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February 7, 2020

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

Our files: 2016-0029
Recommendations re Inquest Report of Heather Dawn Brenan

Dear Chief Judge Wiebe:

Since 1985, Manitoba Ombudsman has been responsible for following up with provincial public bodies that are the subject of inquest recommendations made under the Fatality Inquiries Act. This responsibility arises from an agreement between Manitoba Ombudsman, the Chief Medical Examiner, and the Chief Judge of the Provincial Court. Through our follow-up, we determine what action has been taken to give effect to inquest recommendations and then report the outcome to the Chief Judge.

We are writing to advise you of the results of the inquiries made by our office concerning the inquest report recommendations into the death of Heather Dawn Brenan. At the time, you were the Judge that heard this inquest, and your inquest report (dated December 22, 2015) was released on December 29, 2015.

BACKGROUND

This inquest arose from the death of Heather Dawn Brenan on January 28, 2012, in the Intensive Care Unit of Seven Oaks General Hospital (Seven Oaks). She was 68 years old at the time of her death.

Ms. Brenan was admitted to Seven Oaks on January 24, 2012 after being brought to the Emergency Department with complaints of weakness and difficulty swallowing. She had also suffered substantial weight loss since the month prior. She remained at the Seven Oaks Emergency Department from January 24 to 27, 2012, during which time over 20 health care providers cared for her. She was never admitted to a ward.

On January 27, 2012 at 10:35 p.m., Ms. Brenan was discharged from Seven Oaks by an attending physician. She was transported home by taxi and was dropped off in her back lane to meet a friend who had her keys. Ms. Brenan subsequently collapsed at the doorway of her home and was brought back to the Seven Oaks Emergency Department shortly after midnight on January 28, 2012.

Ms. Brenan was resuscitated in the Emergency Department and transferred to the Seven Oaks Intensive Care Unit (ICU). Her condition continued to deteriorate, and she died during the morning of January 28, 2012.

Upon conclusion of the inquest hearing, you made 25 recommendations which were directed to the Winnipeg Regional Health Authority (WRHA). Our office has followed up with the WRHA as well as Manitoba Health, Seniors and Active Living (MHSAL) regarding the implementation of the recommendations.

RESPONSE TO INQUEST RECOMMENDATIONS

MHSAL provided us with updates on the status of the implementation of the inquest recommendations on October 4, 2016 and February 7, 2018. These responses included detailed status updates from the WRHA. We received additional responses from the WRHA through correspondence dated October 17, 2018, April 28, 2019, November 4, 2019 and January 29, 2020.

Our report on each recommendation is as follows:

RECOMMENDATION #1 *(complete)*

The WRHA should consider implementing a flag within its Utilization System so that any patient in the Emergency Department beyond a certain number of hours, as determined by the WRHA, should be specifically considered by the Utilization Team for follow up.

MHSAL advised us that it has completed implementation of a real-time patient management software system called Oculys. Oculys allows for live monitoring of all wait times for Emergency Department patients at all sites and regionally.

The WRHA advised us that the Oculys system was deployed at its hospitals by November 2016 and its regional summary view was made available in April 2017. In addition to monitoring the wait times for Emergency Department patients, Oculys includes time flags for each step in the patient journey within the Emergency Department. This includes time in the waiting room, treatment time, and waiting time for those who require hospital admission.

The WRHA reports that the Oculys time flag information is available on large screens in the Emergency Department of each hospital. Staff and managers are expected to monitor the flags and take appropriate action. The Oculys system is also available on desktop computers and mobile devices for the Utilization Team and hospital leadership. The Utilization Team and

leadership are also expected to monitor Oculys and provide assistance to the Emergency Department in order to address situations where times have exceeded the expected limit.

As the responses received from MHSAL and the WRHA meet the intent of this recommendation, our follow up of Recommendation #1 is complete.

RECOMMENDATION #2 (*complete*)

The WRHA should move towards finalization of the regional overcapacity protocol.

