Patient Care Quality Review Boards

File No. s.22

December 8, 2022

s.22

Dear s.22

Re: s.22 – Review Board Summary

Thank you for bringing your concerns forward to the Patient Care Quality Review Board. We appreciate your patience.

We recently met to review the complaint you made to the Island Health Patient Care Quality Office. During the meeting we considered all the information provided by both you and the health authority.

Below you will find each of the unresolved issues reviewed, followed by the Board's findings and the recommendation that has been made.

Issue 1: Whether the deployment of the Protection Service Officers followed any applicable policies and procedures.

Finding:

1. The deployment of Protection Service Officers adhered to the expectations laid out by the *Island Health Code White Policy* and the *Island Health Code White Response Plan.*
    - The *Code White Response Plan* states that in instances of emotional crises with no imminent danger, the team response should be to "ask for help from a nearby staff member, [and] have a staff member check in on you at regular intervals. Staff is encouraged to call Protection Services to provide a 'show of presence' as a de-escalation strategy."
    - The *Code White Policy* states that staff should "summon help when you see signs of aggression or escalating behaviour" and "involve on-site security

(where available) immediately when someone is showing signs of violence or aggression."

Issue 2: Whether the staff ambassador's pin violated the *Island Health 5.5.1P Conflict of Interest* Policy.

Findings:

1. Upon review of the *Island Health 5.5.1P Conflict of Interest Policy,* we found that the staff ambassador's pin was in alignment with the expectations laid out about political expression in the workplace.

2. We found that the pin worn by Protective Services Officer was also in alignment with the *5.5.1P Conflict of Interest Policy.*

3. We could not find a policy or a section within an existing policy that identified the party that is responsible for making determinations on appropriateness.

Recommendation:

1. **The Health Authority review the *5.5.3 Political Activity* section of the *5.5.1P Conflict of Interest Policy* and determine who is responsible for making determinations on the appropriateness of items affixed to uniforms.**

Explanation of Findings:

After a review of the *5.5.1.P Conflict of Interest Policy,* we concluded that the pins worn by both the staff ambassador and the Protective Services Officer were in alignment with section *5.5.3. Political Activity* section of the policy. Our review concluded that nametags with personal pronouns and pins honouring the victims of the Residential School system are not encompassed within the definition of partisan political activity as defined by the policy.

We found that the policy lacks specificity with regards to who is responsible for making determinations on appropriateness. This finding led to our recommendation to the health authority to review the *5.5.3 Political Activity* section to determine if it can be made clearer who is obligated to determine the appropriateness of items affixed to work uniforms. We believe that a review of this section of policy and a determination on where the obligation to determine appropriateness lies will offer a greater level of clarity and support for staff who may be unsure of what is appropriate to wear at work.

Issue 3: The patient is dissatisfied with the PCQO investigation and response.

Findings:

1. The PCQO conducted an appropriate investigation into your concerns. The PCQO investigation included:

    a. Involvement of relevant leadership external to the PCQO to gain insight into the event, and to contribute knowledge to the investigation
    b. Involvement of relevant PCQO leadership in crafting the response letter.

2. The PCQO response letter is thorough in explaining the position of the Protection Services and Security Systems relevant to the request for an apology and details on disciplinary actions relevant to the Protective Services Officers.

3. The PCQO took longer than the mandated forty-day time period to provide a response. However, the PCQO informed you at the outset of the potential for delay, stating that staffing issues contributed to the delay in completing the review.

Board Comments:

We observed that there was a period of time of nearly two months where there was no correspondence with the client. We wish to remind the PCQO of the importance of issuing extension requests every twenty business days when delays are expected or experienced.

Given the circumstances of this specific complaint and the vast discrepancy between the accounts by each party, it would be unreasonable to expect either the PCQO or the Board to come to a definitive conclusion or provide clear resolution. The Board strongly supports the need for a safe work environment for healthcare staff and volunteers, as well as patients and visitors, and regrets this experience for all parties involved.

If you have concerns about the fairness of this process and would like to pursue the matter further, you may seek a review by the Office of the Ombudsperson. The Office of the Ombudsperson determines whether BC provincial and local public authorities have acted fairly and reasonably, and whether their actions and decisions were consistent with relevant legislation, policies and procedures. To learn more about the Ombudsperson complaint process, call 1-800-567-3247 or visit their website by using the following link:

https://www.bcombudsperson.ca/

We thank you for contributing to our efforts to improve healthcare quality across BC. We hope that we have addressed your concerns.

Sincerely,

Patient Care Quality Review Boards

pc: Honourable Adrian Dix, Minister of Health
Dr. Doug Cochrane, Chair, Board of Directors, Interior Health
Susan Brown, President & CEO, Interior Health
Patient Care Quality Office, Interior Health

Information reviewed

Review Request
Information from Complainant
Information from PCQO
Medical Records
Guidelines:

- Island Health Code White Policy
- Island Health Complaint Review Toolkit
- Island Health Code of Conduct
- Island Health Code of Conduct – Summary of Changes to Policies and Procedures
- Island Health Code White Response Plan
- Island Health Learning Pathways
- Island Health LGBTQ2 General Information
- Island Health Patient Safety Incident Management Policy
- Island Health PCQO Resource Manual
- Island Health Respectful Workplace Policy
- Island Health 5.5.1P Conflict of Interest Policy
- Island Health Workplace Violence Prevention Program

The Board is independent of the health authorities and members are appointed by the Minister of Health. The Board was established to review unresolved complaints about health care provided by the health authorities and make recommendations for improving the quality of patient or residential care in BC.

Patient Care Quality Review Boards

File No. s.22

December 8, 2022

Leah Hollins
Board of Directors
Island Health
c/o Executive Office
1952 Bay St
Victoria BC V8R 1J8

Re: s.22 – Review Board Letter

Dear Ms. Hollins:

The Patient Care Quality Review Board's review of case # s.22 is now complete. The Board has made one recommendation associated with this case.

Please find attached the Board's letter to both the health authority and the client, which summarizes and explains the Board's findings. The Board Chairs attest that the information contained in these letters accurately reflects the Board's discussion and conclusions relating to this case.

If you should have any questions or require clarification on the Board's findings or recommendations, please do not hesitate to reach out to the Department, including Dempsey Wilford, the Care Quality Analyst assigned to this case, in related discussions and response letters.

The Board thanks the Health Authority for your ongoing commitment to improving health care for all British Columbians.

Sincerely,

Trish Hunt

Trish Hunt, Co-Chair

Susan Morrow, Co-Chair

Patient Care Quality Review Boards
PO Box 9643
Victoria BC V8W 9P1

contact@patientcarequalityreviewboard.ca
Tel: 1-866-952-2448
Fax: (250) 952-2428

Re: s.22 – Review Board Decision

The Island Patient Care Quality Review Board (the Board) has completed its review of the complaint of the above named person to Island Health. Pursuant to Section 13 of the *Patient Care Quality Review Board Act,* the Board reviewed and considered all the information provided by both the client and the health authority.

Case #: s.22	Client Name: s.22
Patient: s.22	Relation: s.22
s.22	
Complaint Sector: Attitude and conduct	Sub Sector: Inappropriate conduct
Health Authority: Island Health	Facility: s.22

PCQRB Primary Outstanding Issue: Whether Protective Services Officers (PSO) interactions adhered to expectations laid out by policy or procedure.

Case Overview:
s.22

Summary of the Complaint:

- s.22 requested during a visit that a staff ambassador remove a "political pin". The pin in question was labeled with pronouns.
- s.22
-
- The patient is not satisfied with the PCQO response. Specifically, the patient is dissatisfied with the length of time it has taken to receive a response, the level of communication from the PCQO, and believes that the response letter contains information that is not factual.

PCQO Involvement:

- When the complaint was received and how: December 14, 2021, by email.
- When the response was provided to the client: April 20, 2022, by letter.

PCQRB Involvement:

- First contacted board: April 12, 2022
- Final acceptance of review: May 5, 2022

The patient brought forward the following unresolved issues that were examined by the Board:

Issue 1: Whether the deployment of the Protection Service Officers followed any applicable policies and procedures.

Finding:

1. The deployment of Protection Service Officers adhered to the expectations laid out by the *Island Health Code White Policy* and the *Island Health Code White Response Plan.*
    - The *Code White Response Plan* states that in instances of emotional crises with no imminent danger, the team response should be to "ask for help from a nearby staff member, [and] have a staff member check in on you at regular intervals. Staff is encouraged to call Protection Services to provide a 'show of presence' as a de-escalation strategy."
    - The *Code White Policy* states that staff should "summon help when you see signs of aggression or escalating behaviour" and "involve on-site security (where available) immediately when someone is showing signs of violence or aggression."

Issue 2: Whether the staff ambassador's pin or the PSO 's pin violated the *Island Health 5.5.1P Conflict of Interest* Policy.

Findings:

1. Upon review of the *Island Health 5.5.1P Conflict of Interest Policy,* we found that the staff ambassador's pin was in alignment with the expectations laid out about political expression in the workplace.

2. We found that the pin worn by Protective Services Officer was also in alignment with the *5.5.1P Conflict of Interest Policy.*

3. We could not find a policy or section within an existing policy that identified the party that is responsible for making determinations on appropriateness.

Recommendation:

1. **The Health Authority review the *5.5.3 Political Activity* section of the *5.5.1P Conflict of Interest Policy* and determine who is responsible for making determinations on the appropriateness of items affixed to uniforms.**

Explanation of Findings:

After a review of the *5.5.1.P Conflict of Interest Policy* we concluded that the pins worn by both the staff ambassador and the Protective Services Officer were in alignment with section *5.5.3. Political Activity* section of the policy. Our review concluded that nametags with personal pronouns and pins honouring the victims of the Residential School system are not encompassed within the definition of partisan political activity as defined by the policy.

