper lift. This needs to be addressed. Staff need to understand the accepted and proper way to lift residents.

RECOMMENDATION 8

That Santa Maria Senior Citizens Home ensure that its *Transfer Lifting and Repositioning* policy is approved by the Regina Qu'Appelle Health Region and that Santa Maria staff understand the policy, its requirements, and how to conduct a proper lift.

The circumstances surrounding Margaret's fall were precipitated by the decision to give her a tub bath. As we have noted, there are differences of opinion about whether this was a good decision, and whether the care aide who made it had the authority to make it, including whether she needed to consult with the supervising nurse. Some told us the care aide had the authority to decide to give Margaret a tub bath, even when her care plan called for bed baths. Others told us care aides cannot deviate from a care plan without approval from the supervising nurse.

RECOMMENDATION 9

That Santa Maria Senior Citizens Home clarify, for both its management and care staff, who has the authority to change or deviate from a resident's care plan.

MEETING THE STANDARDS OF RESIDENT AND FAMILY CENTRED CARE

Relevant Standards

The Ministry's Guidelines state that the intent of the special-care homes program is to "provide a home-like environment, through a consistent resident and family centred approach with a focus on quality for those individuals requiring facility based care."

Standard 1.1 requires homes to ensure residents can make decisions about how they want to live, and to treat residents with the utmost respect and dignity. Homes must consider "their individual beliefs and preferences." The Ministry's patient and family centred care framework states that long-term care homes must provide "respectful, compassionate, culturally safe and competent care that is responsive to the needs, values, cultural backgrounds and beliefs and preferences of [residents] and their family members by working collaboratively with them."

Our Findings

Margaret's Bedsores

Margaret's family did not appear to fully understand the severity of her bedsores or the condition of her skin. Until they looked at her back in the days before her death, they thought she had only one quarter-sized bed sore. They did not realize that her back had become fiery red and scaly, or that by August 2013 her skin was so fragile that it was tearing during routine dressing changes. Family members told us they were shocked when they eventually saw her back.

Progress notes from March 2013 indicate a nurse and a care aide each separately discussed Margaret's general deterioration and bedsores with one of her daughters. The May 2013 care conference included information about the bed sore on her shoulder and the change in mattress. It is unclear how much further detail was provided at that time or whether any conversations followed about the worsening state of her skin. What is clear is that the communication process was incomplete because the family did not understand the gravity of the situation. The Region's chart review after Margaret's death also revealed concerns with how informed Margaret and her family were about her condition. The Region recommended that Santa Maria develop protocols to ensure family awareness and involvement in care planning, which it continued to work on during our investigation.

Her Weight Loss

Margaret's chart indicates Santa Maria staff had intermittent conversations with a visiting family member about Margaret not eating. Her weight loss and poor appetite were raised with family at the May 2013 care conference. By then, she had lost so much weight, her weight loss had slowed – but it does not appear that Santa Maria explained the potential significance of her weight loss to her or her family. Records of the conference do not indicate any concerted plan to counsel her, to provide her daily encouragement and support to eat, or to systematically monitor what she was eating.

Bedsores

Mark had been confined to a wheelchair for ten years, but had never had a bed sore. After entering a long-term care facility, he began to occasionally tell his son Jared that he was in discomfort. Jared made sure staff were aware of this. Mark's health suddenly deteriorated. We were told he was sent to the hospital and died a few days later of sepsis. Hospital staff noted two very large bedsores, which were the source of his infection. Jared was shocked and told us that when he raised this with the facility, he was angry that the initial reason provided was that Mark was sometimes resistant to being repositioned.

When she was admitted to the hospital, her family told emergency staff that she had lost a significant amount of weight in the past year, but her family was surprised to later read in her hospital records that she was “emaciated.” This suggests that while her family knew she had lost a lot of weight, they were not fully aware of its significance.

The Region noted that Santa Maria should have communicated more openly with her family about Margaret’s nutrition and tried to engage them in finding solutions. We agree.

Her Fall

Regarding her fall, Margaret’s chart does not indicate that she was ever asked whether she wanted to go to the hospital, only that the nurse told her daughter that while she appeared fine, she should be taken to the hospital to be sure. Her daughter understood this to mean that she could arrange for Margaret to go to the hospital if she wanted, but that Margaret seemed fine. Her daughter deferred to the nurse’s advice. It was months later, when her family read about “recent fractures” to her spine noted by hospital staff, that they wondered if the fall may have been more serious.

Family told us that Margaret did not want the care aides who had been involved in the fall to care for her anymore. Margaret and her family made this request that evening and again in the days following. Santa Maria does not seem to have registered this request anywhere or to have followed it up.

RECOMMENDATION 10

That, in keeping with resident and family centred care, Santa Maria Senior Citizens Home ensure that:

- a) Processes are put in place to fully inform residents and their families of the resident’s care needs and of Santa Maria’s plans to meet these needs.**
- b) These discussions are documented.**

ARE THERE CLEAR ROLES, RESPONSIBILITIES AND ACCOUNTABILITIES IN THE LONG-TERM CARE SYSTEM TO ENSURE APPROPRIATE STANDARDS OF CARE ARE MET?

WHAT IS ACCOUNTABILITY?

The Ministry's 2011 *Guide to Corporate Governance* is premised on "the shared responsibility of the Government of Saskatchewan, regional health authorities, health care organizations and the health professions for ensuring quality in Saskatchewan's health system" (p. 1.1). Designed for governing bodies such as the boards of the Region, Santa Maria and the Catholic Health Ministry of Saskatchewan, the guide describes accountability as being "subject to direction or sanctions by...a body that confers responsibility." It makes it clear that effective accountability requires:

- Clear roles and responsibilities that are agreed upon and well understood.
- Clear performance expectations that describe agreed-upon inputs, outputs and outcomes.
- Balanced expectations and capacities (authorities, skills and resources) of each party.
- Credible, timely reporting, demonstrating what has been accomplished.
- Review of and feedback on performance, with necessary corrections and adjustments (pp. 2.2-2.3).

It is with this in mind that we considered whether the Ministry, the Region and Santa Maria have clear roles, responsibilities and accountabilities as they work together to plan and provide long-term care.

THE MINISTRY'S ACCOUNTABILITY

The Regional Health Services Act gives the Ministry discretion to decide what level of control it will exercise over the provision of health care, health regions and health care organizations. It has done this in three key ways.

First, every year the Region must submit its operational, financial and health services plans to the Ministry, which then determines the Region's global funding, any allocations for specific services, and any performance targets it expects the Region to meet. Essentially, the Ministry approves the Region's broad operational plan and its budget every year.

Second, with respect to long-term care, under *The Special-care Homes Rates Regulations, 2011*, the Ministry sets the minimum and maximum rates that long-term care homes may charge residents. This gives it control over how

much residents pay, but since the costs of care are higher than the maximum allowable rates, the Ministry is, in effect, controlling how much the health regions subsidize homes.

Third, *The Facility Designation Regulations* requires all long-term care homes to follow the Ministry's Guidelines, which set out the standards that all long-term care homes must follow.

