

Manitoba Ombudsman

750 – 500 Portage Avenue
Winnipeg, MB R3C 3X1
Telephone: 204-982-9130
Toll Free in Manitoba: 1-800-665-0531
Fax: 204-942-7803
E-mail: ombudsma@ombudsman.mb.ca
www.ombudsman.mb.ca

500 av. Portage, Pièce 750
Winnipeg, MB R3C 3X1
Téléphone : 204-982-9130
Sans frais au Manitoba : 1-800-665-0531
Télécopieur : 204-942-7803
Courriel : ombudsma@ombudsman.mb.ca
www.ombudsman.mb.ca

March 11, 2019

The Honourable Margaret Wiebe
Chief Judge
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

Our files: 2014-0553, 0554, 0555 & 2015-0122
Recommendations re Inquest Report for Brian Lloyd Sinclair

Dear Chief Judge Wiebe:

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendations into the death of Mr. Brian Lloyd Sinclair. The December 9, 2014 inquest report of the Honourable Judge Timothy J. Preston was issued on December 12, 2014.

BACKGROUND

The inquest report detailed the circumstances of Brian Lloyd Sinclair's death. Mr. Sinclair died on September 21, 2008, at age 45, in the Emergency Department (ED) at the Health Sciences Centre (HSC).

Many hours earlier, Mr. Sinclair had attended at an inner city primary health care facility (the Health Action Centre or HAC) complaining of abdominal pain and problems with his Foley urinary catheter. He was assessed by a physician, provided a letter from the physician and told to give the letter to the Health Sciences Centre Emergency Department (HSC ED) staff when he arrived there.

At the HSC ED, Mr. Sinclair spoke to the Triage Aide at the ED reception desk and waited. He did not receive assessment or treatment for the next 34 hours, until discovered by another visitor in the ED. Thus, Mr. Sinclair had passed away in the waiting room of the HSC ED, hours prior to when HSC staff discovered he was dead.

The 63 recommendations made by the Honourable Judge Preston were noteworthy, in light of the circumstances of Mr. Sinclair's death. In the course of our monitoring efforts, we communicated with Manitoba Justice and Manitoba Health, Seniors and Active Living (MHSAL).

By its most recent letter dated January 25, 2019, MHSAL advised that of the 63 recommendations, 55 recommendations have been completed and eight are not completed. Of the eight recommendations that are not completed, seven are partially completed and only one recommendation remains open. Regarding the one recommendation that is open (Recommendation #22), MHSAL indicated it is unable to provide a timeline for completion, due to the operational status of the newly created Shared Health, the organization tasked with the recommendation.

RESPONSE TO INQUEST RECOMMENDATIONS

Below are the 63 recommendations and detailed summaries of how Manitoba Justice and MHSAL have addressed them:

Recommendation #1

That the Office of Public Trustee and the RHAs review their policies and procedures to ensure the primary care giver and service providers of any Committee of the Public Trustee are made aware of the Committeeship.

MANITOBA JUSTICE: ... When the Public Guardian and Trustee (PGT) is appointed as committee under The Mental Health Act, steps are taken to notify a variety of agencies and services of the appointment and the extent of the PGT's role in managing the affairs of the client. There is a delegation of a variety of responsibilities involving the needs of each client, to the regional health authority (RHA) where that client resides. ... In addition, the PGT contacts Manitoba Health to ensure the involvement of the PGT as committee can be included in the individual's health record. The PGT advises that the delegation made by the PGT to a RHA continues to be appropriate and forms one element of the communication strategy required to support the client.

...

MHSAL: RHAs and MHSAL have undertaken policy reviews and put in place policies to ensure primary care provider notification of committeeship status.

...

The MHSAL "Communication of Public Committeeship Status" Policy addresses this recommendation, requiring each RHA, the Selkirk Mental Health Centre (SMHC) and Health Corporations to have policies that set out a process for communicating a public committeeship status of a person to the primary care and service providers, ensuring providers' awareness.

Recommendation #2

That Winnipeg Regional Health Authority (WRHA) Home Care review its policies and procedures to ensure that Home Care updates service providers concerning any hospitalization of their clients.

MHSAL: RHAs and MHSAL have undertaken policy reviews. RHA policies and procedures that have been updated and implemented, will ensure service providers are provided information regarding hospitalization of clients.

...

This response applies to this recommendation and recommendations 3, 4 and 5. MHSAL and RHAs assessed the recommendation against the 28 current MHSAL Home Care policies, as well as RHA operational policies, procedures and guidelines. A policy gap was identified in two areas - (i) information sharing at points of transition of care and (ii) the policy on Home Care Service was suspended or withdrawn. RHAs undertook policy and procedures development to address these gaps.