We found that the policy lacks specificity with regards to who is responsible for making determinations on appropriateness. This finding led to our recommendation to the health authority to review the *5.5.3 Political Activity* section to determine if it can be made clearer who is obligated to determine the appropriateness of items affixed to work uniforms. We believe that a review of this section of policy and a determination on where the obligation to determine appropriateness lies will offer a greater level of clarity and support for staff who may be unsure of what is appropriate to wear at work.

Issue 3: The patient is dissatisfied with the PCQO investigation and response.

Findings:

1. The PCQO conducted an appropriate investigation into the patient's concerns. The PCQO investigation included:

    a. Involvement of relevant leadership external to the PCQO to gain insight into the event, and to contribute knowledge to the investigation
    b. Involvement of relevant PCQO leadership in crafting the response letter.

2. The PCQO response letter is thorough in explaining the position of the Protection Services and Security Systems relevant to the request for an apology and details on disciplinary actions relevant to the Protective Services Officers.

3. The PCQO took longer than the mandated forty-day time period to provide a response. The PCQO informed the client at the outset of the potential for delay, stating that staffing issues contributed to the delay in completing the review.

Board Comments:

We observed that there was a period of time of nearly two months where there was no correspondence with the client. We wish to remind the PCQO of the importance of issuing extension requests every twenty business days when delays expected or experienced.

Given the circumstances of this specific complaint and the vast discrepancy between the accounts by each party, it would be unreasonable to expect either the PCQO or the Board to come to a definitive conclusion or provide clear resolution. The Board strongly supports the need for a safe work environment for healthcare staff and volunteers, as well as patients and visitors, and regrets this experience for all parties involved.

A written response to the Board's recommendations is required from the health authority by January 19, 2023, which is 30 business days from the date of this letter. The health authority is also required to communicate with the client following receipt of the recommendations.

This concludes the Board's review of this matter. The Board thanks the health authority for its assistance.

Prepared by:

Dempsey Wilford
Patient Care Quality Review Board

pc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, CEO, Island Health
Patient Care Quality Office, Island Health

Enclosure

File No. s.22

January 6, 2023

s.22

Dear s.22

Thank you for bringing your concerns forward to the Patient Care Quality Review Board. We appreciate your patience and we are sorry for the delay in responding to you. We sympathize with the difficult care experience you had s.22
s.22

We recently met to review the complaint you made to the Island Health Patient Care Quality Office. During the meeting we considered all the information provided by both you and the health authority.

Below you will find each of the unresolved issues reviewed, followed by the Board's findings and any recommendations that have been made.

Issue 1: You are concerned that the appropriate assessments were not completed during your triage and admission s.22 s.22
s.22

Findings:

1. You were in the Emergency Department (ED) for close to three hours without having a full assessment by nursing staff or a physician. You were designated as Canadian Triage & Acuity Scale (CTAS) Level III urgent, which has an ideal time to see a physician of ≤30 minutes. According to the CTAS Guidelines, Level III patients are to be assessed by nursing staff within 30 minutes of arrival in the treatment area and reassessed every 30 minutes thereafter. s.22
s.22

2. s.22

Explanation of Findings:

The Canadian Triage and Acuity Scale (CTAS) was first developed for use in Canadian hospital EDs as a tool to more accurately define a patients need for timely care. Patients are triaged to one of five levels based on their presenting complaint and the type and severity of their signs and symptoms. The overall goal for triage to physician initial assessment is a median time of one hour, and for 90% of patients to be seen within three hours.

While CTAS was introduced in 1998, since 2008 it has been reviewed every four years. The time targets are benchmarks that hospitals strive to achieve, ensuring patients are seen in as timely a manner as possible.

The CTAS guidelines emphasize the importance of assessments in determining acuity and for establishing a baseline for patients, as their condition may change throughout their wait/admission. The components of the appropriate assessments are as follows:

- An initial assessment (general assessment/primary assessment) which includes checking the patient's airway, breathing, circulation, and collecting the pertinent objective (physical appearance, distress, physical assessment) and subjective (onset, course, duration) data based on the patient's presenting concerns.
- A focused assessment (secondary assessment), which is a more detailed physical assessment, ideally within 30 minutes of transfer or arrival to the treatment area.

The Board acknowledges that the COVID-19 pandemic and limited access to primary care continues to impact wait times in the ED, and that CTAS guidelines are objectives rather than established care standards.

Recommendation:

1. **That Island Health considers how CTAS guidelines, which outlines ideal times to receive care based on patients' medical needs, can continue to be managed in an environment where other challenges (such as staffing) continue to impact their achievement. The Board would like to note that specific attention be directed to what the expectations are for patient care after patients have been triaged, but before they have been seen by the ED physician, considering that wait times for ED physician assessments have increased.**

Issue 2: You feel that your rights were violated s.22

s.22

Findings:

1. s.22

2. s.22

3. We acknowledge the hardship you shared with the Board, including the difficult interactions with the nurses, while trying to advocate for your comfort and safety. We found your experience, as described, unreasonable and did not meet the expectations as outlined in Island Health *Critical Components of Care in the Emergency Department*.

4. The Board was not provided with any policies or procedures specific to accessibility or accommodations for disabled patients.

Explanation of Findings:

Island Health *Critical Components of Care in the Emergency Department* outlines that care providers will "Assess and advocate for patient/family needs that include: physical, emotional, psychological, spiritual, and cultural aspects during the course of care in the Emergency room setting." Thus, the provision of a safe and comfortable space to wait for care goes beyond somewhere to lie down but extends to emotional well-being.

Recommendation:

2. **That the health authority develops and implements a policy and protocol for accommodating people with unique accessibility needs in the ED. Implementation through effective knowledge sharing should include elements that foster a culture of accessibility awareness for all staff participating in patient care.**

Board Comment:

The Minister of Social Development and Poverty Reduction announced that, as of September 1, 2022, hundreds of public sector organizations will be required to establish accessibility committees, accessibility plans and an accessibility feedback tool as part of the implementation of the Accessible British Columbia Act. The BC Ministry of Health as well as the health authorities will be participating in this work and the Board is supportive of that work. The Board is hopeful that the upcoming work will look for and consider the design of healthcare spaces to ensure improved accessibility.

Issue 3: You feel that safety standards were not followed, as you report you were left alone in a cubicle without bedrails or a call bell.

Findings:

1. The standardized safety precautions as outlined in Island Health *Critical Components of Care in the Emergency Department* includes the provision of call bells. The PCQO confirmed with the ED that all cubicles in the ambulatory area are equipped with call bells; however, you report that you did not have access to a call bell. We are unable to determine if there was a call bell in your cubicle.

2. You later expressed concern that the exam table you were provided had no bed rails and at the time you worried you might fall off of it. The[s.22] ED Manager confirmed that exam tables do not have side rails and are used in the ambulatory area of the ED. It is unclear whether the use of exam tables for accommodating patients, while waiting to be seen by the ED physician, meets current safety standards.

Explanation of Findings:

Island Health *Critical Components of Care in the Emergency Department* outlines that "Health Care Providers must be familiar and will implement standardized safety precautions i.e.: call bells, side rails, use of restraints."

When exam tables are used for their intended purpose, patients are not left alone for any great length of time. If exam tables are being used for patients while waiting, then it is important to determine their risk of falling off the bed prior to use.

s.22

Recommendation:

3. **That the health authority work with[s.22] ED leadership to review the use of exam tables for patients waiting to be seen in the ED to ensure this practice aligns with the safety needs of patients.**

Issue 4: The patient remains dissatisfied with the PCQO response.

Findings:

1. The PCQO email correspondence with you was very empathetic and addressed your concerns. They appropriately connected you with the s.22 ED manager, who responded to you in a very timely manner.

2. During his follow-up phone conversation with you, the ED Manager acknowledged that many patients with disabilities access the ED and that there are a limited number of beds. The ED Manager reviewed two options s.22
s.22 The Board notes that s.22 has recently purchased over 15 new stretchers for the ED and that there are now enough stretchers for the space that they have.

s.22

If you have concerns about the fairness of this process and would like to pursue the matter further, you may seek a review by the Office of the Ombudsperson. The Office of the Ombudsperson determines whether BC provincial and local public authorities have acted fairly and reasonably, and whether their actions and decisions were consistent with relevant legislation, policies and procedures. To learn more about the Ombudsperson complaint process, call 1-800-567-3247 or visit their website by using the following link:

https://www.bcombudsperson.ca/

We thank you for contributing to our efforts to improve healthcare quality across BC. We hope that we have addressed your concerns.

Sincerely,

Patient Care Quality Review Boards

pc: Honourable Adrian Dix, Minister of Health
Leah Hollins, Board of Directors, Island Health
Kathy MacNeil, CEO, Island Health
Patient Care Quality Office, Island Health

Information reviewed

Review Request
Information from Complainant
Information from PCQO
Medical Records
Guidelines:

- Island Health *Critical Components of Care in the Emergency Department*
- Island Health *Ambulatory Criteria*
- *Implementation Guidelines for the Canadian Emergency Department Triage & Acuity Scale (CTAS)*
- *Revision to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines 2016*
- British Columbia College of Nurses & Midwives *Documentation Practice Standard*
- Island Health *Interprofessional Practice & Clinical Standards*
- Island Health *Physical Assessment Guideline*
- Island Health *Practice Standards: Adult Critical Care Nursing Standards*
- Island Health *Information Transfer at Care Transitions*

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Patient Care Quality Review Boards

File No. s.22

January 6, 2023

Leah Hollins
Board of Directors
Island Health
c/o Executive Office
1952 Bay St
Victoria BC V8R 1J8

Re: s.22 – Review Board Letter

Dear Ms. Hollins:

The Patient Care Quality Review Board's review of s.22 is now complete. The Board has made three recommendations associated with this case.

Please find attached the Board's letter to both the health authority and the client, which summarizes and explains the Board's findings. The Board Chairs attest that the information contained in these letters accurately reflects the Board's discussion and conclusions relating to this case.