Although *The Regional Health Services Act* does not require the Ministry to set standards of care, it has chosen to do so. It told us that even though it sets the standards, it is each health region's responsibility to ensure they are met. While the Ministry has only indirect responsibility for the quality of long-term care, as Margaret's and other cases raised in the media demonstrate, the Minister is ultimately accountable to families and the public for the quality of care provided by long-term care homes. In our view, by exercising its discretion to set the Guidelines, the Ministry has committed itself to ensuring they are properly implemented and followed. The Ministry told us that it has recently begun developing processes to ensure staff in the health regions and long-term care facilities are aware of and understand the Guidelines. But not having a process in place to ensure health regions and long-term care facilities are in fact meeting the standards set by the Guidelines is, in our view, a significant weakness in the Ministry's system of accountability.

THE REGION'S ACCOUNTABILITY

Under *The Regional Health Services Act*, the Region is to plan, deliver and evaluate health services and must ensure its services reflect the Ministry's strategic priorities and performance standards. It is accountable to the Ministry and is expected to comply with direction and guidance provided by the Minister.

While the Region has some policies in place concerning long-term care (for example, its first available bed policy), it does not have a specific policy aimed at helping the long-term care homes in the Region operationalize the Guidelines and ensure they are being met. An official from the Region told us that when the 2013 version of the Guidelines was introduced, the Region felt that the services being provided in its long-term care homes were already largely in keeping with the philosophy and principles of the Guidelines. However, once Margaret's and other cases were made public, the Region has made operationalizing the Guidelines a priority. At the time of our interviews, it was still in the beginning stages of developing the procedures. We were told that it was struggling with how to design procedures that Region and long-term care home staff would not reject as too onerous given their current workloads, or that would require staff to take focus away from other important initiatives.

The Region is directly responsible for overseeing the quality of care provided in its long-term care homes, including contracted homes like Santa Maria. It can do this in a variety of ways, but under *The Regional Health Services Act*, health regions must enter into written agreements with non-region run long-term care homes. The Act requires these agreements to outline, among other things, any performance measures and targets the long-term care home must meet and the reports it must provide the health region.

The 1994 version of the Region's agreement with Santa Maria that was in place during Margaret's time in Santa Maria had a stated purpose to "establish guidelines that will provide public assurance as to the quality of care and service provided in [Santa Maria]" (2(b)). Though it does not cover any topic in much detail, this short agreement states that Santa Maria is accountable for the quality of the services it provides (4(4)), and that the Region is to satisfy itself as to the quality of the services (4(1)). But it does not establish a process by which Santa Maria is to account to the Region for the quality of its services.

The Region and Santa Maria's new, recently-signed *Principles and Services Agreement* states that "the fundamental shared purpose of the [Region] and [Santa Maria] is the provision of safe quality health care services and the joint commitment to work in a collaborative manner to provide a patient/resident focused health system." It also provides, among several other things that, if the Region believes a Santa Maria staff person is not performing to a required standard, Santa Maria must ensure that the sub-standard service ceases. However, without a robust reporting and monitoring system in which the Region is made aware of staff performance issues and other indications that the standards of care in the Guidelines are not being met, it is not clear how the new agreement will better ensure Santa Maria's accountability or the Region's ability to address Santa Maria's failures to meet the Guidelines.

Similar to the Ministry's view of its role with respect to the Region's duties, some Region officials told us they struggle to balance their accountability to ensure standards are being met with the long-term care homes' duty to deliver services. As one Region official told us:

The Region has a role and the facility has a role in all of this. We are not operational. That's [Santa Maria]. [It] is operational and responsible for care delivery. We provide guidance, advice, and assistance. We may suggest different ways they can achieve a hoped for outcome, but the final [work] is the facility and [it] is accountable.

While Santa Maria is clearly responsible for delivering long-term care services to the required standards, it is just as clear that the Region is responsible for holding Santa Maria accountable when it does not. The Region cannot contract out of its responsibility to ensure the care being provided on its behalf

meets provincial standards. The first step in developing a clear accountability framework is accepting accountability. As one Region official told us:

The way I'd characterize the Region's responsibility [is that it is to] ensure the same level of quality and safety is offered at all facilities; [we] want one long-term care program, with no quality and safety distinctions [among homes]. Ultimately we are responsible for the care of residents. If ever [there was] a case that went so horribly wrong, we'd have responsibility for that.

SANTA MARIA'S ACCOUNTABILITY

Santa Maria is directly responsible for the quality of the day-to-day care it provides. Its management and the president of the Catholic Health Ministry of Saskatchewan acknowledged to us that Santa Maria must provide services in accordance with applicable statutes, regulations, the Ministry's directions (including the Guidelines), and the Region's requirements and policies. In addition, Santa Maria has made a public commitment to provide each of its residents high quality, respectful and appropriate care. This commitment is enshrined in its mission, values and philosophy statements and included in its annual reports. It is reviewed with residents and their families upon admission, and included in the admission agreement Santa Maria and residents sign. However, there does not appear to be any immediate consequences for Santa Maria if it fails to meet its commitments.

It does not have a process specifically implementing the Ministry's Guidelines. Its management told us that it believes that the Region should lead regional planning and service delivery, including setting and monitoring regional goals for all long-term care homes. Santa Maria sees the Ministry as having the lead role in setting strategic direction and performance goals for the health system, financing regions, and issuing local directives. While we agree that both the Region and the Ministry have key roles to play in ensuring the long-term care system is providing high quality services, Santa Maria is responsible for ensuring it provides high quality care to its residents.

Until recently, Santa Maria did not have any oversight processes to ensure it was delivering high quality care to each resident. In 2012, it established a quality and service delivery sub-committee of its board that meets quarterly with its Executive Director. We were told that this sub-committee reviews reports and other sources of information about quality of care, such as scores on indicators collected by the Region and the Ministry, critical incident reports, and any significant complaints Santa Maria receives. In addition, due to the series of recent, high-profile concerns that families (including Margaret's) raised in the media, Santa Maria is also involved in a newly formed Quality Oversight Committee with the Region and the Ministry to temporarily oversee the quality of care at Santa Maria. Though we were told

that this committee was initially struck for this specific, time-limited purpose, we were also told by Ministry officials that the committee will continue until there is confidence that the concerns have been resolved.

While these efforts are promising, Santa Maria does not yet have procedures specifically designed to implement the Guidelines and to ensure the standards of care are being met.

THE THREE LEVELS NEED TO WORK TOGETHER

There are over 100 mandatory standards in the Ministry's Guidelines. Despite this, neither the Ministry, the Region nor Santa Maria is doing any systematic work to implement them or any monitoring to ensure they are being met. The Guidelines are generally non-specific and high-level, such that they are open to wide interpretation. To effectively implement them, much more work needs to be done to develop specific rules and requirements that, if followed by care staff, will meet the intent of the Guidelines.