The establishment of provincial policy to set expectation(s) for RHAs to have a policy is not yet finalized. Draft provincial policies are completed but finalization is pending the future state of MHSAL, to ensure alignment for policy oversight, going forward. This work is contingent on the operational status of Shared Health (SH).

Recommendation #3

That WRHA Home Care review its policies and procedures to ensure that each service provider is made aware of the specific care plan for each Committee.

MHSAL: RHAs and MHSAL have undertaken policy reviews. RHAs have policies and procedures that have been implemented, which will ensure service providers are aware of client care plans.

MHSAL repeats the last paragraph of its response under Recommendation#2 here.

Recommendation #4

That WRHA review its policies and procedures to ensure that when a medical service is put on hold, suspended or withdrawn from any client for any reason, that there is an alternate plan in place or that the hold be reviewed on a regular basis.

MHSAL: RHAs and MHSAL have undertaken policy reviews. RHAs have policies and procedures that have been implemented, which will ensure service providers are aware of changes to client care plans.

MHSAL repeats the last paragraph of its response under Recommendation#2 here.

Recommendation #5

That WRHA Home Care reviews its policies and procedures to ensure the provision to service providers of relevant background information of their vulnerable clients.

MHSAL: RHAs and MHSAL have undertaken policy reviews. RHAs have policies and procedures that have been implemented, which will ensure care providers are aware of relevant information of home care vulnerable clients.

MHSAL repeats the last paragraph of its response under Recommendation#2 here.

Recommendation #6

That the RHAs and the Office of the Public Trustee continue to review the feasibility of compatible electronic charting of all relevant medical information for clients of the Public Trustee.

MANITOBA JUSTICE: ... With respect to health and medical records, the PGT has no greater entitlement to health information than would have been available to the client. In most situations, the PGT does not need access to a client's health records. When medical information is required, the PGT will request it from the health provider in a manner similar to how the client would have made a request. In that context, implementing the recommendation that consideration be given to develop some form of shared database amongst RHA, MHSAL and PGT would be problematic from a records management and privacy perspective.

...

MHSAL: An Information Communication Technology (ICT) study had been undertaken to assess the feasibility of compatible electronic charting of all relevant medical information for clients of the Public Trustee. The feasibility study addressed all ICT recommendations from the Brian Sinclair Inquest, identifying that an investment of \$300M ongoing operating costs and approximately \$50M one-time cost would be required to accomplish the recommendations. Further, the assessment identified that the existing ICT capital plan will address, over time, the majority of ICT inquest recommendations.

Consequentially, the ICT plan will be sustained, ensuring, over time, all ICT issues identified in the Brian Sinclair inquest recommendations are addressed.

Recommendation #7

That the Office of the Public Trustee and the RHAs review their policies and procedures to ensure that when a patient is a Committee of the Public Trustee, the patient's Committeeship status is clearly flagged on that patient's medical chart.

MANITOBA JUSTICE: ... The discussions with the WRHA and MHSAL have explored the possibility of changing how and when the involvement of the PGT as committee is

communicated to each of those organizations and health service providers generally. The PGT is supportive of changes which lead to better communication and is prepared to make any changes necessary to PGT processes, procedures or systems that are required to accommodate changes made by RHAs and/or MHSAL.

MHSAL: The ICT feasibility assessment determined that the flagging of Public Trustee committee status is not presently in scope in the ICT plan. Further, it has been determined that the absence of this flag, poses the most material risk to RHAs being able to assure information communication across service entities (relative to committee status) and upholding the RHAs responsibilities therein.

As such, a recommendation to government will be forthcoming proposing specific one time and ongoing operating investments in an ICT solution to mitigate this ongoing risk.

Recommendation #8

That the RHAs review the feasibility of electronic charting for all their facilities.

MHSAL: An ICT study had been undertaken to assess the feasibility of electronic charting for all in scope facilities. The existing ICT capital plan will address, over time, electronic patient record deployment and eChart across all in scope facilities. The financial investment required to achieve this recommendation sooner is not feasible.

Furthermore, MHSAL indicated that its response to recommendation 6, 2nd paragraph (page 4) also applies to this recommendation.

Recommendation #9

That the protocol that requires primary care physicians sending patients to an Emergency Department (ED), to notify the ED in advance by phone, be maintained - including verification of whether a letter has been given to a client to present to the ED staff.

MHSAL: Assessments have been undertaken, affirming that the requirements established by the College of Physicians and Surgeons of Manitoba remain in place and are requirements of physician practice. The College of Physicians and Surgeons of Manitoba (CPSM) has practice standards/ guidelines in place that guide the communication process between primary care physicians and Emergency Departments (EDs).