If you should have any questions or require clarification on the Board's findings or recommendations, please do not hesitate to reach out to the Department, including Laura Kemp, the Care Quality Analyst assigned to this case, in related discussions and response letters.

The Board thanks the Health Authority for your ongoing commitment to improving health care for all British Columbians.

Sincerely,

Trish Hunt

Trish Hunt, Co-Chair

Susan Morrow

Susan Morrow, Co-Chair

Patient Care Quality Review Boards
PO Box 9643
Victoria BC V8W 9P1

contact@patientcarequalityreviewboard.ca
Tel: 1-866-952-2448
Fax: (250) 952-2428

Re: s.22 Review Board Decision

The Island Patient Care Quality Review Board (the Board) has completed its review of the complaint of the above-named person to Island Health. Pursuant to Section 13 of the *Patient Care Quality Review Board Act,* the Board reviewed and considered all the information provided by both the client and the health authority.

Case #: s.22	Patient Name: s.22
s.22	s.22
Complaint Sector: Emergency	Sub Sector: Primary Care
Health Authority: Vancouver Island Health Authority	Facility: s.22 s.22

PCQRB Primary Outstanding Issue:
s.22

Case Overview:
s.22

Summary of the Complaint:

- s.22

s.22

- s.22
-
-
-
-

PCQO Involvement:

- Complaint received via email on February 28, 2022
- Response provided by the manager of s.22 ED by phone on March 16, 2022

PCQRB Involvement:

- First contacted the Patient Care Quality Review Board (PCQRB) by phone on March 16, 2022
- Final acceptance of review was provided by email on May 4, 2022

The client brought forward the following unresolved issues that were examined by the Board:

Issue 1: The patient is concerned that the appropriate assessments were not completed during s.22 **triage and admission** s.22
s.22

Findings:

1. The patient was in the ED for close to three hours without having a full assessment by nursing staff or a physician. The patient was designated as Canadian Triage & Acuity Scale (CTAS) Level III urgent, which has an ideal time to see a physician of ≤ 30 minutes. According to the CTAS Guidelines, Level III patients are to be assessed by nursing staff within 30 minutes of arrival in the treatment area and reassessed every 30 minutes thereafter.[s.22]
   [s.22]

2. [s.22]

Explanation of Findings:

The Canadian Triage and Acuity Scale (CTAS) was first developed for use in Canadian hospital EDs as a tool to more accurately define a patients need for timely care. Patients are triaged to one of five levels based on their presenting complaint and the type and severity of their signs and symptoms. The overall goal for triage to physician initial assessment is a median time of one hour, and for 90% of patients to be seen within three hours.

While CTAS was introduced in 1998, since 2008 it has been reviewed every four years. The time targets are benchmarks that hospitals strive to achieve, ensuring patients are seen in as timely a manner as possible.

The CTAS guidelines emphasize the importance of assessments in determining acuity and for establishing a baseline for patients, as their condition may change throughout their wait/admission. The components of the appropriate assessments are as follows:

- An initial assessment (general assessment/primary assessment) which includes checking the patient's airway, breathing, circulation, and collecting the pertinent objective (physical appearance, distress, physical assessment) and subjective (onset, course, duration) data based on the patient's presenting concerns.
- A focused assessment (secondary assessment), which is a more detailed physical assessment, ideally within 30 minutes of transfer or arrival to the treatment area.

The Board acknowledges that the COVID-19 pandemic and limited access to primary care continues to impact wait times in the ED, and that CTAS guidelines are objectives rather than established care standards.

Recommendation:

1. **That Island Health considers how CTAS guidelines, which outlines ideal times to receive care based on patients' medical needs, can continue to be managed in an environment where other challenges (such as staffing) continue to impact their achievement. The Board would like to note that specific attention be directed to what the expectations are for patient care after patients have been triaged, but before they have been seen by the ED physician, considering that wait times for ED physician assessments have increased.**

Issue 2: The patient feels that s.22 **rights were violated** s.22
s.22

Findings:

1. s.22

2. The patient was s.22 given an exam table in a cubicle, within an hour and twenty minutes of arrival, while s.22 waited to be assessed by the physician.

3. We acknowledge the hardship the patient states s.22 experienced, including the difficult interactions with the nurses, while trying to advocate for s.22 comfort and safety. The Board found that this was unreasonable and did not meet the expectations as outlined in Island Health *Critical Components of Care in the Emergency Department*.

4. The Board was not provided with any policies or procedures specific to accessibility or accommodations for disabled patients.

Explanation of Findings:

Island Health *Critical Components of Care in the Emergency Department* outlines that care providers will "Assess and advocate for patient/family needs that include: physical, emotional, psychological, spiritual, and cultural aspects during the course of care in the Emergency room setting." Thus, the provision of a safe and comfortable space to wait for care goes beyond somewhere to lie down but extends to emotional well-being.

Recommendation:

2. **That the health authority develops and implements a policy and protocol for accommodating people with unique accessibility needs in the ED. Implementation through effective knowledge sharing should include elements that foster a culture of accessibility awareness for all staff participating in patient care.**

Board Comment:

The Minister of Social Development and Poverty Reduction announced that, as of September 1, 2022, hundreds of public sector organizations will be required to establish accessibility committees, accessibility plans and an accessibility feedback tool as part of the implementation of the Accessible British Columbia Act. The BC Ministry of Health as well as the health authorities will be participating in this work and the Board is supportive of that work. The Board is hopeful that the upcoming work will look for and consider the design of healthcare spaces to ensure improved accessibility.

Issue 3: The patient feels that safety standards were not followed, as s.22 reports s.22 was left alone in a cubicle without bedrails or a call bell.

Findings:

1. The standardized safety precautions as outlined in Island Health *Critical Components of Care in the Emergency Department* includes the provision of call bells. The PCQO confirmed with the ED that all cubicles in the ambulatory area are equipped with call bells; however, the patient reports that s.22 did not have access to a call bell. We are unable to determine if there was a call bell in the patient's cubicle.

2. The patient later expressed concern that the exam table s.22 was provided had no bed rails and at the time s.22 worried s.22 might fall off it. The s.22 ED Manager confirmed that exam tables do not have side rails and are used in the ambulatory area of the ED. It is unclear whether the use of exam tables for accommodating patients, while waiting to be seen by the ED physician, meets current safety standards.

Explanation of Findings:

Island Health *Critical Components of Care in the Emergency Department* outlines that "Health Care Providers must be familiar and will implement standardized safety precautions i.e.: call bells, side rails, use of restraints."

When exam tables are used for their intended purpose, patients are not left alone for any great length of time. If exam tables are being used for patients while waiting, then it is important to determine their risk of falling off the bed prior to use.

s.22

Recommendation:

3. **That the health authority work with s.22 ED leadership to review the use of exam tables for patients waiting to be seen in the ED to ensure this practice aligns with the safety needs of patients.**

Issue 4: The patient remains dissatisfied with the PCQO response.

Findings:

1. The PCQO email correspondence with the client was very empathetic and addressed the patient's concerns. They appropriately connected s.22 with the s.2 ED manager, who responded to the patient in a very timely manner.

2. During a follow-up phone conversation s.22 the ED Manager acknowledged s.22 that there are a limited number of beds. The ED Manager reviewed two options s.22 s.22 s.22 The Board notes that s.2 has recently purchased over 15 new stretchers for the ED and that there are enough stretchers for the space that they have.

Board Comment:

We wanted to take the opportunity to highlight that there appears to be an opportunity for increased understanding of disability rights and accommodations from leadership. We want to ensure that there is clear understanding of the differences in providing accommodation to improve accessibility in services from cultural and Indigenous safety.

A written response to the Board's recommendations is required from the health authority by February 17, 2023, which is 30 business days from the date of this letter. The health authority is also required to communicate with the client following receipt of the recommendations.

This concludes the Board's review of this matter. The Board thanks the health authority for its assistance.

Prepared by:

Laura Kemp, CQA
Patient Care Quality Review Board

pc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, CEO, Island Health
Patient Care Quality Office, Island Health

Enclosure

Patient Care Quality Review Boards

File No. s.22

February 2, 2023

s.22

Dear s.22

Thank you for bringing your concerns forward to the Patient Care Quality Review Board. We appreciate your patience and we are sorry for the delay in responding to you. s.22
s.22

We recently met to review the complaint you made to the Island Health Patient Care Quality Office. During the meeting we considered all the information provided by both you and the health authority.

Below you will find the unresolved issue reviewed, followed by the Board's findings and any recommendations that have been made.

Issue 1: You are dissatisfied with the PCQO response to your concerns that you were injured s.22
s.22

Findings:

1. s.22

2. The PCQO conducted a thorough review of your care experience, including gathering statements from the technologists that participated in your care

encounter and consulting with Medical Imaging leadership. Factors that we considered in our assessment of the PCQO review are as follows:

- The PCQO gathered statements from the s.22 technologists s.22 s.22

- You recall leaving multiple voicemails with the PCQO requesting that you be called back on the phone. The PCQO did not contact you by telephone. The PCQO does not have a record of your voicemail requests that you be telephoned.

- The PCQO originally offered you the option of having an in-person meeting with Island Health Medical Imaging leadership to discuss the review results. However, due to COVID-19, the in-person meeting was subsequently proposed as a videoconference and you declined that offer. We found that the health authority's decision to withdraw the offer of an in-person meeting was reasonable in the context of the pandemic.

- As there were some missed communications with you during the course of the PCQO's review, a two-week timeline extension was required. While the PCQO recorded in the Patient Safety Learning System (PSLS) that you were asked for an extension to the review timeline, you do not recall this request. We noted there is no designated area in the PSLS to record verifiable details of a client's consent to an extension, e.g. date or method of communication.

- The PCQO response letter was detailed and conveyed the information expected from a comprehensive PCQO review.