For example, the Guidelines do not specify a minimum number of baths a resident must receive over a certain period, but instead require "good personal hygiene such as clean and healthy appearing skin." Similarly, they do not specify how many staff members are needed for a given number of residents, or the minimum hours of care each resident needs per day. They only require that there be a safe and effective mix of staff based on residents' needs. The Ministry told us that broad standards such as these are better than specific standards, because highly operational, Ministry-set minimum care standards are too inflexible to be effectively applied at the local level. It told us that if it was to set province-wide minimum care standards, there is the potential that residents could get the minimum level of care when some may need more and others could fair well with less. Since safe and appropriate care varies from resident to resident and day-to-day, the Ministry believes the broad outcome-focused standards in the Guidelines are better, safer, more flexible, and more respectful of individual needs. The Ministry told us establishing specific standards is, therefore, best left to the health regions and long-term care homes, who are in a better position to specifically consider each resident's needs.

While we appreciate that care staff are best able to understand residents' needs and, therefore, to decide how to best meet them, the Ministry should establish a structured accountability framework to ensure that its standards are implemented appropriately and similarly in comparable circumstances. The Ministry needs to ensure that residents do not experience significantly different standards of care from one region to the next or from one home to the next. The Region needs to ensure standards of care are similar in all its homes (both Region-run and contracted homes). And long-term care homes

like Santa Maria need to ensure that the Ministry's standards of care are consistently met day-to-day.

A Ministry-led initiative to ensure the Guidelines are operationalized equitably across the province at the regional and local levels would be a positive step towards ensuring residents in long-term care receive high quality care. Once done, however, there must be a system in place for ensuring the operationalized Guidelines are met consistently.

We acknowledge that the Region and Santa Maria are already involved in the Ministry's province-wide quality improvement and assurance initiatives, and track a number of things that could indicate when care is falling below the standards in the Guidelines, including:

- Regular quality of care indicator monitoring to assure improving performance with respect to falls, continence, pressure ulcers, restraints, pain, etc.
- Critical incident reporting (Region and Santa Maria staff told us, and we know from Margaret's case, that critical incidents are not being reported consistently).
- Feedback from resident and family advisory committees.
- Accreditation surveys by Accreditation Canada. (This is currently inapplicable to Santa Maria, because, contrary to standard 17.2 of the Guidelines, it is not accredited. It is taking steps to be accredited as part of the Region's 2017 survey).
- Issues arising when visiting a home on an ad hoc basis – for example, issues seen or informed about while visiting for other purposes, or ad hoc issues that come to the attention of the Minister's office, the Ministry, the Region or Santa Maria management.
- Concerns raised with the Region's Client Representatives (soon to be known as Patient Advocates and known in other health regions as Quality of Care Coordinators).

While these efforts are all useful, none directly involve monitoring whether the Region or Santa Maria (or any other home) is meeting the standards in the Guidelines. Ensuring that health regions and all long-term care facilities meet minimum standards of care is vitally important if the Guidelines are to be meaningful.

To accomplish the broad goals of *The Regional Health Services Act*, the Ministry, health regions and long-term care homes must work closely together. *The Regional Health Services Act* does not diminish the Ministry's responsibility to be informed about, and ensure that the Region and Santa Maria

meet provincial goals and objectives for Saskatchewan's long-term care system. Equally, Santa Maria's status as a contracted facility does not diminish the Region's ability or responsibility to ensure it is meeting regional and provincial goals and standards. And though it should go without saying, long-term care homes like Santa Maria are directly responsible for ensuring the services they provide meet both regional and provincial standards. All three are accountable to residents and their families.

While Saskatchewan's long-term care service delivery model is decentralized, accountability for its performance is not. The Ministry, all health regions and all long-term care facilities are responsible for the quality of long-term care in the province. However, the Ministry, the Region and Santa Maria differ in their interpretation about their roles, which is compromising their ability to be truly accountable. According to the Ministry's *Guide to Corporate Governance*, accountability begins with setting and communicating expectations, goals and targets with reference to clear standards and benchmarks. To develop a robust system of accountability, all three levels of Saskatchewan's long-term care system need to work collaboratively to establish clear performance expectations. None of them should be made to account for things outside of their control or be able to avoid accountability for things within their control. In addition, the public needs to know that this is being done.

RECOMMENDATION 11

That the Regina Qu'Appelle Health Region:

- a) **Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-care Homes*.**
- b) **Identify, track and report on specific and measurable outcomes that ensure the standards of care in the *Program Guidelines for Special-care Homes* are met consistently for each long-term care resident.**
- c) **Include these specific and measurable outcomes as performance requirements in its agreements with long-term care facilities.**

RECOMMENDATION 12

That the Ministry of Health ensure that all health regions:

- a) Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-care Homes*.**
- b) Identify, track and report on specific and measurable outcomes that ensure the standards of care in the *Program Guidelines for Special-care Homes* are met consistently for each long-term care resident.**
- c) Include these specific and measurable outcomes as performance requirements in their agreements with long-term care facilities.**

RECOMMENDATION 13

That the Ministry of Health implement a publicly accessible reporting process that families can use to see whether each long-term care facility is meeting the *Program Guidelines for Special-care Homes*.

ARE THERE EFFECTIVE PROCESSES IN PLACE FOR ADDRESSING THE CONCERNS OF RESIDENTS AND THEIR FAMILIES?

RELEVANT STANDARDS

Standard 17.3 of the Guidelines requires all long-term care homes to have a process for residents, family, friends and persons with the legal authority to make decisions for residents to report concerns about quality of care. The Guidelines do not dictate the features that a proper concern-handling process must have, but do require long-term care homes to have a communication plan to ensure residents and their families understand the process. Each home must have procedures for investigating, documenting, and responding to residents' and families' concerns. They must also provide residents with information about the role of the health region's Client Representatives. Standard 12.2 requires information about the concern-handling process to be included in each home's resident information handbook.

In addition, standard 2.4 establishes that residents have the right to appeal decisions made in a home. It requires homes to have a process for informing residents of this right and detailed procedures for how appeals will be conducted. It also requires homes to identify resources to assist residents with the appeal process, including, for example, the Region's Client Representatives.

Finally, as of September 1, 2012, subsection 20(4) of *The Ombudsman Act, 2012* requires long-term care homes to have procedures and provide means to permit residents to communicate in private with the Ombudsman, and to inform each resident about the right to communicate with us, how to communicate with us, and the services we provide.

CONCERN HANDLING AT SANTA MARIA WHEN MARGARET WAS A RESIDENT

When Margaret was a resident at Santa Maria, it did not have written procedures for handling resident and family concerns. It only had what was included in its Resident Information Handbook:

A Lack of Communication

Lynette's family told staff of a long-term care facility that they wanted to be actively involved in their mother's care, including her care plan development, supporting her at meal times, taking her on outings and helping with personal care. They asked to be advised of any significant events that would affect her health. They told us they were frustrated that they were not told of several events, including an influenza lockdown, changes to her medication, and that she had wandered out of the facility for several hours. Lynette's family told us that when they tried to bring these and other issues forward, they were repeatedly redirected to managers they had already unsuccessfully contacted. They told us they now had to concerns for Lynette's well-being and felt disrespected.