Recommendation #10

That the RHAs continue to review their policies and procedures to examine the feasibility of letters from primary care physicians to EDs being sent electronically.

MHSAL: In the fall of 2016, the Health Senior Leadership Council limited the scope of this recommendation to only those individuals under the public trustee. An assessment of policies and procedures were undertaken, identifying that the limiting enabler in doing this function is the absence of identification of individuals who are committees. This

recommendation is not feasible in the absence of the implementation of the ICT solution proposed in recommendation 7.

Recommendation #11

That WRHA review its policies and procedures to ensure that primary care facilities develop a uniform protocol for the transportation of clients with mobility or cognitive challenges to other health care facilities.

MHSAL: In the fall of 2016, the Health Senior Leadership Council limited the scope of this recommendation to only those individuals under the public trustee. A review of RHA current practices, degree of risk presented by this issue, implications on RHA operations and alignment with RHA mandates occurred. MHSAL and RHA policies have been developed.

Operational governance roles are of particular question with the establishment of Shared Health (SH), thus some operational governance policies previously held by MHSAL may move to SH. Thus, the implementation of the policies is contingent on the operational status of SH.

Recommendation #12

That all RHAs review their policies and procedures to ensure that vulnerable persons, including persons with mobility issues, are assisted by staff with the triage process immediately upon their arrival at an ED.

MHSAL: RHAs and MHSAL have undertaken policy reviews and put in place policies to ensure this recommendation is addressed. RHA policy audits were undertaken in January 2017.

The MHSAL policy "Emergency Department Registration, Triage and Waiting Room Monitoring Policy" was implemented in August 2016. It required all regions to have policies and protocols in place, in response to a variety of policy gaps identified through the inquest (recommendations 12, 15, 17, 19 and 33). RHAs were audited on compliance with the policy in January 2017.

Recommendation #13

That paper triage lists at any ED be eliminated and that each presenting person's information be entered electronically into a hospital registration system upon first point of contact by ED staff.

MHSAL: Paper triage has been eliminated in EDs; policies have been developed and audited, entrenching this requirement. Registering the patient, at the first point of contact, is incongruent with the national triage standards to triage first. The objectives of the policies developed establish the intent to do both triage and registration simultaneously. The ability to electronically register patients at first point of contact is further limited at

in scope facilities by ICT and infrastructure. The deployment of Emergency Department Information System (EDIS) has addressed ICT requirements. The infrastructure assessment completed has identified the highest risk sites for this issue and proposes risk mitigation on these sites through safety and security (see recommendation 14 and 24).

...

Paper triage was eliminated across Manitoba following direction to do so within 3 months of the release of the inquest recommendations on December 12, 2014. RHAs were required to report to MHSAL, confirming they had eliminated paper triage methods and RHAs reported compliance with the direction.

Recommendation #14

That RHAs review the floor plan of all EDs to ensure that no persons in the ED waiting room requiring medical care face away from the triage desk.

MHSAL: Floor plans reviewed. Infrastructure assessments completed. Future infrastructure recommendations are coming forward to address high-risk sites which cannot meet this recommendation and recommendation 24, based on existing ED layout and infrastructure.

All rural emergency departments with greater than 10,000 visits per year have made accommodations to ensure that persons in the waiting rooms can be seen at the triage desk, predominantly the addition of CCTV cameras. As this work is ongoing and long-term, a timeline cannot be estimated.

Recommendation #15

That RHAs review their policies and procedures to ensure that persons in ED waiting rooms are awakened at regular intervals.

MHSAL: RHAs and MHSAL have undertaken policy reviews and put in place policies to ensure this recommendation is addressed. RHA policy audits were undertaken in January 2017.

In addition, the department repeated its response to recommendation #12, per the second paragraph in blue text under that recommendation.

Recommendation #16

That the RHAs review the feasibility of secondary traumatic stress training for all ED staff.

MHSAL: Assessment of existing activities in place and RHA investments required to attain this recommendation, have occurred. Training standards will be imbedded into operational and governance policy to be implemented and audited on a go forward basis.

...

The following training is available across regions: Vicarious trauma training is provided to all RHAs. Additionally, Northern Regional Health Authority (NRHA) provides online psychological First Aid for all ED staff to complete.

Recommendation #17

That the RHAs review their policies and procedures to ensure that staff intervenes when a person is vomiting in an ED.

MHSAL: RHAs and MHSAL have undertaken policy reviews and put in place policies to ensure this recommendation is addressed. RHA policy audits were undertaken in January 2017.

Recommendation #18

That the RHAs review their policies and procedures with respect to interview notes taken on behalf of hospital Administration after the occurrence of critical incidents, with a view to having the notes dated and initialed or otherwise authenticated by the interviewee.