Explanation of Findings:

We found some discrepancies between Medical Imaging leadership's description of current best practices s.22 and the official Protocol that is followed by the department. While s.22 positioning is preferred for these scans, there are other acceptable positions available s.22 s.22 for the duration of the scan. The PCQO provided us with evidence that positioning options had been discussed with staff, and the technologists working the day

of your scan assert that they incorporate that practice into their workflow. However, we did provide a suggestion in our letter to the health authority that they review their Protocol to ensure that practice is clearly outlined for current and future Medical Imaging staff.

If you have concerns about the fairness of this process and would like to pursue the matter further, you may seek a review by the Office of the Ombudsperson. The Office of the Ombudsperson determines whether BC provincial and local public authorities have acted fairly and reasonably, and whether their actions and decisions were consistent with relevant legislation, policies and procedures. To learn more about the Ombudsperson complaint process, call 1-800-567-3247 or visit their website by using the following link:

https://www.bcombudsperson.ca/

We recognize that these may not be the results you were hoping to receive. We did our best to fairly and objectively examine your care experience and we thank you for contributing to our efforts to improve healthcare quality across BC. We hope that we have addressed your concerns. Please accept our well wishes s.22

s.22

Sincerely,

Patient Care Quality Review Boards

pc: Honourable Adrian Dix, Minister of Health
Leah Hollins, Board of Directors, Island Health
Kathy MacNeil, CEO, Island Health
Patient Care Quality Office, Island Health

Information Reviewed

Review Request
Information from Complainant
Information from PCQO
Medical Records

Guidelines:

- Island Health *Myocardial Perfusion Protocol*
- Island Health *PCQO Resource Manual*
- Island Health *PCQO Complaint Review Toolkit*

The Board is independent of the health authorities and members are appointed by the Minister of Health. The Board was established to review unresolved complaints about health care provided by the health authorities and make recommendations for improving the quality of patient or residential care in BC.

Patient Care Quality Review Boards

File No. s.22

February 2, 2023

Leah Hollins
Board of Directors
Island Health
c/o Executive Office
1952 Bay St
Victoria BC V8R 1J8

Re: s.22 – Review Board Letter

Dear Ms. Hollins:

The Patient Care Quality Review Board's review of s.22 is now complete. The Board has made no recommendations associated with this case.

Please find attached the Board's letter to both the health authority and the client, which summarizes and explains the Board's findings. The Board Chairs attest that the information contained in these letters accurately reflects the Board's discussion and conclusions relating to this case.

If you should have any questions or require clarification on the Board's findings or recommendations, please do not hesitate to reach out to the Department, including Regan Kirkland, the Care Quality Analyst assigned to this case, in related discussions and response letters.

The Board thanks the Health Authority for your ongoing commitment to improving health care for all British Columbians.

Sincerely,

Trish Hunt

Trish Hunt, Co-Chair

Susan Morrow

Susan Morrow, Co-Chair

Patient Care Quality Review Boards
PO Box 9643
Victoria BC V8W 9P1

contact@patientcarequalityreviewboard.ca
Tel: 1-866-952-2448
Fax: (250) 952-2428

Re: s.22 – Review Board Decision

The Island Patient Care Quality Review Board (the Board) has completed its review of the complaint of the above-named person to Island Health. Pursuant to Section 13 of the *Patient Care Quality Review Board Act,* the Board reviewed and considered all the information provided by both the client and the health authority.

Case #: s.22	Client Name: s.22
s.22	s.22
Complaint Sector: PCQO Response	Sub Sector: Administrative Fairness
Health Authority: Island Health	Facility s.22

PCQRB Primary Outstanding Issue:
The client does not feel the PCQO responded appropriately s.22
s.22

Case Overview:
s.22

Healthcare Delivery Timeframe:

- s.22

Summary of the Complaint:

- s.22
-
-

PCQO Involvement:

- The client emailed the PCQO on January 24, 2022.

s.22

- When provided review options by the PCQO, the client chose an in-person meeting with leadership s.22 . Due to COVID, the meeting was offered instead as a videoconference. On March 29, 2022, when the PCQ Officer emailed the client to set up the videoconference, the client declined the videoconference meeting, s.22
  s.22
- The PCQ Officer replied on March 30, 2022, that due to COVID-19 in-person meetings were not possible at that time and offered to provide the PCQO's findings in a letter and then offered s.22 a videoconference for any follow-up questions s.22 may have.
- The client did not respond and the PCQO Response Letter was emailed to the client s.22

PCQRB Involvement:

- The client sent the Review Request form on April 12, 2022.
- The Care Quality Liaison spoke with the client on June 10, 2021 and explained to the client that as professional conduct was outside of the scope of the Board and that we would only be able to review the PCQO response to s.22 concerns.
- The Final Acceptance was emailed to the client on July 18, 2022.

The client brought forward the following unresolved issues that were examined by the Board:

Issue 1: The client is dissatisfied with the PCQO response to s.22 concerns that s.22 was injured s.22
s.22

Findings:

1. s.22

2. The PCQO conducted a thorough review of the client's care experience, including gathering statements from the technologists that participated in the client's care

encounter and consulting with Medical Imaging leadership. Factors that we considered in our assessment of the PCQO review are as follows:

- The PCQO gathered statements from the s.22 technologists s.22 s.22

- The client recalls leaving multiple voicemails with the PCQO requesting that s.22 be called back on the phone. The PCQO did not contact the client by telephone. The PCQO does not have a record of the client's voicemail requests that s.22 be telephoned.

- The PCQO originally offered the client an option of having an in-person meeting with Island Health Medical Imaging leadership to discuss s.22 review results. However, due to COVID-19, the in-person meeting was subsequently proposed as a videoconference and the client declined that offer. We found that the health authority's decision to withdraw the offer of an in-person meeting was reasonable in the context of the pandemic.

- As there were some missed communications with the client during the course of the PCQO's review, a two-week timeline extension was required. While the PCQO recorded in the Patient Safety Learning System (PSLS) that the client was asked for an extension to the review timeline, the client does not recall this request. We noted there is no designated area in the PSLS to record verifiable details of the client's consent to an extension, e.g. date or method of communication.

- The PCQO response letter was detailed and conveyed the information expected from a comprehensive PCQO review.

Board Comments:

1. Over the course of reviewing materials provided for this case, we noted that the procedures listed s.22 s.22 do not align with the current practices as shared with the PCQRB by Medical Imaging leadership, or as documented in the minutes from the

s.2 | Nuclear Medicine Department Staff Meeting on May 29, 2020. We suggest that the Protocol be reviewed and adjusted to align with current practices, with an aim to clarify requirements for technologists and to reinforce the options s.22
s.22

2. The fields available in the PSLS for documenting client consent to timeline extensions are relatively limited. PCQRB staff will consult with BCPSLS in the interest of exploring a more detailed record of client consent to extensions within the PSLS, including the date of consent and method of request. As client consent is required for extensions, a more robust record of those requests would be helpful for general record-keeping and circumstances when cases require further review.

The Board made no recommendations in regard to this review.

This concludes the Board's review of this matter. The Board thanks the health authority for its assistance.

Prepared by:

Regan Kirkland
Care Quality Analyst
Patient Care Quality Review Board

pc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, CEO, Island Health
Patient Care Quality Office, Island Health

Enclosure

Ministry of Health - Information Briefing Note - Cliff 1217321

Prepared for: Honourable Adrian Dix, Minister of Health **- For information**

Title: Patient Care Quality Review Board Recommendation on Mental Health Act Policy

Purpose: To respond to a recommendation made to the Minister of Health in Patient Care Quality Review Board (PCQRB) file s.22

Background: A patient was detained under the Mental Health Act (MHA)
s.22

s.22 the PCQRB expressed concern that while regional policies relating to safe exit, restraints, and discharge of persons experiencing mental illness ensure the safety of staff and protect health authorities from liability, they are not client centred. The PCQRB felt that, aside from the mandatory requirement to obtain consent for treatment (Mental Health Act Form 5) and notification of rights (Mental Health Act Form 13), clients involuntarily admitted under the MHA could benefit from a provincial policy specifically intended to protect their safety and dignity, and to ensure their inclusion in care and discharge planning wherever feasible. They recommended the Minister of Health issue provincial policy – informed by service users – to that end (see Appendix A).

Discussion: The Ministry's Patient Care Quality team brought the recommendation to the Mental Health and Substance Use Division, which has responsibility for the MHA (see Appendix C for process).

In BC, the care of clients involuntarily admitted to designated psychiatric facilities is governed by the MHA and its regulations and standards, with provincial policy guidance provided by The Guide to the Mental Health Act (the Guide). The public, plain-language guide includes comprehensive tools for clients, families and their advocates, police, health practitioners, and administrators, and supports regional and facility level policy development with detailed information and advice on each requirement of the MHA.

The Mental Health and Substance Use Division is in the process of updating the Guide, informed by broad stakeholder consultation, including service users. Per the PCQRB recommendation, these updates will include guidance on protecting the safety and dignity of MHSU clients and their loved ones, including them in care and discharge planning where feasible, and communicating their rights.

This work is part of a suite of initiatives in response to the BC Ombudsperson's 2019 report Committed to Change, which made several recommendations to address widespread inconsistencies in the completion of forms required under the MHA. In response, the MHSU Division has developed standards, audit requirements, and a compilation of MHA education materials for staff of designated mental health facilities, under the MHA with additional changes to the regulations, including a review of all MHA forms and standards underway to address seclusion, restraint, and extended leave provisions.

These initiatives are targeted for completion in the fall of 2023 and implementation will be monitored by the Ministry of Health.