Santa Maria welcomes resident/family comments on health needs, expectations, and/or experience with health services, and views them as an opportunity to improve the quality of programs we provide.

Staff members who are first made aware of a complaint/concern make every effort to acknowledge and resolve the issue at the point of service delivery.

We encourage residents and family who have a complaint/concern regarding the delivery of resident care to speak to the Registered Nurse/Registered Psychiatric Nurse in charge at the time of the occurrence.

If your concern is not resolved please contact the Director of Care for further discussion.

The Executive Director may be contacted to discuss continuing issues, suggestions etc.

Therefore, Santa Maria was not meeting all the concern-handling requirements of the Guidelines. It had no clear procedures for investigating, documenting and responding to concerns. It also did not identify the Region's Client Representative or have procedures allowing residents to contact the Ombudsman. It is also not clear to us whether Santa Maria ever provided Margaret or her family any more information about its concern-handling process other than what was written in its Resident Information Handbook.

Margaret's family's experiences with raising concerns directly with staff as provided in the Handbook suggest to us that the process was not very effective. For example, Margaret's family told several staff they were concerned she was being offered food and drinks that she did not like, and that she was not being offered food and drinks often enough. They told us that after raising one of these issues, things would improve for a couple of days, but would then revert and they would have to raise them again.

Staff told us they are only reading the previous day's notes at the beginning of their shifts (the exception being after the weekend, when they read the previous two days' notes). So, if a resident's family raised an important concern on a Monday, staff working on Wednesday following would not inform themselves about it, even though the information was available to them in the system. We were told that staff do not have the time to read the notes from more than the previous day. This practice seems to have affected how responsive Santa Maria was to con-

Concern Handling After a Fall

Sue lived in another province and frequently phoned her mother Jill, who lived in a long-term care facility. One day, the facility contacted Sue and said that Jill had fallen but seemed okay. Sue told us that, on the fifth night after the fall, Jill was incoherent on the phone. Sue stayed on the line and called the nurse's desk from her cell phone to ask that someone check on Jill. The nurse did so and, unaware that Sue was still on the phone, scolded Jill for leaving her phone off the hook, then told her to be quiet and go to bed. Sue told us she called back the next day to express concern and that Jill was taken to hospital and diagnosed with a fractured pelvis. Sue said she lodged a complaint with the facility and was promised a full review. Later, Sue was told that staff did not feel that Jill's condition merited further assessment, that the nurse was simply "having a bad day," and no further action would be taken. Sue told us she was disheartened and fearful for her mother's safety.

cerns about Margaret's care. As well, her family's repeated requests that the two care aides involved in Margaret's fall no longer work with her appear to have been ignored.

In our view, when a resident or a family member raises concerns with a staff member, even simple requests like a preference for orange juice, there needs to be an easy way for the staff member to let the rest of the staff know. We acknowledge that Santa Maria is a busy, dynamic workplace and that staff feel pressure to keep up the pace. However, residents and their families should not have to explain the same concern over and over again.

RECOMMENDATION 14

That Santa Maria Senior Citizens Home implement an efficient process for ensuring that all staff caring for a resident are, and remain, aware of concerns and preferences raised by the resident and family members.

CONCERN HANDLING FOLLOWING MARGARET'S DEATH

The internal concern-handling process that followed Margaret's death when her family wrote Santa Maria's Director of Care and the independent chart review conducted by the Region left the family very dissatisfied. They believed they were not given enough information, they were lied to, that neither Santa Maria nor the Region properly investigated their concerns, and that there were no consequences for what they believed were failures that contributed to Margaret's death.

Though Santa Maria did not have a clear and defined complaint handling process or any appeal procedures as required by the Guidelines, the Director of Care in fact carried out an investigation and responded to the family's concerns. We found several problems with how this investigation was done. First, it is not clear that the Director of Care gave the family a full explanation about what he was going to investigate and how he would proceed. Second, when he met with the family, he appears to have been unprepared to provide them with meaningful and understandable answers to their questions, or to assure them that Santa Maria had taken their concerns seriously. In fact, the family believed some of what he told them contradicted their understanding of certain events. Third, even when they asked, he refused to let the family look at the investigation report. So, even though the Director of Care acknowledged that Margaret's care was not up to Santa Maria's standards and intended to reassure her family that Santa Maria was going to change things for the better, the way he presented the information to them at the meeting had the opposite effect, inflaming their belief that they were being lied to and that they were not being taken seriously.

After the Region did its chart review, Region officials met with Margaret's family, along with Santa Maria's Executive Director, with the intent of fully explaining their findings. However, it seems that once Margaret's family demanded compensation for her death, the Region and Santa Maria decided to focus on responding to that position rather than fully and fairly explaining how they reviewed Margaret's care, the decisions and findings they made during their reviews, and why Santa Maria believed the Region's recommendations were reasonable and would lead to positive changes at Santa Maria.

SANTA MARIA'S CURRENT CONCERN HANDLING PROCESS

In December 2014, Santa Maria adopted a new *Management of Resident/Family Concerns* policy (GEN 63.1) to provide residents and their families ways to raise comments or concerns "with respect to their health needs, expectations, and/or experiences with the health system." In the new policy, residents and their families are asked to first raise concerns with the staff or physicians at the point of service. If unresolved, concerns are to be escalated, first to either the Resident Care Coordinator, the Nurse Manager or the Director of Care, and then to Santa Maria's Executive Director. If concerns cannot be resolved by Santa Maria internally, the policy directs residents and families externally to the Region's Client Representatives. Finally, the policy advises residents to contact the Ombudsman if their concerns remain unresolved after Santa Maria and the Region have tried.

Residents and families may raise concerns verbally or in writing. Concerns may also be raised anonymously. The policy states that concerns will be acknowledged and responded to in the same format in which they were raised, and establishes timeframes for acknowledging concerns that are received.

In our view, Santa Maria's new policy appears to address most of the substantive requirements outlined in Guidelines about concern-handling and appeals. It provides a process for concerns about a resident's quality of care to be reported, and that they are to be investigated, responded to and resolved. It also describes how confidentiality is to be maintained. And it references the role of the Region's Client Representatives in taking concerns directly or to review concerns that are first raised internally. We note, however, that it does not explain how these new procedures will be communicated and understood by residents and their families as required by the Guidelines. It also does not identify resources available to help residents with the appeal process other

than the Region's Client Representative, and does not include details to ensure that complaints are handled in a procedurally fair manner.

RECOMMENDATION 15

That Santa Maria Senior Citizens Home take steps to ensure that its *Management of Residents/Family Concerns* policy meets the requirements of standards 17.3 and 2.4 of the *Program Guidelines for Special-care Homes* and is widely available and communicated to staff, residents and their families.