MHSAL: Policy analysis and feasibility assessment was conducted, determining that this recommendation is incongruent with critical incident policy and legislation, and is not feasible.

...

The Critical Incident Reporting and Management Policy provides direction to regional health authorities and provincial organizations with respect to critical incident reporting, investigation, disclosure and recording, and notification to the Minister in accordance with the legislation. The review determined that undertaking this recommendation would be incongruent with this policy.

Recommendation #19

That the RHAs review handover policies in the ED to ensure that the oncoming triage and reassessment nurses are fully briefed on the status of persons present in the waiting room.

MHSAL: RHAs and MHSAL have undertaken policy reviews and put in place policies to ensure this recommendation is addressed. RHA policy audits were undertaken in January 2017.

In addition, the department repeated its response to recommendation #12, per the second paragraph in blue text under that recommendation.

Recommendation #20

That all RHAs review the feasibility of a security presence at the entrance to an ED.

MHSAL: A feasibility assessment was undertaken by all RHAs, identifying that to address this recommendation, an investment of approximately \$4.5M ongoing operating would be required for all in scope facilities. The relative risks necessitating a 24/7 security presence at in scope EDs have not materialized, and as such, this has been determined to not be feasible or required at this time.

Recommendation #21

That ED Security staff receive training in the areas of substance abuse and dealing with persons with physical or mental challenges.

MHSAL: Assessment of existing activities in place and RHA investments required to attain this recommendation have occurred. Training standards will be imbedded into operational and governance policy to be implemented and audited on a go forward basis.

Recommendation #22

That all RHAs review the feasibility of implementing the recommendations of the Brian Sinclair Critical Incident Review Committee.

MHSAL: This recommendation was determined to be redundant of most other recommendations with the exception of the RHA development of role descriptions for all Emergency Department (ED) staff, presently underway. Shared Health Manitoba (SH) will also play a role in establishing the standards for education and roles of ED staff provincially.

Accordingly, actions associated with this recommendation are contingent on the operational status of SH, which is undertaking provincial oversight including the development of standardized job descriptions. A timeline for this work cannot be estimated at this time.

Recommendation #23

That all RHAs review the feasibility of the presence of a Community Support Worker for EDs, where deemed appropriate.

MHSAL: Feasibility assessment was undertaken, identifying that an ongoing operating investment of approximately \$3.34M per annum would be required. Recommendations on pursuit of this investment have been deferred, awaiting outcomes of the Health System Sustainability and Innovation Review (HSIR), aka KPMG Report, and ED Wait Times Task Force recommendations.

Recommendation #24

That all RHAs review the feasibility of creating a distinct pre-triage area for EDs, where deemed appropriate.

MHSAL: Infrastructure assessments have been completed. Future infrastructure recommendations are being worked on, to address high-risk sites that cannot meet this recommendation and recommendation 14, based on existing ED layout and infrastructure.

Recommendation #25

That all RHAs review the feasibility of replicating the HSC ED front-end procedures throughout the system, where deemed appropriate.

MHSAL: Given the variation in infrastructure, ICT and staffing at all in scope EDs, this recommendation has been determined not feasible.

Recommendation #26

That the RHAs continue to review, create and implement long-term strategies for the recruitment and retention of nurses.

MHSAL: Evidentiary documentation has been compiled provincially and for each RHA on existing strategies for mid and long term nursing recruitment.

The review resulted in identifying multiple strategies in place across regions, including but not limited to the Nursing recruitment and retention fund, relocation assistance, refresher programs, various education grants, various mentorship programs, and regional implementation of the "Grow your own" program.

Recommendation #27

That the RHAs continue to review a rotation of roles and hours of work for ED Nurses in an effort to reduce fatigue.

MHSAL: The regions review and adjust staffing rotations and hours of work in emergency departments, on an annual basis and more frequently as part of regular operational planning. RHAs have submitted evidentiary documentation confirming that these activities occur annually and as part of regular operational planning processes.

Recommendation #28

That RHAs, health care site Directors, Nurse Directors and Manitoba Nurses Union (MNU) representatives continue to convene ongoing meetings focused on an interdisciplinary, integrated health care model for Emergency Medicine.

MHSAL: All RHAs, with the exception of Northern Regional Health Authority (NRHA), have submitted responses indicating that ongoing interdisciplinary meetings on integrated health care for Emergency Room (ER) Medicine services occur regularly. Follow up with NRHA will occur.

Recommendation #29

That the WRHA review the feasibility of establishing Transition Centres for vulnerable patients discharged from urban EDs, where deemed appropriate.

MHSAL: Health System Leadership Council (HSLC) directed an alternate solution be implemented, as transitional housing for homeless individuals is not within the mandate of the health care system. RHAs were directed to identify processes by which the RHAs engage with social support / homelessness service entities within each RHA. Evidentiary documents from each RHA, addressing the matter, have been submitted accordingly.