The WRHA advised us that the overcapacity protocol is a plan that can be activated when the system is experiencing a sudden increase in activity in the Emergency Department and demand for hospital admission. There are a variety of actions that can be taken at the individual hospital level or at the system level to respond to this demand, and the plan includes four levels of escalating action. This plan was approved in 2016, and MHSAL has confirmed that the protocol document has also been approved.

As the protocol outlined in Recommendation #2 has been finalized, our follow up of this recommendation is complete.

RECOMMENDATION #3 (*not feasible*)

That the WRHA review the initiative to move 19 geriatric patients out of Seven Oaks General Hospital to a long-term care facility and convert that space to 30 medicine beds, and consider whether the WRHA can move this initiative to a higher priority within the WRHA plan overall.

MSHAL advised us that relocating Seven Oaks' Geriatric Mental Health Unit has been determined not to be feasible. MSHAL explained that this recommendation will need to be considered for future capital expansion.

RECOMMENDATION #4 (*complete*)

That the WRHA consider the feasibility of creating either an alternate space at Seven Oaks General Hospital for a unit similar to a Critical Decision Unit, where Emergency Department doctors can transfer patients, who are expected to remain in the Emergency Department for over 24 hours, to the Health Medical Officer, or the WRHA consider the feasibility of a Hospitalist model at Seven Oaks , where care of a patient is transferred to the care of a Hospitalist wherever the patient is located in the hospital.

MHSAL advised us that a review of long-stay Emergency Department patients was conducted in order to determine whether the care required and/or volume of patients supported a Critical Decision Unit. This review was completed in March 2016 and determined that there is no physical space for a Critical Decision Unit at Seven Oaks.

MHSAL concluded that Family Medicine attending physicians and/or physician assistants will assume the care of patients, once admitted, even if they remain in the Emergency Department waiting for a bed.

Given MHSAL's review and conclusion of this matter, our follow up of Recommendation #4 is complete.

RECOMMENDATION #5 (*complete*)

That the WRHA consider the feasibility of adopting a pilot project at Seven Oaks General Hospital so that bed availability information is shared with the Emergency Department – and the Emergency Department is informed as to when the bed is cleaned and available. This information should be shared in paper format until it can be made available in electronic format.

MHSAL advised us that Oculys, the patient management software system referenced under Recommendation #1 above, allows for real-time reporting on the status of all inpatient beds. As noted under Recommendation #1, the Oculys system was deployed with the WRHA's hospitals by November 16. Our follow up of Recommendation #5 is complete.

RECOMMENDATION #6 (*complete*)

That the WRHA consider creating a policy to be provided to families involved in critical events, explaining what information will, and will not, be made available and an explanation of how communication and meetings between the parties will be dealt with through the review process.

In further response to this recommendation, the WRHA has created a new Critical Incident policy. In the spring of 2019, it advised us that the policy had been put through a stakeholder consultation period which identified the need for operational guidelines and tools to be developed in order to ensure successful implementation of the policy.

The WRHA states that by November 2019, it implemented standard operating procedures for the critical incident process. These procedures include patient and family engagement through dedicated client relations support and verbal/written critical incident information. The WRHA explained that these procedures are shared with patients and families through conversations and written material, including an explanation of the information and meetings available for patients and families. MHSAL further advised us that families are provided a brochure by the Manitoba Patient Safety Instituted entitled "A Guide to Critical Incident and Disclosure: Information for Patients and Families".

With respect to critical incident reviews, the WRHA states that there is a process to centrally monitor timelines for reviews, and all reviews nearing the 88-day benchmark are escalated to the CEO for intervention.

The response from the WRHA goes further than considering the creation of a policy. Stakeholder consultation identified the need for additional guidelines and tools to ensure successful implementation. As of January 2020, a new Critical Incident Policy has been approved and circulated by the WRHA Executive Council that has put the recommendation into effect. Our follow up of Recommendation #6 is complete.