HANDLING CONCERNS RAISED BY SANTA MARIA'S STAFF

Santa Maria's staff should be encouraged to come forward with concerns about quality of care, whether reported to them or that they themselves have witnessed, and be assured that Santa Maria will properly investigate and resolve the concerns similar to any other concern raised by a resident or a family member. Neither the Ministry's Guidelines nor Santa Maria's new policy address how it is to handle concerns about resident care raised by staff.

During our investigation, some staff at Santa Maria told us they do not feel safe raising concerns with management. Some were fearful to speak to us. Some told us that they feared for their jobs if management discovered that they had spoken out. Others worried about being disciplined, being reported to their professional body, or being bullied. Others told us that their concerns are not taken seriously.

We were given a copy of a letter dated June 10, 2014, signed by 51 Santa Maria staff members that was sent to the Minister of Health and the Catholic Health Ministry of Saskatchewan. The letter raises concerns about how Santa Maria is managed. While many of the concerns were specific to staff, some concerns were about resident care. Representatives from the Region, Santa Maria's board and its management told us that the letter was reflective of the attitude of some difficult staff members who simply disliked the changes Santa Maria was making. This response seems to support the views of some staff that their concerns are not taken well or seriously. If Santa Maria's management and board respond defensively when concerns are raised to them, it is understandable that staff also become defensive when concerns are raised about their work. It should be a goal of Santa Maria to view its concern-handling process as an opportunity to be inquisitive and improve things, including addressing potentially larger systemic issues.

RECOMMENDATION 16

That Santa Maria Senior Citizens Home provide a comprehensive process to investigate and protect anyone, including staff, who, in good faith, raise questions or concerns about a resident's care.

CONCERN HANDLING IN THE BROADER LONG-TERM CARE SYSTEM

Under the Guidelines, the Ministry requires long-term care facilities to have complaint handling and appeal processes in place. However, in our view, the Guidelines lack specific requirements to help ensure that these processes are fair and reasonable. The Guidelines should provide more detail to ensure concern-handling and appeal processes are procedurally fair, such as requiring:

- Decision-makers to gather and consider all relevant information about a concern before making decisions.
- Decision-makers to keep an open mind about the outcome and be free from bias or a reasonable perception of bias.
- Decision-makers to provide meaningful reasons for any decisions made or actions taken.

Concerns About Speaking Up

At 97, Annie could feed herself. Her daughter Marie was often told that Annie didn't seem to want to eat, so she would be taken back to her room without having eaten. Marie began visiting at mealtimes, and noticed that staff often forgot to set the wheelchair brakes. When she tried to reach her food, the chair would move slightly backwards, away from the table. When seated close to the table with the brakes applied, she would begin to eat. Marie reminded staff to apply the brakes during mealtimes. After this, Marie told us that friendly smiles were replaced with silence and hostile looks, and that staff came less often to her mother's room. Marie didn't know what to do. Her mother's well being was in the hands of these staff who seemed to feel that she was watching them. She advised us that she no longer had confidence that her mother's basic needs would be met, and was frustrated that her attempts to help seemed to have made the situation worse.

- A reasonable review or appeal process to be available to people who disagree with a decision or action that affects them.
- All concern-handling processes to be timely and proceed without unreasonable delay.

Standard 2.1 of the Guidelines requires homes to ensure residents have their concerns heard, reviewed, and resolved without fear of retribution. However, both families of Santa Maria residents and members of its staff reported feeling ostracized and blamed for damaging Santa Maria's reputation and staff morale if they reported concerns. Margaret herself expressed concerns to her family about whether her family's questions about

her care might negatively affect her and make staff less willing to help her. This fear is not uncommon and can cause difficult situations to escalate. For example, we had a case where family members were accused of harassing staff and a case from another health region where a family member was banned from a facility.

We note that while standard 12.2 (w) refers to the Ombudsman, it does not, however, address the requirements of section 20 of *The Ombudsman Act, 2012* which requires every facility to have procedures to inform residents about our services, and to facilitate residents communicating with us in private.

The primary objectives of any concern handling process should always be to resolve individual issues in a timely fashion and to prevent them from escalating, but it is also important for improving services for everyone.

RECOMMENDATION 17

That the Ministry of Health amend the *Program Guidelines for Special-care Homes* to provide more details of the steps needed in concern-handling and appeal processes, and ensure that the processes are procedurally fair.

ARE THERE OTHER FACTORS THAT MIGHT BE AFFECTING THE QUALITY OF LONG-TERM CARE?

SANTA MARIA'S WORK ENVIRONMENT

In 2012, Santa Maria came under new ownership and management. Seeing deficiencies in how care was being provided, the new management decided Santa Maria needed to move to a “Resident and Family Centred Care” model from what it saw as a “facility-focused” model in which decisions were driven by the needs of staff, not residents. According to management, the changes it implemented were aimed at improving care for residents and increasing staff accountability. Some of the changes included new care approaches (for example, the introduction of a primary care model of care), improvements in charting, better monitoring of medication, the introduction of enhanced dining to give residents more choice over what and when they ate, and a more inclusive care conference process designed to increase families’ involvement.

Along with these changes, management advised us that it eliminated one eight-hour position, reduced two shifts by two hours, hired a ward clerk, changed the hours of some shifts, and increased its emphasis on staff performance and attendance. There was also an increased emphasis put on staff training. For example, in response to Margaret’s fall, all care staff were to be retrained on the Transfer Lift Repositioning requirements. In addition, Santa Maria hired a non-clinical educator. On top of all the changes Santa Maria was making itself, it was also involved in provincial initiatives, such as having Resident Care Coordinators available on each floor.

Among several other staff performance-related initiatives, starting in October 2012, Santa Maria issued a series of 14 memoranda entitled “Expectations of Behaviour Series” (GEN 49.1). Topics included giving residents first priority, communicating respectfully with co-workers, reporting bad behaviour, and assisting residents and families. Management also introduced initiatives to decrease the number of sick days taken by staff, and took a more assertive approach to managing what it viewed as historical performance issues. We were told by care staff and some management that there were so many performance issues, a “discipline day” was instituted one day a week to deal with investigations and staff disciplinary issues.

Staff told us that Santa Maria was a stressful place to work. They told us that management imposed constant operational changes without consulting them, and that the relationship between management and staff was strained. Many told us that, while they supported the rationale behind management’s initiatives, they had issues with how they were introduced and implemented. Some felt they could have improved initiatives by pointing out weaknesses before they were implemented if management had consulted them up front. Some said that management would announce changes, but then not implement them for several months, or at all. Management explained to us that their intention was to provide advance notice. Some staff

suggested that Santa Maria had simply gone through too many changes too quickly.

Care staff told us that management are rarely present on the floors where care is being provided and do not actually understand the day-to-day operations and pressures care staff are under. Many care staff told us that they consistently had more work to complete in a single shift than was safely and reasonably possible. In their view, increases in the needs of residents, coupled with a high number of unfilled positions, changes to shift configurations, and the reduction of certain care hours, all added to their daily workload. Some staff told us that because of vacant positions, their requests for holidays and other time off are being routinely denied. Some also suggested that when people called in sick, they were either not replaced or replaced for only part of the shift, so shifts would be short-staffed – though they also acknowledged this was often because replacement staff were unavailable. Nevertheless, some staff told us that they were required to work unscheduled overtime as a result. Management said that this was not a requirement, but a request.