Advice: The Mental Health and Substance Use Division is currently updating the Guide to the Mental Health Act in consultation with service users, which will include the policy guidance recommended by the PCQRB. This work is targeted for completion in the fall of 2023, and implementation will be monitored by the Ministry in consultation with health authorities. s.13

s.13

Program ADM/Division: Darryl Sturtevant/Mental Health & Addictions Division
Phone number: 236-478-3550
Program Contact (for content): Gerrit van der Leer, A/ED MHSU and Manpreet Khaira, ED HSB
Drafter: Steph Cahill, A/Director Patient Care Quality
Date: February 14, 2023

Patient Care Quality Review Boards

File No. s.22

October 22nd 2019

Honourable Adrian Dix
Minister of Health
Room 337, Parliament Buildings
Victoria BC V8V 1X4

Dear Minister Dix:

Re: s.22 – Review Board Decision

The Vancouver Island Patient Care Quality Review Board (the Board) has completed its review of the complaint of the above-named person to Island Health.

Summary of Complaint and Unresolved Issues:

The Vancouver Island Patient Care Quality Review Board (the Board) has completed its review of the complaint of the above-named person to Island Health. Pursuant to Section 13 of the *Patient Care Quality Review Board Act,* the Board reviewed and considered all the information provided by both the complainant and the health authority.

s.22

The Island Health Patient Care Quality Office (PCQO) responded to the complainant on July 11, 2018. Subsequently the complainant brought forward the following unresolved issues that were examined by the Board:

Patient Care Quality Review Boards
PO Box 9643
Victoria BC V8W 9P1
contact@patientcarequalityreviewboard.ca
Tel: 1-866-952-2448
Fax: (250) 952-2428

Issue 1: The patient disagrees with the way s.22 was discharged s.22
s.22

Issue 2: The patient would like the Board to review whether policies and procedures were followed s.22 under the *Mental Health Act*.

Issue 3: The patient is unsatisfied with the PCQO's response because it contains the following inaccuracies:

s.22

Minister Dix, the Board reviewed and considered all the information provided by both the patient and the health authority, pursuant to Section 13 of the *Patient Care Quality Review Board Act* and based its decision on the information in the attached list of documents.

In addition to the Board's findings the health authority as outlined in the letter to Ms. Leah Hollins, Chair of the Board of Directors for Island Health, the Board made the following recommendation for your consideration:

1. **The Board recommends that the Minister of Health create a policy, directed at patients and consumers of mental health services, created with the input of these service users, with the express purpose of ensuring that patients and service users are aware of their rights as it pertains to dignity and patient safety and are included in their care planning and discharge planning wherever feasible.**

The Board expressed concern that in many cases policies relating to safe exit, restraints, and discharge of persons experiencing mental illness are intended for staff and Health Authority employees, rather than patients. While these policies protect employee safety and protect health authorities from liability, no such safeguards exist for patients, aside from the 'Notification of Rights' documentation mandated for involuntary patients under the *Mental Health Act*.

This concludes the Board's review of this matter. We appreciate the opportunity to provide a recommendation for your consideration in regard to this care quality complaint.

Yours truly,

Richard Swift, Q.C., Chair
Vancouver Island Patient Care Quality Review Board

Attachments

Information reviewed

Review Request
Information from Patient
Information from PCQO
Medical Records
Guidelines: *Safe Exit Guidelines for MHSU Sites, Restraints and Use of Force Procedures, Interprofessional Practice and Clinical Standard – Emergency Restraint and/or Seclusion*
MHSU Policy – Involuntary Admission Process in Accordance with the Mental Health Act *of BC MHSU Discharge/Transition Procedure, Guide to the* Mental Health Act, *Restraints and Alternative Ways of Managing Unsafe Patient Behavior*

MINISTRY OF HEALTH PROCESS
PATIENT CARE QUALITY REVIEW BOARD RECOMMENDATIONS TO THE MINISTER OF HEALTH

Objective and Scope

The Patient Care Quality (PCQ) Review Board is appointed by the Minister of Health (the Minister) under the *PCQ Review Board Act* to review healthcare complaints unresolved by Health Authority PCQ Offices. The Review Board may make non-binding recommendations to a health authority or the Minister for resolution and quality improvement. This document focuses on the process to address recommendations to the Minister.

When a recommendation is made to the Minister, we aim to ensure that:

- Decision support is timely, consistent, and comprehensive,
- Impacted program areas and subject matter experts are engaged,
- Ministry commitments are communicated and actioned, and
- Outcomes are evaluated to inform improvements to future recommendations.

Roles and Accountabilities

PCQ Review Board:

- Reviews patient complaints unresolved by health authority PCQ Offices by:
  a. Investigating information and records relating to the circumstances, policies/procedures, and entities involved,
  b. Convening an expert panel from Minister-appointed PCQ Review Board members to consider the patient's experience and care, and
  c. If indicated, making evidence-based recommendations for resolving concerns and/or improving healthcare quality in BC.

PCQ team, Hospital Services Branch, Hospital and Provincial Health Services Division:

- Receives and evaluates recommendations from the PCQ Review Board, and liaises for additional information if needed,
- Identifies and collaborates with responsible programs to coordinate decision support for the Minister's response,
- Monitors the implementation of Ministry commitments, evaluates the impact of the PCQ program, and supports continuous improvement, and
- Reports publicly on recommendations received and the effectiveness of the PCQ process.

Responsible Program Area(s):

- Situate recommendation in the context of program perspective and strategic direction,
- Provide subject matter expertise to ensure effective, evidence-based decision support,
- Determine best possible options and advice and provide supporting evidence/rationale,
- Action and/or lead resulting commitments within their scope of accountability, and

- Communicate implementation progress to PCQ team.

Minister of Health:

- Reviews decision support and authorizes Ministry action in response to PCQ Review Board recommendations, and
- Responds to PCQ Review Board Chairs to outline commitments, timeline, and reasoning.

Process Overview

1. *Recommendation*

The PCQ Review Board issues a recommendation to the Minister via a review letter. The recommendation to the Minister is also shared with the client who brought the concern forward and the involved health authority. The Ministry **PCQ team** receives and evaluates the recommendation using their expertise in the legislation and leading practices in complaints.

2. *Review*

The **PCQ team** identifies and collaborates with responsible program areas to coordinate a decision briefing note for the Minister and a response letter to the Review Board Chair and complainant. The PCQ team drafts the background section for the decision briefing note, and drafts letters to the complainant and PCQ Review Board Chair based on program area analysis and recommended option.

Responsible program areas consult stakeholders and consider recommendation in context of program perspective, strategic direction, and subject matter expertise to identify best possible options and advice for decision support. Responsible programs draft analysis and options for the decision briefing note, which inform the Ministry's response.

3. *Approval*

Executive Directors for **PCQ team** and **responsible program areas** mutually approve the decision support and forward for responsible program area ADMs, DMO, and MO review/approval. HPHSD ED approves PCQ-related content and approach, while responsible program area ADMs approve analysis, options, and recommended action.

The **Deputy Minister** signs the response to the complainant to describe the Ministry's commitment in response to the recommendation and provide a program contact for the work. The **Minister** signs the response to the PCQ Review Board Chair.

4. *Implementation*

Responsible program areas action/lead commitments and update **PCQ team** on progress until Ministry action is complete.

PCQ team updates PCQ Review Board on recommendation progress, reports publicly on recommendations in annual report, and integrates learning into program evaluation.

From: HLTH Corporate Operations HLTH:EX (HLTH.Corporate.Operations@gov.bc.ca)
To: hlth Ministerial and Executive Assistants (hlthmaea@Victoria1.gov.bc.ca)
Cc: HLTH Corporate Operations HLTH:EX (HLTH.Corporate.Operations@gov.bc.ca); DMO Operations HLTH HLTH:EX (DMO.HLTHOperations@gov.bc.ca); Murray, Heather HLTH:EX (Heather.Murray@gov.bc.ca); Andrachuk, Andrea HLTH:EX (Andrea.Andrachuk@gov.bc.ca)
Subject: 1217321 - ProgGen IBN for Min Dix - PCQRB Recommendation s.22 MHA policy
Sent: 02/16/2023 21:21:11
Attachments: 1217321 - ProgGen IBN for Min Dix - PCQRB Recommendation s.22 MHA policy.docx, 1217321 Appendix A PCQRB Review Letter to Minister s.22 .pdf, s.22 s.22 1217321 Appendix C MOH Process for PCQRB Recommendations.docx, 1217321 - email addresses.docx
Message Body:

Good afternoon,

The attached briefing document has been prepared for the Minister's information and to provide advice on responding to the PCQRB recommendation regarding *Mental Health Act* policy. This has been approved by Kristy Anderson, ADM, Darryl Sturtevant, ADM, and Deputy Minister Brown.

Also attached is 'Appendix A' (incoming from the PCQRB) and s.22 s.22 I will also forward the e-app (50893) to your office for processing the response, per usual method.

Regards,

Sylvia Rose (she/her)
Documents Clerk
Corporate Operations Unit
Ministry of Health
Sylvia.Rose@gov.bc.ca

I am grateful to live and work on the unceded lands of the Lək̓ʷəŋən People , known today as the Esquimalt and Songhees Nations.

From: s.22
To: OfficeofthePremier, Office PREM:EX (Premier@gov.bc.ca); Health, HLTH HLTH:EX (HLTH.Health@gov.bc.ca); Babchuk.MLA, Michele LASS:EX (Michele.Babchuk.MLA@leg.bc.ca)
Subject: 1240819 s.22 10th Incoming - s.22 North Island health crisis s.22
Sent: 02/10/2023 20:37:33
Message Body:

HLTH MO fyi to HSWBS - jp - Add to 1240819 s.22 upload to CLIFF and eApps; advise divisional coordinator and eApp Assignee

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s.22

From: s.22
To: OfficeofthePremier, Office PREM:EX (Premier@gov.bc.ca); Health, HLTH HLTH:EX (HLTH.Health@gov.bc.ca); DMOFFICE, HLTH HLTH:EX (HLTH.DMOFFICE@gov.bc.ca); Babchuk.MLA, Michele LASS:EX (Michele.Babchuk.MLA@leg.bc.ca)
Subject: 1240819 s.22 Incoming - Dr Nataros/Minister Dix
Sent: 02/09/2023 20:55:05
Message Body:

HLTH MO fyi to HSWBS - jp - Add to 1240819 s.22 ; upload to CLIFF and eApps; advise divisional coordinator and eApp Assignee

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Can you comment on the recent statement from IH and Minister Dix regarding Dr Nataros?