RECOMMENDATION #7 (*complete*)

All patients requiring stays in the Emergency Department of greater than 24 hours should be admitted to hospital under the care of a dedicated physician and placed in an inpatient bed. Each site must develop a process to comply with this directive, in order to increase accountability and patient safety.

MHSAL advised us that in April 2017, the "Healing our Health System" plan was announced. The plan was aimed at reorganizing care and group patient populations. WRHA states that this plan establishes three acute care hospitals with emergency departments, and three community hospitals that will provide a variety of services (specifically sub-acute care) which will free up acute beds for admissions from hospital. The WRHA also implemented a Consultation and Admission from the Emergency Department Policy (dated February 2018) that identifies physician responsibilities for prompt consultation and admission of patients in the Emergency Department.

In November 2019, we were advised by the WRHA that the last major changes related to the Healing our Health System were completed in September 2019. Through the implementation of this plan, the WRHA has incrementally increased sub-acute or lower acute bed capacity. Sub-acute patients, beds and services are now consolidated at Concordia Hospital, Victoria Hospital and Seven Oaks Hospital. Additionally, the WRHA added "transitional" beds which also address the sub-acute patient population. The WRHA states that there will continue to be ongoing analysis of capacity and demand, as well as continuing efforts to make more inpatient beds available by improving patient flow and reducing Alternate Level of Care[1] days.

As the responses we received from MHSAL and the WRHA address the intent of this recommendation, our follow up of Recommendation #7 is complete.

RECOMMENDATION #8 (*ongoing*)

That the WRHA continue to work towards a fully implemented regional policy that all patients requiring stays in the Emergency Department of greater than 24 hours, should be admitted to hospital under the care of a dedicated physician and placed in an inpatient bed. Each site should develop a process to comply with this directive, in order to increase accountability and patient safety.

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[1] According to University of Manitoba resources, an Alternate Level of Care (ALC) patient is someone occupying an acute care hospital bed but is not acutely ill or does not require the intensity of resources or services provided in a hospital setting. *(http://mchp-appserv.cpe.umanitoba.ca/viewConcept.php?printer=Y&conceptID=1416)*

As part of the Healing our Health System plan, referenced under Recommendation #7, the WRHA has established Clinical Assessment Units at Grace Hospital, Health Sciences Centre and St. Boniface Hospital in Winnipeg. These units are responsible for moving patients requiring a short stay admission out of the Emergency Department and into inpatient beds. MHSAL advised us that policies were in development to support the transition of patients to the Clinical Assessment Units.

As also referenced under Recommendation #7, the WRHA advised us that it has implemented the Consultation and Admission from the Emergency Department Policy, which identifies physician responsibilities for prompt consultation and admission of patients from the Emergency Department.

We recognize that work is ongoing to implement the intent of this recommendation. Given that Clinical Assessment Units have been established, the Consultation and Admission from the Emergency Department Policy has been implemented, and the development of policies to support the process of transitioning patients to the Clinical Assessment Units is underway, follow up on Recommendation #8 is discontinued.

RECOMMENDATION #9 (*complete*)

The University of Manitoba, Department of Emergency Medicine should collaborate with the WRHA Emergency and Occupational Therapy Programs to develop standards of care for Functional Assessments or have a screening tool of vulnerable patients in the ED.

MHSAL advised us that an Interprofessional Collaborative Care project began in May 2016 and focused on assessing and maintaining the functional status of Emergency Department patients. It involved various disciplines and sites. The WRHA advised that as a result of this project, a Functional Assessment Screening Tool was jointly developed by the departments of Nursing and Occupational Therapy and was implemented in the clinical documentation tool (ClinDoc) on May 5, 2016. It is used in all WRHA Emergency Departments.

Given that this screen tool has been put in place, our follow up of Recommendation #9 is complete.

RECOMMENDATION #10 (*complete*)

All WRHA hospitals should work with the Regional Occupational Therapy Program to ensure nursing based Functional Assessments are performed with patient safety as the foremost consideration.