Recommendation #30

That the RHAs identify staffing demands in all EDs and strategically plan to supply adequate staffing for all EDs.

MHSAL: The regions regularly review and identify staffing demands in emergency departments, on both an annual basis and as part of regular operational planning. RHAs have submitted evidentiary documentation confirming that these reviews occur annually and as part of operational planning processes.

Evidentiary documentation reviewed included: RHA's daily assessments of staffing ratios and scheduling. The assessments included ensuring hours of work are compliant to existing collective agreements.

Recommendation #31

That an ongoing review of staffing ratios for all EDs be undertaken by all RHAs, to match supply to demand.

MHSAL: The regions regularly review and identify staffing ratios for all EDs to ensure the supply of staff matches the demand for them. RHAs have submitted evidentiary documentation indicating that these reviews occur annually and more frequently as part of regular operational planning processes.

Recommendation #32

That the RHA Directors, Site Directors, ED Directors and the Ministry of Health review the feasibility of strategic planning to implement accountability structures, including measurement and reporting systems.

MHSAL: A feasibility review has been completed. The province and the regions follow a framework that sets out processes for strengthening the accountability of the health system. The framework document is available at:

<http://www.gov.mb.ca/health/rha/docs/ahsa2009.pdf>

In satisfaction of this recommendation, the province and regions have developed evidentiary documentation, outlining how accountability processes occur regularly.

Recommendation #33

That the RHAs review the feasibility of creating a region-wide Overcapacity Protocol, such as the Alberta Overcapacity Plan, where deemed appropriate.

MHSAL: RHAs and MHSAL have undertaken policy reviews and put in place policies to ensure this recommendation is addressed. RHA policy audits were undertaken in January 2017.

In addition, the department repeated its response to recommendation #12, per the second paragraph in blue text under that recommendation.

Recommendation #34

That the RHAs review the feasibility of providing on-site diagnostic equipment in EDs, where deemed appropriate.

MHSAL: An assessment of the operational requirements of RHAs, at in scope facilities (necessitating increased on-site diagnostic equipment) was conducted. The assessment concluded that current diagnostic equipment available at in scope facilities, is sufficient for patient and provider requirements.

Recommendation #35

That the RHAs review the feasibility of a seven-day workweek for the office of the Home Care Coordinator.

MHSAL: This recommendation was incorporated into Home Care review & recommendations. It will be addressed by actions determined through the home care review. This recommendation will be further addressed through Shared Health / RHA Clinical Services planning, and is accordingly contingent on the operational status of Shared Health.

Recommendation #36

That the relevant utilization representative(s) meet with the Ministry of Health, Housing and Healthy Living representatives to continue to review bed registry and guidelines for transfers and discharge of patients from hospitals, including the feasibility of a seven-day work week.

MHSAL: It has been determined that the Ministry of Housing does not have a role to play in the long-term clinical care and associated housing of patients. WRHA has implemented a 7-day workweek for utilization managers. It has been determined that this requirement is not warranted in facilities outside of Winnipeg.

Discharge guidelines have been reviewed by RHAs and will be further informed by standards developed by SH. Shared Health will also review and propose recommendations on bed registries provincially. Accordingly, this recommendation is contingent on the operational status of Shared Health.

Recommendation #37

That RHAs review the feasibility of the implementation of the delivery of primary care, after-hours, urgent services, where deemed appropriate.

MHSAL: Evidentiary documentation has been prepared demonstrating the current and planned actions of the province and RHAs in satisfaction of this recommendation.

The following have been undertaken to achieve after hours service delivery of primary care:

- In 2014, the CPSM issued a policy statement to all physicians, which outlined practice coverage of physicians for after hours and vacation.
- As part of the Doctors Manitoba Agreement, physicians employed or contracted by a RHA are required to follow specific duties as outlined in a “Job Description for General Practitioner Physicians”. Among several duties related to timely access to primary care, physicians are required to participate in after-hours services.
- MHSAL has undertaken numerous steps to increase system and provider capacity that will improve and increase access overall and at the time patients want/ need it, such as supporting provider groups to implement Advanced Access, adding resources to support interprofessional practice, the opening of eight Access Centres in Winnipeg and the creation of My Health Teams.

Recommendation #38

That the WRHA review the feasibility of community health care facilities with integrated models of care.

MHSAL: Evidentiary documentation has been prepared, demonstrating that the current and planned actions of the province and RHAs are in satisfaction of this recommendation.