Many staff reported that their work schedules result in burn out and increased sick leave. One called the schedule “horrendous.” As stated by one of the care staff: “I pray every night that I do the right things and make the right decisions. One person cannot do it all. It is beyond me and I try really hard.”

Some stated that when they tried to raise issues, management was either unavailable, or unsupportive and blaming. One employee told us:

Staff feel blamed for a lot of things.... [There is] a lot of discipline. [The management] seemed to really be pointing fingers. For example, incident reports weren't taken as an opportunity to [seek good] change for the facility but rather felt very blaming towards staff and disciplining. “You did this and will be disciplined.” [As a result,] I felt the incident reports weren't coming as often as they should.

Many expressed that they feel unsupported, unduly judged and at times intimidated by management. As stated by one supervisory staff member, “When we don't treat staff well, how do we expect them to treat residents well?”

For its part, management officials also expressed frustration with the employer-employee relationship. Some dismissed most staff issues and concerns as simply the complaints of disgruntled individuals resistant to change. Some told us that most of Santa Maria's staff supported the changes, that there were only a handful of employees who resisted. Members of management described these employees as a group who behaved as if they ran the facility and were only there “for the paycheque.”

When we asked about shifts having to work short-staffed, management told us it schedules as many staff on each shift as its budget permits, and it has an unwritten rule not to work short-staffed (meaning working with fewer staff than were scheduled, due to absences). It uses overtime to fill shifts to the extent it can. Management told us it is rare that shifts are ever short-staffed. Staff, however, are of the impression that they are working short-staffed (meaning to them that there are not enough people scheduled to do the work).

Based on information shared with us, there appears to be a culture of distrust and a disconnect between what Santa Maria management and staff see as issues. Santa Maria's strained employer-employee relationship could affect the quality of care it is providing. It would be best for staff, management and residents if this relationship improved. We believe that it would be time well spent for Santa Maria management and staff to work together to improve their relationship and start to see themselves as one team working together for a common goal: to ensure all residents are getting high quality care.

Santa Maria is supported by many agencies, including the Region, the Saskatchewan Association of Healthcare Organizations, the Catholic Health Ministry of Saskatchewan, and the unions representing its workforce. These organizations have expertise to assist Santa Maria in re-gaining a healthy workplace atmosphere and to help it deal with organizational change.

RECOMMENDATION 18

That Santa Maria Senior Citizens Home take steps to identify the issues straining its employer-employee relationship and implement an inclusive plan to address these issues.

A SYSTEM UNDER STRAIN

Our investigation focused only on the care being provided to one resident in one long-term care home in one health region. In Margaret's case, we found that the standards of care in the Ministry's Guidelines were not met. However, over the course of our investigation, we came to the conclusion that this was not a unique situation.

This is not the first case to receive public attention. In April 2013, family members went public with their complaints about the quality of care their loved ones were receiving in another long-term care facility. In May 2013, to address these concerns, the Minister of Health instructed the Chief Executive Officers of all health regions to immediately visit their long-term care facilities to hear resident concerns and see firsthand the pressures and issues homes were facing. The CEOs reported back, identifying several areas needing im-

mediate improvement including: food issues, care issues (complexity of care, behaviour management, delay in provision of care), safety (residents' needs, staff training, staffing levels), resident mix, and aging infrastructure. Among the actions identified to deal with the immediate issues, \$10 million dollars was committed to address the most pressing issues identified by each health region.

While we appreciate that the Ministry, health regions and long-term care facilities (including Santa Maria) have recently taken steps to improve long-term care, many of the officials we spoke to during our investigations raised the factors listed below as issues that continue to affect the quality of care being provided to residents in long-term care. We did not have the time to investigate these issues during this investigation. However, they were raised constantly enough to warrant mentioning them in this report.

The Changing Needs of Residents in Long-term Care

We were told that residents in long-term care today have significantly greater needs than twenty years ago. Back then, residents were mostly assessed as needing level 1 and 2 care, with some needing level 3. Those needing level 4 care were typically placed in hospitals. By the late 1990s, it was determined that those requiring level 1 and 2 would be better served in the community or other supportive living environments (for example, personal care homes and assisted living facilities). Today, residents in long-term care facilities typically require level 3 or 4 care. This means that the amount of daily care and support each resident needs has increased. As well, we were told that there are now more medically complex residents in long-term care, and many who struggle with some form of dementia.

Ministry officials acknowledged that the needs of today's long-term care residents are different than a generation ago. However, they suggested that the level of care needed has remained fairly stable over the last ten years. They pointed to the Long-Term Care Minimum Data Set (MDS) and stated that long-term care homes routinely gather information about resident needs. Homes are required under standard 9b.1 of the Guidelines to collect certain information about residents and submit it so it can be analyzed and the needs of residents can be reported on. However, some Region and Ministry officials told us that MDS data collection is not consistent in every facility, and some Santa Maria staff questioned whether staff are properly trained and have enough time to properly collect and input MDS data, so it can be used in a broad and meaningful way.

It is not clear if the current needs of residents in the long-term care system are sufficiently known or understood.

Staffing Long-term Care Homes

Staffing Levels

The Guidelines do not set staffing levels for long-term care homes. It is up to the homes to decide, while operating within their budget, how many staff they need to meet the Ministry's standards of care. During this investigation, many families who contacted us told us that there did not appear to be enough staff to provide care to their loved ones in facilities.

Care staff – nurses and care aides – all described feeling like there are impossible expectations put on them in terms of their work load, so they triage, determining what needs to be done first and ignoring other residents while they try to get their work done. They admitted that they cut corners. They rarely have time to try to assist residents with their social or psychological needs, even though this is expected, according to the Guidelines. We spoke with many dedicated professionals for whom these decisions weighed heavily.

We were also told that they face discipline if they do not finish all of their work, or when they make choices about what to do and others disagree with their decision. At the end of the day, many people we spoke to told us they do not feel there are enough care staff:

Neglect! Yes of course, it's absolutely frequent. Not intentional neglect, but the type of neglect that happens when the workload is too heavy, not organized well, and not supported. It is sad, but residents wait to use the bathroom and get their medications in a timely manner. Call bells are not being answered promptly. Residents are waiting for dressing changes because of a lack of time, (and often wait until the next shift) and residents in their rooms waiting to be fed because there just aren't enough hands.

It was also raised as a concern by one Region official who commented:

The nursing homes are providing care to people who would have previously been in a more medical setting. [If we look at] Margaret's situation – to reposition her, to spend time to get her to eat, the amount of time to properly clean her, to provide the skin and mouth care she needed – multiply [that time] by the number of residents; there is not enough time in a care aide's shift.

We were also told that looking only at the numbers of staff is short-sighted – that the question is not whether there is enough staff, but whether the right staff are doing the right job at the right time.