I believe that their actions are in retaliation for speaking out. They are attempting to muzzle him and influence public opinion.
Minister Dix said about the retaliation ' that would never happen' s.22 Ben Williams cites 'patient safety' issues as a deflection of his and the overall organizational senior leadership dereliction of their respective duties. Doctors have professional accountability processes to abide by and get to answer to that.
What accountability processes do administers like Ben Williams, Kathy MacNeil and the IH board have?
They say the public, the public who they tell what to think by controlling the narrative.

Can you speak more to the retaliation you experienced or patient safety issues you are aware of?

s.22

Patient safety is conveniently thrown around for attention.
If Dr Nataros engaged in unsafe patient safety practices he gets to account for it through established professional processes, not a press conference. If it is truly patient safety that IH is concerned about rather than defending their appointed positions, how do they explain:
Unnecessary regional patient DEATHS in Alert Bay and Port Hardy?
Continually putting patients at risk with unpredictable MESSAGING and CARE PROVISION regarding regional hospital closures and regional clinic access?
Not SUPPORTING all local health care providers to provide safe care?

The public service announcements put out by IH say that it is 'unfortunate and not ideal' that patients suffer. That's the extent of their efforts and accountability on patient safety. Our patients and care teams deserve more.

What do you think of Physician Assistants as a solution for the region?

It's a creative solution and has merit. I believe that the Ministry is stuck on the administration and oversight of PAs in our region. PAs could be a welcome solution to our staffing crisis.

From: Aitken, Kimberley (Kimberley.Aitken@islandhealth.ca)
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Cc: Fielding, Scott (Scott.Fielding@islandhealth.ca); XT:James, Lisa HLTH:IN (lisa.james@islandhealth.ca); Shufelt, Karen (Karen.Shufelt@islandhealth.ca); Sundborg, Carole (Carole.Sundborg@islandhealth.ca); Patient Care Quality Office (PCQO) (PatientCareQualityOffice@islandhealth.ca)
Subject: Response to Review Board Decision s.22
Sent: 02/14/2023 23:25:12
Attachments: image001.jpg, s.22 PCQRB s.22 Response.pdf, s.22 PCQRB s.22 Response to Client.pdf
Message Body:

HLTH MO fyi to HPHSD – ss –

_____

Good Afternoon,

Please see the attached sent on behalf of Leah Hollins, Board Chair, Island Health.

Kind regards,

Kimberley

Kimberley Aitken *(she/her)* | Administrative Assistant, Executive Office
Phone: 250-370-8959 ex. 18959 | email: kimberley.aitken@islandhealth.ca
Courage • Aspire • Respect • Empathy

February 14, 2023

Ms. Trish Hunt and Ms. Susan Morrow, Co-Chairs
Vancouver Island Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9P1

Dear Ms. Hunt and Ms. Morrow,

Re: Patient Care Quality Review Board (PCQRB) s.22

Thank you for your letter of January 6, 2023, with regard to the complaint raised by s.22 We appreciate the response provided by the PCQRB, and pursuant to legislative requirements, offer the following with regard to the recommendations.

RECOMMENDATION 1:
That Island Health considers how CTAS guidelines, which outlines ideal times to receive care based on patients' medical needs, can continue to be managed in an environment where other challenges (such as staffing) continue to impact their achievement. The Board would like to note that specific attention be directed to what the expectations are for patient care after patients have been triaged, but before they have been seen by the ED physician, considering that wait times for ED physician assessments have increased.
RESPONSE TYPE:
Accepted
STATUS OF RECOMMENDATION:
In Progress Island Health recognizes due to the increased volume of patients presenting to the Emergency Department (ED), and the current decrease in availability of front line acute care staff, the ability to see patients within current recommended CTAS guidelines has been challenged and can negatively impact the patient experience. In support of the Board's findings, Island Health will share this case with ED leadership involved in strategic work around reducing ED wait times and the impact on patient experience. In keeping with current process, staff will use the CTAS triaging process to determine the urgency with which the patient requires care relative to the other patients waiting to be seen, as well as the recommended frequency of reassessment while the patient is waiting. Nursing staff in the ED will continue to advise patients to re-engage triage if their presenting condition changes while in the waiting area. Timely reassessment of patients waiting to be seen will continue to ensure unavoidable delays do not affect patient safety.

RECOMMENDATION 2:
That the health authority develops and implements a policy and protocol for accommodating people with unique accessibility needs in the ED. Implementation through effective knowledge sharing should include elements that foster a culture of accessibility awareness for all staff participating in patient care.
RESPONSE TYPE:
Accepted with Modification
STATUS OF RECOMMENDATION:
In Progress As noted, in your letter, the Ministry of Health and Health Authorities will be participating in work in support of implementation of the Accessible British Columbia Act, including establishing accessibility committees, accessibility plans and an accessibility feedback tool. At Island Health, this work is underway as part of the Clinical Governance Improvement Initiative (CGII), which was launched in the fall of 2021. CGII is focused on improving clinical policy, program planning, and practice standards development and implementation by clarifying accountability and decision processes. Included in the CGII work will be creation of a committee to respond to new legislation and regulatory changes, including the Accessible British Columbia Act. Island Health is establishing a standardized approach to integrating the person, family and community voice in clinical governance and decision-making. Within this, we will be creating specific processes to elicit meaningful input, with a focus on inclusive and diverse representation. The Health Authority will be consulting with multiple community groups in mid-2023 to build this approach and the consultation process will include persons with disabilities or persons representing a disability-serving organization.

RECOMMENDATION 3:
That the health authority work with s.22 **ED leadership to review the use of exam tables for patients waiting to be seen in the ED to ensure this practice aligns with the safety needs of patients.**
RESPONSE TYPE:
Accepted with Modification
STATUS OF RECOMMENDATION:
In review of the recommendation, Island Health has determined the use of exam tables is not standard practice and in an attempt to meet the requested need of the patient, regular process was bypassed in this situation. ED leadership will remind staff about patient safety in the ED, including highlighting use of exam tables by patients while waiting for a physician does not comply with Island Health processes and could be detrimental to safe patient care.

I trust this information is helpful, and once again, thank the PCQRB for its thoughtful review.

Sincerely,

Leah Hollins
Board Chair, Island Health

cc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, President & CEO, Island Health
Scott Fielding, Executive Director, Quality, Safety & Improvement, Island Health
Karen Shufelt, Acting Director, Patient Care Quality Office, Island Health

February 14, 2023 PCQRB #s.22

s.22

Dears.22

Thank you for contacting the Patient Care Quality Review Board (PCQRB) regarding your experiences while seeking medical attention at s.22 , specifically your concerns with the care provided to you in the Emergency Department (ED).

On behalf of Island Health, please accept my sincere apologies for any actions which may have contributed to your feelings your rights were not recognizeds.22 while you waited to be assessed by a doctor. I appreciate how challenging it must have been navigating your care journey and can only imagine how distressing it must have been for you during this very difficult time. Patients require exceptional communication, support, and accommodations, and it is clear we failed to deliver this to you. We can, and must, do better.

As you will have seen from their letter to you, the PCQRB has made three recommendations to Island Health. The first is:

- That Island Health considers how CTAS guidelines, which outlines ideal times to receive care based on patients' medical needs, can continue to be managed in an environment where other challenges (such as staffing) continue to impact their achievement. The Board would like to note that specific attention be directed to what the expectations are for patient care after patients have been triaged, but before they have been seen by the ED physician, considering that wait times for ED physician assessments have increased.

Island Health recognizes due to the increased number of patients presenting to the ED, and the current decrease in the availability of front-line acute care staff, the ability to see patients within current recommended CTAS (Canadian Triage and Acuity Scale) guidelines has been challenging, and this can have a negative impact on patient experience. In support of the Board's findings, Island Health will share your case with ED leadership to emphasize the importance of the patient experience. Staff will continue to use the CTAS triaging process to determine the urgency with which the patient requires care relative to the other patients waiting to be seen, as well as the recommended frequency of reassessment while the patient is waiting. Nursing staff in the ED will continue to advise patients to re-engage triage if their presenting condition changes while in the waiting area. Timely reassessment of patients waiting to be seen will continue and is important to ensure unavoidable delays do not affect patient safety.

...2/

Executive Office
Located at: 2101 Richmond Road | Victoria, BC V8R 4R7 Canada
Mailing address: 1952 Bay Street | Victoria, BC V8R 1J8 Canada
Tel: 250-370-8699 | Fax: 250-370-8750
viha.ca

The Board's second recommendation is:

- That the health authority develops and implements a policy and protocol for accommodating people with unique accessibility needs in the ED. Implementation through effective knowledge sharing should include elements that foster a culture of accessibility awareness for all staff participating in patient care.

Work is underway at Island Health to establish a standardized approach to bringing the person, family, and community voice to clinical governance and decision-making. We will be creating specific processes to elicit meaningful input, with a focus on inclusive and diverse representation. The Health Authority will be consulting with multiple community groups in mid-2023 to build this approach and the consultation process will include persons with disabilities or persons representing a disability-serving organization.

Recommendation three from the board states:

- That the health authority work with s.2 ED leadership to review the use of exam tables for patients waiting to be seen in the ED to ensure this practice aligns with the safety needs of patients.

In review of the recommendation, Island Health has determined the use of exam tables is not standard practice and the regular process was bypassed in this situation. ED leadership will remind staff about patient safety in the ED, highlighting the use of exam tables for patients waiting for a physician, does not comply with Island Health processes and could be detrimental to safe patient care.

s.22 I hope this information provides you with some reassurance your concerns have been heard. Island Health's Executive Director of Quality, Safety, and Improvement, Scott Fielding, and Karen Shufelt, Director of the Patient Care Quality Office, would be pleased to speak with you should you wish to learn more about what is being done to address these recommendations. Please feel free to reach out to them at Scott.Fielding@islandhealth.ca or Karen.Shufelt@islandhealthc.ca.