Feasibility assessments reviewed the need for consistency in access to primary care across the province and, the readiness of regional and primary care provider assessment for establishing integrated models of care. Progress has been made on the implementation of the Primary Care Strategic Plan, to address:

- Primary care capacity planning – a robust planning process with the regional, primary care and provincial representatives in its second year. This process identifies gaps in primary care and potential solutions, to stabilize primary care.
- Enrollment at a home clinic, to identify Manitobans that have a regular primary care provider. As of December 1, 2017, 62% of Manitobans have been officially enrolled.
- There are Primary Care Networks operational in three regional health authorities in Manitoba.
- 40 new inter-professional team members have been hired to work with Fee-for-Service (FFS) physicians, to increase access to primary care and enable physicians to spend more time with patients, to meet their medical needs.

MHSAL was further investigating access to improved primary care services. Efforts to improve coordination between primary care providers and sites, other health and social services to meet patients' needs through information sharing, referral pathways and service inventories are currently underway.

Recommendation #39

That RHAs continue to review the feasibility of incorporating more Nurse Practitioner positions in EDs, where deemed appropriate.

MHSAL: Feasibility assessments were undertaken. RHAs have an indication of where Nurse Practitioners (NPs) are in place and where they could be in place, in future, if supply of NPs is available. MHSAL recommended a deferral of further work on this recommendation, to align with clinical services models and NP placement determination, in correlation with the Clinical Services Planning report (CSP report) and KPMG reports.

Recommendation #40

That RHAs review the feasibility of recruiting and retaining Hospitalists, where deemed appropriate.

MHSAL: Shared Health Manitoba will further assess this issue in congruence with recommendations of the Provincial and Clinical Services plan and Health Sustainability Innovation Review.

Recommendation #41

That RHAs review the feasibility of the implementation of “one way consults” from the ED to the hospital ward, where deemed appropriate.

MHSAL: Provincial Medical Leadership Council (PMLC) has advised that this is not feasible. However, processes to improve consultation and admission from the ED will be further assessed following operational status of Shared Health.

Recommendation #42

That the RHAs review the feasibility of hiring and retaining Physician Assistants to work in EDs, where deemed appropriate.

MHSAL: Actions on this recommendation were deferred pending the outcomes of KPMG report, Clinical Services Planning report (CSP report) and emergency task force report. The KPMG report titled "Health System Sustainability and Innovation Review" was released in full on May 31, 2018. Further action on this recommendation is contingent on the operational status of Shared Health.

Recommendation #43

That the RHAs review the feasibility of creating a process to establish a deadline for admitting a "boarded" ED patient to a hospital bed, where deemed appropriate.

MHSAL: Similar to recommendation 41, processes to improve consultation and admission from the ED will be further assessed, following operational status of Shared Health.

Recommendation #44

That the RHAs create a Hospital Length-Of-Stay Reduction Committee to monitor and optimize patient flow in RHA hospitals.

MHSAL: All RHAs have flow committees that consider issues of length of stay. In addition, issues of length of stay and flow optimization will be further considered by SH to establish provincial benchmarks for RHAs to adhere to. The establishment of provincial benchmarks for flow will occur in conjunction with the SH-led clinical services planning, the completion date of which is unknown.

Recommendation #45

That the WRHA engage in strategic planning with the Ministry of Health and Manitoba Housing for the funding and construction of more long term care facilities.

MHSAL: MHSAL developed a 10-year Personal Care Home (PCH) plan, and presented it to the Health System Leadership Committee (HSLC), who accepted the plan as satisfactory evidentiary documentation for this recommendation.

In 2016, the government announced a commitment for the establishment of 1200 additional PCH beds and the completion date for this is unknown.

Recommendation #46

That WRHA continue pursuing the feasibility of the recruitment and retention of more Nurse Practitioner services in personal care homes.

MHSAL: Feasibility assessments were undertaken. RHAs have an indication of where Nurse Practitioners (NPs) are in place, and where they could be in place in the future-if the supply of NPs becomes available. MHSAL recommended a deferral of further work on this recommendation, pending the operational status of Shared Health.

Recommendation #47

That the RHAs review the feasibility of the creation of a single electronic health record accessible to all health care facilities.

MHSAL: An ICT study had been undertaken to assess the feasibility of electronic charting for all in scope facilities. The existing ICT capital plan will address, over time, electronic patient record deployment and eChart across all in scope facilities. The financial investment required to achieve this recommendation sooner is not feasible.

In addition, the department advised that its response to recommendation 6 (i.e. that an investment of \$300M ongoing operating costs and approximately \$50M one-time cost would be required to accomplish the recommendation) applies to this recommendation.

Recommendation #48

That the Ministry of Health and the RHAs review the feasibility of the expansion of Primary Care Networks.