The Mixture of Staff

Many people told us there are simply not enough qualified staff, including health administrators (managers), nurses (Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses), and care aides to provide care to the standards required under the Guidelines. Like staffing levels, the Guidelines also do not specifically prescribe the type of staff that long-term care homes require. Standard 11.7 references that long-term care homes may employ a mix of health care providers to meet the needs of residents in the safest and most effective way. While long-term care homes employ health administrators, nurses, and care aides, many lack access to other specialized health care professionals. We were told there are not enough registered dietitians, physical therapists, occupational therapists, speech language pathologists, social workers and physicians with geriatric expertise employed in the system. Standards 10.5 and 10.6 require access to the right professional services. This access is important in ensuring that residents' needs can be met to the standards required.

The Number of Available Care Aides

Care aides provide personal care to residents. Several people told us that it is difficult to fill vacant care aide positions with qualified staff. Others suggested that not enough people complete the Continuing Care Assistant (CCA) program offered by the Saskatchewan Polytechnic or other similar programs offered by the Saskatchewan Indian Institute of Technology, Saskatoon Business College and Lakeland Regional College. Tuition for the Polytechnic's program ranges from \$4,700 to \$5,200. It confirmed that there is a high demand for care aides. In 2012-2013, 324 individuals completed the Polytechnic's program. Though the Ministry has expressed interest in having more students complete these programs, the Polytechnic is limited by physical space and the availability of practicum placement opportunities.

In response to the shortage of trained care aides, the Ministry has approved the hiring of untrained care aides, a practice often referred to as "learn as you earn." Some long-term care homes offer new employees incentives to complete the CCA program. Others collaborate with educational institutions to make it easier for their employees to work and study as a care aide concurrently. The Canadian Union of Public Employees, which represents care aides in five health regions, offers up to \$5,000 for its members to either upgrade their skills or complete the CCA program. We were told, however, that there are challenges that come with hiring untrained staff on the condition they complete their training on the job.

Some of these employees struggle to balance work and family demands while trying to complete the CCA program. For others, it can be too costly. Some employees do not complete the program within the required two-year time-frame. Others do not complete it at all, which may result in termination and the hiring of new staff, and the process starts again. Until they complete the

program, it falls to the qualified care aides or nurses on staff to provide them with on-the-job training and support. As stated by one union official, “There simply is no time to do so. I am too busy trying to do my job never mind telling you how to do your job.”

For its part, Santa Maria told us that it only hires individuals with at least some care aide training, including individuals who have partially completed the CCA program or a nursing program, who have foreign nursing credentials but cannot work as nurses in Canada, or who have completed a program similar to the CCA program in another jurisdiction.

Despite the number of graduates in the province each year, the “learn as you earn” incentives, and the recognition of equivalent training, the recruitment and retention of care aides was raised to us as a concern that could be affecting the long-term care system.

The Changing Role of Nurses

We were told that nurses (Registered Nurses and Registered Psychiatric Nurses) employed in the long-term care system provide direct nursing care and supervise other care staff, including Licensed Practical Nurses and care aides. In addition, we were told that many nurses are increasingly undertaking more administrative duties and reporting obligations for incidents, falls, wounds, pain, and other issues. We were told that everything from admissions to dealing with incidents is taking more of nurses’ time than it did in the past.

We were also told that at times, there are not enough nurses on duty. For example, we were told that Santa Maria has one nurse working nights for the entire building – covering three floors and 147 residents. Union officials told us this is actually better than what occurs in some other long-term care homes, where there is no nurse on duty at night, but only a nurse available on call. Standard 11.7 of the Guidelines only requires that nursing care be available on call.

Minimum Hours of Care per Resident

Many families we spoke to expressed concern that their loved ones were not receiving enough care time in a long-term care facility. Currently, the Guidelines do not include a specific minimum number of hours of care a resident should receive.

At one time, however, there were hours of care set out in regulations. *The Housing and Special-Care Homes Regulations* enacted in 1966 set out set hours of care for three categories of residents. Residents receiving “intensive personal or nursing care accommodation” were to be provided

at least two hours of personal or nursing care per day. Residents receiving “limited personal care accommodation” were to be provided at least 45 minutes of personal care per day. And residents receiving “supervisory care accommodation” were to receive at least 20 minutes of direct supervisory care per day.

According to one Ministry official, these standards were removed because they were outdated. They were put in place at a time when there were a lot of level 2 care residents and few level 4 care residents in the long-term care system. As time went on, they were “not followed anyway because clients were so different from what [the standards were initially] based on. So ... rather than have a situation where standards are not followed, we removed them.” Ministry officials told us that the new Guidelines were developed to replace these outdated standards and to provide the regions with flexibility to determine the care needs of individual residents.

Funding Long-term Care Facilities

We were told by the Region that the funding it gives to each long-term care facility is based on the number of beds it provides, and that it has used this formula to determine funding since 1994. We were told that the funding process needs to be updated, because it does not take into account that the needs of the residents in those beds have now increased.

The Ministry told us that it does not have a formula for funding long-term care beds. It provides the health regions a global budget to allocate at their discretion to meet the local needs.

A PUBLIC TRUST

Residents in long-term care homes are vulnerable. Families place their loved ones in the trust of these facilities. At a minimum, families expect that their loved ones will be safe, clean and properly fed. Families understand that accidents may happen, but if they do, they expect that these will be communicated promptly and honestly. They also expect their loved ones to be treated with kindness and dignity.

How do we, as a province, ensure this happens? The Ministry and the health regions have a responsibility to manage this broader picture. They provide the funding, leadership, regulations and need to provide monitoring to support long-term care homes in keeping this trust. Given what we have heard, we think the Ministry and health regions need to look more closely at the long-term care system and ask themselves questions such as: What are the care

“Mom was the most loving and caring person you have ever met. All we want is for her to be shown some respect and dignity in her last years.”

- family member of a resident
in a long-term care facility

needs of current and future long-term care residents in Saskatchewan? How many care aides should there be? What is a suitable staff mix? Should there be minimum care hours? Is the system funded to support the level of care required in the Guidelines? What does respectful treatment look like? And how do we meaningfully engage families and keep them informed?

RECOMMENDATION 19

That the Ministry of Health, in consultation with the health regions and other stakeholders:

- a) Identify the care needs of current and future long-term care residents.**
- b) Identify the factors affecting the quality of long-term care delivery.**
- c) Develop and implement a strategy to meet the needs of long-term care residents and to address the factors affecting the quality of long-term care in Saskatchewan; and make the strategy public.**

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Finding

Santa Maria staff did not ensure Margaret's skin was free of bedsores as required. They also did not refer her to the Wound Care Centre as required, nor report her stage 3 or higher bedsores to the Region as required.

RECOMMENDATION 1

That Santa Maria Senior Citizens Home implement a process to ensure that its staff:

- a) Can identify, manage and treat bedsores.
- b) Understand that they must pay particular attention to advanced or complicated bedsores and know when to consult external resources about treatment.
- c) Follow prescribed care plans when caring for bedsores.
- d) Are aware of the duty to report bedsores as required by standard 17.1 of the *Program Guidelines for Special-care Homes*.