The responses from MHSAL and WRHA relating to Recommendation #9 address this recommendation. As such, our follow up of Recommendation #10 is complete.

RECOMMENDATION # 11 (*complete*)

The WRHA consider designing and implementing a program on a regional level, involving Occupational Therapy/Physical Therapy, to ensure patients in the Emergency Department who remain longer than 24 hours, are mobilized regularly wherever possible.

The WRHA advised us that the Functional Assessment Screening Tool referenced under Recommendation #9 provides indications for care plans to include mobilization assistance for patients who are unable to mobilize independently. As the issue of mobilization has been addressed in this screening tool, our follow up of Recommendation #11 is complete.

RECOMMENDATION #12 (*complete*)

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

WRHA advised that the seven-day work week has been implemented at all hospitals since April 2016 with good results, with patients being discharged home with Home Care services on the weekends. As this response addresses this recommendation, our follow up of Recommendation #12 is complete.

RECOMMENDATION #13 (*complete*)

That the WRHA consider the feasibility of developing a model where: the role of Home Care Coordinators and Professional Nurses in the community is enhanced; that clients' performance and functionality in the community is monitored; and if necessary, the type of care they are receiving in the community is enhanced, to avoid these clients from returning to the Emergency Department.

MHSAL advised a new nursing care delivery model has been implemented in six community areas. MHSAL also advised of an approach where teams of care providers, known as "My Health Teams", are linked to specific Home Care staff. According to the MHSAL website, "My Health Teams" work with patients and other care providers to plan and deliver services for a specific geographic area, community, or population. MHSAL advised us that this has been implemented in two areas and the WRHA has been enhancing their primary care model to support individuals in the community. Additionally, a new service to facilitate hospital discharges (Priority Home Care) has been implemented.

WRHA advised that rapid response nursing for Home Care and Priority Home programs was implemented in November 2017. Nurses working in this program are available to make same day or next day visits to patients in the community to address any new or emergent needs. The WRHA advised that the reorganization of nursing services for Home Care was completed in February 2018 for all community areas. The new model provides the visiting nurse the ability to adjust the visit frequency based on changes in the patient's condition and assigns primary responsibility for each client to a single nurse.

As MHSAL and the WRHA's responses address the intent of this recommendation, our follow up of Recommendation #13 is complete.

RECOMMENDATION #14 (*complete*)

That the WRHA continue working to enhance the services of Home Care and Allied Health Workers to include staffing on weekends.

MHSAL advised us that term positions within Allied Health Resources in the Seven Oaks Emergency Department were approved as permanent positions in April 2016 and that there is Allied Health staffing currently in place seven days a week. As a result, our follow up of this recommendation is complete.

RECOMMENDATION #15 (*complete*)

That the WRHA Emergency Program Guidelines for Safe Hand Off (May 2012) be implemented at all WRHA Emergency Department sites to ensure complete, safe and accurate exchange of information at hand off.

MHSAL advised that the WRHA Emergency Program Guideline for "safe hand off" has been reviewed and revised. WRHA advised that the guideline has been implemented as of August 9, 2017. As a result, our follow up of this recommendation is complete.

RECOMMENDATION #16 (*complete*)

That the WRHA Emergency Program Guidelines for Safe Hand Offs be used as a template for developing a similar set of expectations and practice tools for hand off between sites.

MHSAL advised that the WRHA has established "safe hand off" procedures including written documentation and verbal transfer of care between sites and units. WRHA advised that the policy "Safe Patient Handover and Transfer of Accountability" has been implemented as of December 2017.

A standard operating protocol was implemented at the end of 2018 to support the consistent application of safe handover principles and is posted on the intranet site for all staff to reference.

As MHSAL's response in this matter addresses this recommendation, our follow up of Recommendation #16 is complete.

RECOMMENDATION #17 (*complete*)

That the WRHA consider creating a Safe Hand Off tool to be used in all Emergency Departments for patients remaining longer than 24 hours. The Safe Hand Off tool would be used at handover by all nurses and doctors involved in the patient's care.