Again, please accept my apologies for your experiences. By bringing your concerns to the PCQRB, you have helped Island Health improve patient care and for that, we are very grateful.

Sincerely,

Leah Hollins
Island Health Board Chair

cc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, President & CEO, Island Health
Scott Fielding, Executive Director, Quality, Safety & Improvement, Island Health
Karen Shufelt, Interim Director, Patient Care Quality Office, Island Health

From: Aitken, Kimberley (Kimberley.Aitken@islandhealth.ca)
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Cc: XT:James, Lisa HLTH:IN (lisa.james@islandhealth.ca); Fielding, Scott (Scott.Fielding@islandhealth.ca); Shufelt, Karen (Karen.Shufelt@islandhealth.ca); Patient Care Quality Office (PCQO) (PatientCareQualityOffice@islandhealth.ca); Sundborg, Carole (Carole.Sundborg@islandhealth.ca)
Subject: Response to Review Board Decision s.22
Sent: 01/17/2023 19:50:33
Attachments: image001.jpg, 21359 PCQRB s.22 Response.pdf, 21359 PCQRB s.22 Response to Client.pdf
Message Body:

HLTH MO fyi to SSD – CV –

Hello,

Please see the attached sent on behalf of Leah Hollins, Board Chair, Island Health.

Kind regards,

Kimberley

Kimberley Aitken *(she/her)* | Administrative Assistant, Executive Office
Phone: 250-370-8959 ex. 18959 | email: kimberley.aitken@islandhealth.ca
Courage • Aspire • Respect • Empathy

January 17, 2023

Ms. Trish Hunt and Ms. Susan Morrow, Co-Chairs
Vancouver Island Patient Care Quality Review Board
PO Box 9643
Victoria, BC V8W 9P1

Dear Ms. Hunt and Ms. Morrow,

Re: Patient Care Quality Review Board (PCQRB) File s.22

Thank you for your letter of November 23, 2022, with regard to the complaint raised by s.22 and for granting an extension to the response time on this file. We appreciate the response provided by the PCQRB, and pursuant to legislative requirements, offer the following with regard to the recommendations.

RECOMMENDATION 1:
We recommend reporting through the Patient Safety Learning System to ensure adequate time to implement the necessary client supports and care team planning for transitions.
RESPONSE TYPE:
Accepted with Modification
STATUS OF RECOMMENDATION:
In Progress Island Health will continue to work to ensure client and staff safety are prioritized when a client requires the use of a lift to transfer from bed to a chair, wheelchair, scooter and/or commode. This includes using existing reporting, documentation and communication tools within Community Health Services (CHS) to ensure any potential safety concerns or issues are identified by a clinician or Community Health Worker (CHW). This also means adhering to WorkSafeBC and Island Health's Occupational Health and Safety guidelines. In support of the recommendation, a review of current reporting, documentation and communication pathways for client related concerns will be completed to ensure timeliness, appropriateness and adherence to process. Island Health commits to reviewing and refreshing communications and education for CHS staff on reporting, documentation and communication pathways, including how and when to complete a Patient Safety Learning System report. To complete a fulsome process review, communication refresh, and provide comprehensive staff education, CHS leadership projects to conclude this recommendation in December 2023.

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RECOMMENDATION 2:
We recommend the health authority improve their *Home Support Service Planning and Referral Process* to include more client-focused steps when transitioning and changing home support care plans. The process should include: • **adequate time allotted for clients to arrange supports prior to significant changes in care;** • **verification that clients have necessary supports in place prior to plan implementation; and** • **consideration for clients who do not have the community connections or financial means to supplement a proposed care plan.** **In situations where the above steps cannot be met, the health authority explore options for appropriate short-term alternatives (i.e., temporary long-term care placement, respite care, etc.) for home support clients.**
RESPONSE TYPE:
Accepted with Modifications
STATUS OF RECOMMENDATION:
In Progress Island Health will be conducting a review of the current Home Support service planning and referral process to improve documentation and communication pathways between the client and their care team. The review of current practices will focus on client-focused considerations including the referral and care processes and/or what to do when there are required changes to the care plan and/or short-term alternatives required. In addition, Island Health will provide clarity, through education to clients, on the roles and responsibilities of the care team and their obligations to the client when the client makes an informed choice to live at risk.

I trust this information is helpful, and once again, thank the PCQRB for its thoughtful review.

Sincerely,

Leah Hollins

Leah Hollins
Board Chair, Island Health

cc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, President & CEO, Island Health
Scott Fielding, Executive Director, Quality, Safety & Improvement, Island Health
Karen Shufelt, Interim Director, Patient Care Quality Office, Island Health

January 17, 2023 PCQRB #s.22

s.22

Dear s.22 ,

Thank you for contacting the Patient Care Quality Review Board (PCQRB) regarding your experiences of care with Island Health, specifically Home and Community Care.

On behalf of Island Health, please accept my sincere apologies for any disruption caused by the transition between lift systems in your home. I can only imagine how distressing it must have been for you during this very difficult time. Patients require exceptional communication and support when there are necessary changes in a care plan and it is clear we failed to deliver this to you. We can, and must, do better.

As you will have seen from their letter to you, the PCQRB has made two recommendation to Island Health. The first is:

- We recommend reporting through the Patient Safety Learning System to ensure adequate time to implement the necessary client supports and care team planning for transitions.

In upholding the Board's first recommendation, Island Health has committed to the following enhancements to current practices:

- Island Health will continue to work to ensure client and staff safety are prioritized when a client requires the use of a lift to transfer from bed to a chair, wheelchair, scooter and/or commode. This includes using existing reporting, documentation and communication tools within Community Health Services (CHS) to ensure any potential safety concerns or issues are identified by a clinician or Community Health Worker (CHW). This also means adhering to WorkSafeBC and Island Health's Occupational Health and Safety guidelines.
- In support of the recommendation, a review of current reporting, documentation and communication pathways for client related concerns will be completed to ensure timeliness, appropriateness and adherence to process. Island Health commits to reviewing and refreshing communications and education for Community Home Support staff on reporting, documentation and communication pathways, including how and when to complete a Patient Safety Learning System report, which is the Provincial system used by all Health Authorities to report a safety event. Completion of the process review, communication refresh, and staff education is projected for December 2023.

. . . /2

Executive Office
Located at: 2101 Richmond Road | Victoria, BC V8R 4R7 Canada
Mailing address: 1952 Bay Street | Victoria, BC V8R 1J8 Canada
Tel: 250-370-8699 | Fax: 250-370-8750
viha.ca

The Board's second recommendation is:

- We recommend the health authority improve their Home Support Service Planning and Referral Process to include more client-focused steps when transitioning and changing home support care plans. The process should include:
  - adequate time allotted for clients to arrange supports prior to significant changes in care;
  - verification that clients have necessary supports in place prior to plan implementation; and
  - consideration for clients who do not have the community connections or financial means to supplement a proposed care plan.

  In situations where the above steps cannot be met, the health authority explore options for appropriate short-term alternatives (i.e., temporary long-term care placement, respite care, etc.) for home support clients.

In support of the Board's recommendation, Island Health will be conducting a review of the current Home Support service planning and referral process to improve documentation and communication pathways between the client and their care team. The review of current practices will focus on client-focused considerations including the referral and care processes and/or what to do when there are required changes to the care plan and/or short-term alternatives required. In addition, Island Health will provide clarity, through education, to clients on the roles and responsibilities of the care team and their obligations to the client when they make an informed choice to live at risk.

s.22 I hope this information provides you with some reassurance your concerns have been heard. Island Health's Executive Director of Quality, Safety and Improvement, Scott Fielding, and Karen Shufelt, Director of the Patient Care Quality Office, would be pleased to speak with you should you wish to learn more about what is being done to address these recommendations. Please feel free to reach out to them at Scott.Fielding@islandhealth.ca or Karen.Shufelt@islandhealth.ca.

Again, please accept my apologies for your experiences. By bringing your concerns to the PCQRB, you have helped Island Health improve patient care and for that, we are very grateful.

Sincerely,

Leah Hollins

Leah Hollins
Island Health Board Chair

cc: Honourable Adrian Dix, Minister of Health
Kathy MacNeil, President & CEO, Island Health
Scott Fielding, Executive Director, Quality, Safety & Improvement, Island Health
Karen Shufelt, Interim Director, Patient Care Quality Office, Island Health

From: s.22
To: Health, HLTH HLTH:EX (HLTH.Health@gov.bc.ca); DMOFFICE, HLTH HLTH:EX (HLTH.DMOFFICE@gov.bc.ca); OfficeofthePremier, Office PREM:EX (Premier@gov.bc.ca); Babchuk.MLA, Michele LASS:EX (Michele.Babchuk.MLA@leg.bc.ca); XT:Williams, Ben HLTH:IN (ben.williams@islandhealth.ca); XT:MacNeil, Kathryn HLTH:IN (Kathryn.MacNeil@islandhealth.ca)
Subject: *North Island Crisis
Sent: 02/08/2023 22:35:53
Message Body:

HLTH MO fyi to HPHSD - jp – s.22

Dear Honourable Minister Dix

I was reflecting on your recently expressed confidence in HA leadership at Island Health and how this affects the health care crisis in the North Island.

A few things stand out for me s.22
s.22

Kathy MacNeill:
1.What were the recent Summit recommendations relative to the Novotone report from 8yrs ago and how were they different from the recent Ministry announcement?
2.What processes were you referring to for staff to flag concerns?
The stifled process where HA (health authority) officials never f/u on issues raised?
LMAC and HAMAC which are within the remit of the HA which remains unresponsive?
A PSLS and Respectful Workplace system that has become a standard for HA deflection?
A Safe reporting system that is meant to be non punitive and that you cannot hold accountable appointed executives (who are not elected) that are insulated and above reproach in a public system?
College complaints to adjudicate licence issues raised by HA that cover up HA administrative incompetence?