Finding

Santa Maria did not ensure that Margaret's care was accurately recorded in her chart, as required.

RECOMMENDATION 2

That Santa Maria Senior Citizens Home implement a process to ensure residents' charts are up to date and that staff know when and what to chart, in accordance with standards 16.1 and 16.2 of the *Program Guidelines for Special-care Homes*.

Finding

Santa Maria did not meet the Ministry's Guidelines for ensuring Margaret received adequate nutrition and fluids.

RECOMMENDATION 3

That Santa Maria Senior Citizens Home implement a process to ensure that residents receive adequate hydration and nutrition in accordance with standard 13.5 of the *Program Guidelines for Special-care Homes*.

Finding

Santa Maria did not take appropriate steps to effectively flag and address Margaret's significant weight loss.

RECOMMENDATION 4

That Santa Maria Senior Citizens Home implement a process to ensure that when a resident's weight change exceeds a certain threshold (established in consultation with a dietician) that it be reported to the Director of Care (or equivalent), as well as the resident and family, so that any appropriate interventions can be considered and agreed upon.

Finding

Santa Maria did not update Margaret's care plan as frequently as would reasonably be expected given her significant weight loss, the appearance of her bedsores and her overall deterioration.

RECOMMENDATION 5

That Santa Maria Senior Citizens Home audit residents' charts and care plans in accordance with its *Quality Assurance* policy (NUR 9.3).

RECOMMENDATION 6

That Santa Maria Senior Citizens Home implement a process to ensure that care plans are reviewed and updated in accordance with standard 15.5 of the *Program Guidelines for Special-care Homes*.

Finding

Santa Maria did not effectively manage Margaret's pain.

RECOMMENDATION 7

That Santa Maria Senior Citizens Home implement a process to ensure effective recognition, assessment and management of residents' pain in accordance with standard 1.4 of the *Program Guidelines for Special-care Homes*.

Finding

There is no consensus among Santa Maria staff and between Santa Maria and the Region about what is required to comply with the transferring, lifting and repositioning procedures and to conduct a proper transfer.

RECOMMENDATION 8

That Santa Maria Senior Citizens Home ensure that its *Transfer Lifting and Repositioning* policy is approved by the Regina Qu'Appelle Health Region and that Santa Maria staff understand the policy, its requirements, and how to conduct a proper lift.

Finding

There is no consensus among Santa Maria staff about whether and in what circumstances care aides may deviate from a resident's care plan.

RECOMMENDATION 9

That Santa Maria Senior Citizens Home clarify, for both its management and care staff, who has the authority to change or deviate from a resident's care plan.

Finding

Santa Maria did not record whether it fully informed Margaret or her family about the status of her bedsores, the significance of her weight loss, her nutrition and hydration, or whether it fully engaged Margaret or her family in implementing solutions to these problems. Santa Maria also failed to follow up with Margaret and her family about the potential significance of her fall and their request that the care aides involved in her fall no longer work with her.

RECOMMENDATION 10

That, in keeping with resident and family centred care, Santa Maria Senior Citizens Home ensure that:

- a) **Processes are put in place to fully inform residents and their families of the resident's care needs and of Santa Maria's plans to meet these needs.**
- b) **These discussions are documented.**

Finding

Neither the Region nor the Ministry has undertaken to ensure that the Ministry's standards are being met and applied consistently and equitably across the Region and the province. All three levels of Saskatchewan's long-term care system need to work collaboratively to establish clear performance expectations and hold one another accountable for meeting those expectations.

RECOMMENDATION 11

That the Regina Qu'Appelle Health Region:

- a) **Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-care Homes*.**
- b) **Identify, track and report on specific and measurable outcomes that ensure the standards of care in the *Program Guidelines for Special-care Homes* are met consistently for each long-term care resident.**
- c) **Include these specific and measurable outcomes as performance requirements in its agreements with long-term care facilities.**

RECOMMENDATION 12

That the Ministry of Health ensure that all health regions:

- a) **Develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-care Homes*.**
- b) **Identify, track and report on specific and measurable outcomes that ensure the standards of care in the *Program Guidelines for Special-care Homes* are met consistently for each long-term care resident.**
- c) **Include these specific and measurable outcomes as performance requirements in their agreements with long-term care facilities.**

RECOMMENDATION 13

That the Ministry of Health implement a publicly accessible reporting process that families can use to see whether each long-term care facility is meeting the *Program Guidelines for Special-care Homes*.

Finding

When Margaret was a resident at Santa Maria, its staff were not always aware of, and did not always consistently respond to, Margaret's preferences and her and her family's concerns.

RECOMMENDATION 14

That Santa Maria Senior Citizens Home implement an efficient process for ensuring that all staff caring for a resident are, and remain, aware of concerns and preferences raised by the resident and family members.

Finding

Santa Maria's new *Management of Resident/Family Concerns* policy addresses most of the requirements in the Ministry's Guidelines about concern-handling and appeals. However, it does not explain how residents and their families will be informed of appeal levels and procedures, and what resources (besides the Region's Client Representative) are available.

RECOMMENDATION 15

That Santa Maria Senior Citizens Home take steps to ensure that its *Management of Residents/Family Concerns* policy meets the requirements of standards 17.3 and 2.4 of the *Program Guidelines for Special-care Homes* and is widely available and communicated to staff, residents and their families.

Finding

Neither the Ministry's Guidelines nor Santa Maria's *Management of Resident/Family Concerns* policy address how Santa Maria is to handle concerns about resident care that are raised by its staff.

RECOMMENDATION 16

That Santa Maria Senior Citizens Home provide a comprehensive process to investigate and protect anyone, including staff, who, in good faith, raise questions or concerns about a resident's care.

Finding

The Ministry's Guidelines lack specific requirements to help ensure that the concern-handling and appeal processes at long-term care homes are fair and reasonable.

RECOMMENDATION 17

That the Ministry of Health amend the *Program Guidelines for Special-care Homes* to provide more details of the steps needed in concern-handling and appeal processes, and ensure that the processes are procedurally fair.

Finding

Santa Maria's strained employer-employee relationship and work environment could be affecting the quality of care it is providing to residents.

RECOMMENDATION 18

That Santa Maria Senior Citizens Home take steps to identify the issues straining its employer-employee relationship and implement an inclusive plan to address these issues.

Finding

Based on what we heard from long-term care staff, management and families, Saskatchewan's long-term care system appears to be under strain. It is not clear whether the system is structured to meet the needs of residents in long-term care now and in the future.

RECOMMENDATION 19

That the Ministry of Health, in consultation with the health regions and other stakeholders:

- a) Identify the care needs of current and future long-term care residents.
- b) Identify the factors affecting the quality of long-term care delivery.
- c) Develop and implement a strategy to meet the needs of long-term care residents and to address the factors affecting the quality of long-term care in Saskatchewan; and make the strategy public.



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