MHSAL: Evidentiary documentation has been prepared, demonstrating the current and planned actions of the province and RHAs in satisfaction of this recommendation. The second phase of the Provincial Evaluation of My Health Teams was completed April 2018.

Recommendation #49

That the WRHA review the feasibility of the expansion of Nurse Practitioner-operated Quick Care Clinics to help ease wait times at EDs and Primary Care Physicians' offices.

MHSAL: Evidentiary documentation has been prepared, demonstrating the current and planned actions of the province and RHAs in satisfaction of this recommendation.

Recommendation #50

That the WRHA and the Ministry of Health continue to create strategies to educate the public about the existence, function and location of community health care centres.

MHSAL repeated here, its response (in blue text) to recommendation 49. Furthermore, MHSAL confirmed that its current educational methods and strategies are sufficient to satisfy the recommendation, and indicated that:

No specific action on this recommendation outside of routine practices is required at this time. MHSAL and RHAs will continue to adjust tactics and messaging as required to reach a broad spectrum of the population.

Recommendation #51

That the WRHA review the feasibility of creating an integrated “engagement and diversion” program for the homeless.

MHSAL: HSLC directed alternate solution be implemented, as transitional housing and homelessness programs are not within the mandate of the health care system. RHAs were directed to identify processes by which the RHAs engage with social support/homelessness service entities within each RHA. Evidentiary documents from each RHA have been submitted accordingly.

RHAs were required to submit letters to MHSAL, indicating how they partner with these agencies. All RHAs did so in November 2016, reflecting various kinds of partnerships with various kinds of social services agencies.

Recommendation #52

That the RHAs review the feasibility of the installation of an electronic board to monitor the status of the patients in the ED, where deemed appropriate.

MHSAL: An ICT study had been undertaken to assess the feasibility of installation of electronic boards for monitoring patient status, determining that this practice is standard in EDIS deployment. EDIS deployment, at in scope facilities, is part of the existing ICT plan and has occurred. EDIS deployment at sites with less than 10,000 visits, but at risk due to population or geography, are not in scope to the current EDIS ICT plan and would require additional investment and authority from government.

Recommendation #53

That the RHAs and MNU continue to review the feasibility of persons presenting at EDs seeing a nurse first.

MHSAL: Policy objectives establish intent to do both triage and registration simultaneously. The ability to electronically register patients at first point of contact is further limited at in scope facilities by ICT and infrastructure. The deployment of EDIS has addressed ICT requirements. The infrastructure assessment completed has identified the highest risk sites for this issue and proposes risk mitigation on these sites through safety and security (see MHSAL’s response to recommendations 14 and 24).

Recommendation #54

That the RHAs review policies and procedures with a view to implementing uniform pre-triage systems at all EDs.

MHSAL: Given the variation in infrastructure, ICT and staffing at all in scope EDs, this recommendation has been determined not feasible.

Recommendation #55

That the RHAs review the feasibility of incorporating training in the area of emotional safety for health care professionals.

MHSAL: Assessment of existing activities has occurred. Assessment of RHA financial investments required to attain this recommendation has occurred. Shared Health will take a lead role on establishing standards of education required for health system employees in the areas of resiliency training, and cultural safety and competency.

Recommendation #56

That the RHAs review the feasibility of recruiting and retaining an Indigenous Elder for EDs, where deemed appropriate.

MHSAL: Review and analysis undertaken, and recommendation determined to be not culturally appropriate. Alternate solution proposed focusing on access to spiritual care and / or Elder, on request.

Recommendation #57

That the WRHA Indigenous Health Services continue to make efforts to recruit and retain the services of Indigenous Elders to be present in the HSC ED during peak hours, seven days a week.

MHSAL: Review and analysis undertaken and, recommendation determined to be not culturally appropriate in an ED environment. Alternate solution proposed, focusing on ensuring access to spiritual care, Elder, interpreter or resource workers on request or as needed.

Recommendation #58

That the RHAs review the feasibility of the hiring and retention of Indigenous Discharge planners, where deemed appropriate.

MHSAL: Through review, it has been determined that hiring and retention of Indigenous Discharge planners is not culturally appropriate. RHAs have undertaken collaboration with Indigenous communities, to improve processes and the coordination of discharge planning for Indigenous Manitobans.

Recommendation #59

That the WRHA Indigenous Health Services review their informational pamphlets at each hospital site to ensure that the pamphlets are available in Manitoba's Indigenous and Inuit languages.

MHSAL: Review and analysis of informational pamphlets was completed. It was determined that this approach is not culturally responsive or appropriate, and that alternate methods of improving communication which are more appropriate, will be pursued, including the following alternate actions, which are in place among RHAs:

- Indigenous Health Programs Interpreters and the Language Access phone line.
- “It’s Safe to Ask” posters are posted in Indigenous languages.
- RHA posters available in English, French, Ojibway and Dakota languages.