MHSAL advised that WRHA has developed "safe hand off" tools, which were circulated to sites and implemented in August 2017 (as discussed under Recommendations #15 and #16). As a result, our follow up of Recommendation #17 is complete.

RECOMMENDATION #18 (*complete*)

That the WRHA continue to pursue education and culture change within the WRHA with the objective of including the patient and families in discussion of the patient status and treatment, including performing handovers at bedside.

MHSAL advised that WRHA will continue to offer Collaborative Care team education. MHSAL further advised that a survey to determine the status of bedside reporting and other forms of communication was completed in March 2016.

WRHA advised that WRHA policy "Safe Patient Handover and Transfer of Accountability" was implemented in December 2017. The policy requires that patients and families are to be included in the bedside handover whenever possible. The policy applies in all clinical areas.

As the responses from MHSAL and the WRHA meet the intent of this recommendation, our follow up of Recommendation #18 is complete.

RECOMMENDATION #19 (*complete*)

That documentation practice be specifically targeted for improvement through continuing education for current staff and also increased in the general orientation program for new Emergency Department nurses.

MHSAL advised that documentation standards have been standardized at all sites. MHSAL further advised that orientation for Emergency Department documentation is delivered at all sites and regionally.

WRHA advised that the documentation standards were implemented in August 2017 and education on the standards and tools is included in orientation for new staff. Education of existing staff took place prior to the implementation of the tool.

Given MHSAL and WRHA's responses in this matter, our follow up of Recommendation #19 is complete.

RECOMMENDATION #20 (*complete*)

That the Emergency Program review and reinforce the need to report on all pertinent information including any specific adverse reactions or experiences and that these are properly documented and communicated by physicians and nurses giving or receiving report on a patient at hand off.

MHSAL advised that their response to Recommendation #17 applies to this recommendation. WRHA advised that the "safe hand off" tools standardize the collection, documentation and reporting of all pertinent data. As a result, our follow up of Recommendation #20 is complete.

RECOMMENDATION #21 (*complete*)

That the WRHA Emergency Program Guideline for Safe Discharge be implemented beginning May 21, 2012, to provide better guidance for discharge planning.

MHSAL advised that the WRHA Emergency Program Guideline for Safe Discharge has been implemented at all sites. WRHA added that the "Safe Patient Discharge Guideline" was approved March 27, 2017 and the accompanying checklist ensures that all aspects of safe discharge are assessed and documented.

Given the responses from MHSAL and WRHA, our follow up of Recommendation #21 is complete.

RECOMMENDATION #22 (*complete*)

Senior Management and Emergency Leadership, at all sites, should be of the need to maintain a culture of patient safety in their Emergency Departments; regardless of the pressure to maintain patient flow. To this end, Physicians are encouraged to discharge patients only when it is safe and reasonable to do so. To that end, the Guidelines for Safe Discharge, that have now been implemented across all sites, should assist both Physicians and Nurses in ensuring the discharge plan developed for each patient is both appropriate and safe. Nursing and other staff, should be encouraged to make any patient-related concerns known to the Physician, so that they can act as a check and balance for the Physician.

MHSAL advised us that a "Culture of Safety" review was conducted and the results did not demonstrate staff confidence in management in this area. As such, additional staff education and a communication plan beyond safe patient discharge resources was required.

The WRHA advised us that in April 2018, its Board of Directors identified that patient safety (including a culture of safety) is an ongoing priority for the WRHA. To that end, a partnership with the Canadian Patient Safety Institute is in place to increase Board and leadership knowledge in the area, as well as to assist in developing patient safety plans for the organization.

MHSAL explained to us that a Safe Discharge Checklist has been implemented to ensure compliance with the Guidelines for Safe Discharge and also ensure standardized documentation practices at discharge. The WRHA further advised that education about the guidelines reinforces the accountability of nurses and physicians in ensuring safe discharge practices.

The WRHA also explained that the creation of Sub-Acute and Clinical Assessment Units has provided additional options for patients who may not have acute medical needs but require a

longer period of recovery. These units were established in the first phase of the Healing our Health System plan.

MHSAL also advised that posters placed in the Emergency Departments encourage patients and their families to share any concerns with staff.

As the responses received from MHSAL and the WRHA address the intent of this recommendation, our follow up of Recommendation #22 is complete.

RECOMMENDATION #23 (*complete*)

That the WRHA consider the feasibility of periodically determining the level of compliance with the Guidelines for Safe Hand Off, Safe Discharge Guideline, the Safe Transportation Guideline and the Safe Patient Checklist, and that it seek ways to continually improve compliance.

MHSAL advised that an audit regarding level of compliance with the Guidelines for Safe Hand Off, Safe Discharge Guideline, the Safe Transportation Guideline and the Safe Patient Checklist was completed in May 2016, and that the audit results were shared. The WRHA further advised that the audit results have been provided to the Joint Emergency Council (Physician and Nursing leaders from each WRHA Emergency Department), Quality and Patient Safety and to the Emergency Patient Advisory Committee. Nursing leaders at each site have shared the results with staff at each facility.

MHSAL stated that the WRHA Emergency Department Review Team will continue to conduct quarterly onsite audits of compliance with these guidelines, and will continue to review patients' experiences in this area.

As the MHSAL and WRHA responses address the intent of this recommendation, our follow up of Recommendation #23 is complete.

RECOMMENDATION #24 (*complete*)

That the WRHA Emergency Program Leadership work with site Emergency Departments to improve communication between staff and patients and their families, being sensitive to the stress experienced by patients during an emergency visit.

MHSAL advised that patient communication in the Emergency Department is addressed in annual staff updates. The WRHA added that in addition to the annual updates to staff, feedback on patient experience (comment cards and surveys) are shared with staff at regular staff meetings. This information and suggestions for improvements are discussed at the Emergency Patient Advisory Committee and the feedback from these public advisors is also shared routinely with staff. As these practices address the intent of this recommendation, our follow up of Recommendation #24 is complete.

RECOMMENDATION #25 (*complete*)

That patients requiring stays in the Emergency Department, of greater than 24 hours, should be considered for prophylactic Heparin. Evidence-based protocols should be developed to this end.

MHSAL advised that an Emergency Department-specific guideline, based on best available evidence, has been developed and approved for implementation by the Emergency Department Medical Directors' Council.

WRHA expanded on this by explaining that the "VTE (venous thromboembolism) Guideline" approved for use in the Emergency Department is based on available evidence for the use of anticoagulants such as Heparin to prevent the formation of clots. The guideline was approved in January 2017 and was then implemented into the electronic order sets used by physicians in the Emergency Department. This means that it automatically appears in the list of options for each patient for the physicians to consider based on their clinical judgment.

As the WRHA and MHSAL's responses in this matter address the implementation of this recommendation, our follow up of Recommendation #25 is complete.

CONCLUSION

The purpose of an inquest is to determine the cause, manner or circumstances in which a death occurred so that recommendations can be made to change provincial laws or the programs, policies and practices within provincial government, agencies or institutions to prevent deaths in similar circumstances.

I am pleased to provide you our final report in this matter. The WRHA and MHSAL have provided responses to all inquest recommendations, and have identified one recommendation (#3) where implementation is considered not feasible as it is a longer term matter involving capital expenditure. The responses provided by WRHA and MHSAL represent an ongoing commitment to continue efforts to fully implement the recommendations. As such, we have concluded our follow up on this matter.

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

Yours truly,

Jill Perron
Manitoba Ombudsman

cc: Ms. Karen Herd, Deputy Minister, Manitoba Health, Seniors and Active Living
Ms. Vickie Kaminski, Chief Executive Officer, Winnipeg Regional Health Authority
Dr. John K. Younes, Chief Medical Examiner