Recommendation #60

That the RHAs strategically plan with Manitoba First Nations to review the feasibility of the establishment of rural Indigenous personal care homes in the Province of Manitoba, where deemed appropriate.

MHSAL: Evidentiary documentation was provided of work being undertaken by RHAs in consultation with Indigenous Manitobans, which include determining alternate priorities relative to First Nation PCH care.

Evidence of the following actions was provided:

- Strategic planning of rural Indigenous personal care homes (PCHs) was raised at the Intergovernmental Committee on Manitoba First Nations Health (ICMFNH) planning day in March 2016. Licensing and standards were identified as the focus for work on this committee rather than any expansion of PCHs for Indigenous persons.
- The Intergovernmental Committee on Manitoba First Nations Health and Social Development work plan for 2016-17 highlighted the provision of technical support/ coordination for the Manitoba First Nations Personal Care Home Network, to support accreditation and licensing of all eight First Nations PCHs.
- Two facilities are licensed, with work underway to seek direction around licensing for the six facilities that remain outstanding.

Recommendation #61

That the WRHA reviews the feasibility of expanding the Indigenous Resource Worker position to include weekends.

MHSAL: An analysis was undertaken, identifying that this recommendation is not financially feasible and that focus on service coordination and appropriate resourcing based on client needs were more appropriate.

The focus was revised towards service coordination and appropriate resource provision for the following:

- Indigenous Resource Workers;
- Regional Discharge Planning Coordinators;
- Liaisons present in select facilities with larger Indigenous patient populations across regions.

This plan has been implemented.

Recommendation #62

That the WRHA review the training of all ED security personnel to ensure that they receive cultural safety training.

MHSAL: An assessment of existing activities has occurred. Assessment of RHA financial investments required to attain this recommendation have occurred. Shared Health will take a lead role on establishing standards of education required for health system employees in the areas of resiliency training, and cultural safety and competency.

Indigenous cultural training for security staff is in place in Prairie Mountain Health (PMH), NRHA and WRHA. Indigenous cultural training is not in place in Interlake-Eastern Regional Health Authority (IERHA), but will be addressed through Shared Health education and standardization. Southern Health / Santé Sud (SH-SS) has advised that they do not have security. Therefore, this recommendation is not applicable to SH-SS.

Recommendation #63

That the RHAs develop and initiate policies for the implementation of mandatory and ongoing cultural safety training for all health care workers and that the RHAs ensure that cultural safety training includes a component that has been designed and delivered with the assistance of Indigenous persons.

MHSAL: An assessment of existing activities has occurred. An assessment of RHA financial investments required to attain this recommendation has occurred. SH will take a lead role on establishing standards of education required for health system employees in the areas of resiliency training, and cultural safety and competency.

All regions provide Indigenous cultural awareness and/or cultural safety training to staff on an optional, encouraged or required basis, depending on the role/ position of the staff.

In its response of May 4, 2018, MHSAL stated:

“Manitoba has undertaken several studies to identify opportunities for improvement in the health care system, including the Provincial Clinical Preventative Services Planning Report (PCPSP), the Wait Times Reduction Task Force Report (WTRTF), and the Health Sustainability and Innovation Review (HSIR).

Acting on the findings from several of these studies, Shared Health Manitoba (SH) was recently established to improve patient care and services, and provide coordinated clinical support to RHAs. SH will allow government to work across the province to realign and refocus the health care system. The development of provincially standardized processes and activities associated with some recommendations will occur by SH, once it is fully established and operational”.

In its most recent response of January 25, 2019, MHSAL repeated its advice in its letter of May 4, 2018.

MHSAL further stated, “... recommendations with actions impacted by the implementation of Shared Health have been identified”. MHSAL identified recommendation outcomes that required revision to align with the department’s update for accuracy. Accordingly, we included in our discussion of the recommendations, MHSAL’s most recent updates on the 63 recommendations as of January 25, 2019.

CONCLUSION

Given that the majority of the recommendations discussed above have been completed, a few have been found unfeasible, and the eight outstanding recommendations are in the process of being implemented by MHSAL and SH, our office is concluding our monitoring of this matter at this time.

Please note that an electronic copy of this report will be posted on the Manitoba Ombudsman website at www.ombudsman.mb.ca.

Yours truly,



Marc Cormier
Acting Manitoba Ombudsman

cc: Ms. Karen Herd, Deputy Minister, Manitoba Health, Seniors and Active Living
Mr. Dave Wright, Deputy Attorney General and Deputy Minister, Manitoba Justice
Mr. Brock Wright, Chief Executive Officer, Shared Health
Dr. John K. Younes, Chief Medical Examiner