Ben Williams:
1.What recruitment strategy and provider resource/stabilization plan do you have apart from revolving door mandatory ROS physicians and you offering to do a Locum in PM?
Are Agency nursing and Locum physicians the new model given the lack of support professionally or remuneratively for diagnostic, nursing and physician staff that are here?
Is your role as VP of medicine and CMO any more than a subjective interpretation and upholding of the Medical Staff bylaws and staff rules? Is there a reason for your general absence in your appointed leadership role?

Especially notable is the self declared accolades and success on the health care crisis by HA executives ....basically a pat on the back to let us know how well they're doing and how thankful we should be for having them in their positions.Where are the objective measurements of their efforts? What tangible or articulated plan do they have for the Ministry announcement made?

There appears lots of clarity on what their job isn't and what they cannot do....Is that a Ministry restriction?
Whose responsibility is it to provide health care?
Ministry? Health authority or board?
Doctors?
What are each others responsibilities in this care delivery?
Ben Williams states it's the doctors' responsibility to come up with a plan to tell them how to do their respective jobs. Basically doctors are the fall guys for their incompetence and physical and supportive absence in leadership.
What accountabilty process do health authority executives have?
Execs tell the Board who tell the Minisrty
How does the Board know?
Who informs the execs?
.....not frontline staff,patients and community leaders.

The same executives telling themselves what a great job they're doing while patients and providers continue to suffer.

Which community in our region said they support a withdrawal of services and have limited access to labs, community services, hospital or ER care?
Is it too much to ask for predictable messaging and delivery of acute and clinic care to the communities?
The Ministry announcement says hospitals in Alert Bay and PH will remain open for the day yet patients still access care in PM during this time.Did the Minister or HA ask why?
How is it that indigenous and rural patients get worse care and poorer resource? Why does the Joint standing committee remain an arbitrary nepotistic committee that has no patient or community input.

Dear Honourable Minister, perhaps you care to listen to the brokenness and confidence you expressed in the HA administration of the following:
No MAID support/co-ordination with families and docs left to struggle to offer this service.
No maternity support to midwives or physicians with preterm deliveries in ER or hallway.
A CT scanner but no basic diagnostics like lab and X-ray.
Patients in the region dying due to a lack of care co-ordination and nursing/physician support.
The spending/ service delivery mismatch for Clinics and hospital in PH, PM, Port Port Alice and Sointula.
A MH observation room at a site with no MH support around the legality and application of the Mental Health Act.
Withdrawal of support to the FN communities of Wuikinxv and Zeballos but also Sointula and surrounding communities of Coal Harbour, Quatsino, Fort Rupert, Kingcome, Guildford and Wuikinuxv
No physician contracts for PH, PM or Sointula.
Abandonment of patients and providers in Alert Bay.
Cumbersome and token income guarantee for ER coverage for PM to cover the regions ER with 4 docs with no discussion with those docs who are forced to provide ER care to the region with physician vacancies.
An expectation of Ben Willlams that PM docs sign a contract to work at PH, a 'closed'site.
No demonstrated executive understanding of patient access and flow
No patient safety or provider support lens.

s.22

So we remain invisible as a region of people and providers.
This is a call for your action Minister not more rhetoric and placating exercises.We need health authority representatives who can see us and hear us, executives that are competent, ethical and responsible. Perhaps you care to review the DoBC physician satisfaction survey and staff survey for Island Health?

I would also like to call upon all regional patients and elected community leaders to reflect on the health care crisis in the North Island. Recent recognition of our struggle and the promise of increased funding and a new physician remuneration model is really encouraging.We have an opportunity for success but not with the current local and senior health authority representatives who have perpetuated the health care gaps.

Our patients and care teams need and deserve new Island Health leadership.

———————————————————
s.22

From: s.22
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: Fwd: Suspension of ER doctor
Sent: 02/10/2023 23:25:16
Message Body:

HLTH MO fyi to HPHSD - jp

Sent from my iPhone

Begin forwarded message:

From: s.22
Date: February 10, 2023 at 12:13:09 PM PST
To: adrian.dix.MLA@leg.bc.ca
Subject: Suspension of ER doctor

Dear Mr. Dix

I want you to know how concerned &
Appalled after hearing about Dr Ben
Williams decision to suspend the only
ER doctor in Pt Hardy!
He also is publicly claiming he cares about the health care in the north island.
He clearly does not !
Dr. Nataros is a beloved doctor in the community of Pt Hardy , and he felt he needed to speak out publicly.
Island health has clearly done nothing to offer help in the on going hospital closures there.
I applaud this young doctor who has
Spoken out about the needs in the NI
What is going on with island health ?
I believe that there is a need to down size some of these senior positions
In island health and free up some funding for the front line workers.
I would start with Ben Williams position.

s.22

Sent from my iPhone

From: Dix.MLA, Adrian LASS:EX (Adrian.Dix.MLA@leg.bc.ca)
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: FW: Suspended Physician on north island
Sent: 02/10/2023 19:47:14
Message Body:

HLTH MO fyi to HSPHSD - jp - CorpOps Note: s.22

From: s.22
Sent: February 9, 2023 5:41 PM
To: Dix.MLA, Adrian <Adrian.Dix.MLA@leg.bc.ca>
Subject: Suspended Physician on north island

And you wonder why healthcare employees don't speak out? This intimidation and bullying is rampant throughout the entire system and everyone is afraid to speak up. It is absolutely corrupt and must change, starting with axing fifty percent of the managers. We need nurses and physicians, affording them respect for the enormous workloads they endure, not smearing them with biased rhetoric and intimidation. It's time to see the pitfalls in healthcare and clean house of the plethora of managers. The savings can be directed to nurses and physicians. Any employee with a nursing designation should provide direct patient care, not aspire to a management position. Hire more nurse practitioners to work alongside physicians and help relieve stress in Emerg and wards. Consult nurses and physicians when planning change, not some manager who just doesn't know, or doesn't care to know. As Oprah says "get with the program". We are in crisis here. Thank-you.
s.22

Sent from Yahoo Mail for iPhone

From: Dix.MLA, Adrian LASS:EX (Adrian.Dix.MLA@leg.bc.ca)
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: FW: embarrassing for NDP
Sent: 02/09/2023 17:35:11
Message Body:

HLTH MO fyi to HPHSD - ss - s.22

-----Original Message-----
From: s.22
Sent: February 9, 2023 9:34 AM
To: Dix.MLA, Adrian <Adrian.Dix.MLA@leg.bc.ca>
Subject: embarrassing for NDP

Embarrassment for NDP. Nurses and doctors have told us on the news, they were reluctant to criticize Island Health due to retaliation, and Dr. Nataros in Port Hardy did, and that's exactly what happened.
Feb 2 he called for the resignation of Dr. Ben Williams, and Dr. Nataros had his EM medicine suspended. It looks ridiculous here and for BC, (saying something was questionable providing care, when he's the only dr., rushed, stressed, doing his best, begging for help).
AND, Minister Dix was asked about Dr. Nataros's emergency suspension and said, "No this would never happen." It's so clumsy for Island Health and Dr. Ben Williams. Restore Dr. Nataros, while investigating.
s.22

From: Dix.MLA, Adrian LASS:EX (Adrian.Dix.MLA@leg.bc.ca)
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: FW: Dr. Nataros
Sent: 02/13/2023 19:51:06
Message Body:

HLTH MO fyi to HPHSD – ss –s.22

From: s.22
Sent: February 11, 2023 8:19 AM
To: Dix.MLA, Adrian <Adrian.Dix.MLA@leg.bc.ca>
Subject: Dr. Nataros

Things are not well in Island Health. Toxic workplaces within Island Health is not a new thing. You want people to believe this doctor is being suspended because of a support dog? If that's the case, this is still messed up. Support animals are a valid resource for calming humans. There is more danger from other patients. s.22
s.22 Maybe provide healthcare workers and patients with support and safety from patients? That is a real threat.
I do not for a moment think this is about a dog. It is bullying from upper management and government. It looks like government silencing a doctor. If the NDP is this low, I give up. No point even voting.
I'm leave my other contact info but I know it is fruitless. I haven't ever received a response to even very specific questions.

From: s.22
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: FW: bad services for FN and Black patients
Sent: 04/30/2023 00:14:14
Message Body:

HLTH MO fyi to HSWBS - jp

Dear Health Minister Adrian Dix,

I am forwarding this to you so you might have some understanding of the bias BIPOC and other people are still subjected to when trying to obtain health services. Just so you know, I don't blame the gov't as much as I do the BC College of Physicians and Surgeons. I understand that the College holds a virtual monopoly over healthcare and thus is an extremely powerful lobby group effectively beholden to no one. I don't believe it is working in the public interest so much as working in the interest of its members. No professional interest group, association, or union should ever be trusted to set the rules for and to regulate its own membership, it doesn't work because it is not in their interest to do so. I have never actually seen a working example of self-regulation, it is always abused.

I think it best that people working in public healthcare become direct employees of the gov't and subject to public accountability. The CMPA acts in a cartel-like fashion and probably should be disbanded altogether. Making doctors direct employees working in publicly funded spaces would also eliminate a lot of the complaints doctors have about business costs and paperwork. Honestly I'd rather have a doctor who got straight Bs and cares more about people than a doctor who got straight As and cares more about money.

The Yukon has a good program where they pay for health training in return for a few years of service in the Yukon. A similar program could be started in BC with reserved seating in our health programs for participants. It could encourage more diverse people, who are not currently considering training in healthcare because of finances or slightly lower grades, to apply and work in the health professions.

Good luck managing the doctors, it seems to me much like attempting to herd recalcitrant cats.

Sincerely,
s.22

Sent from Mail for Windows

From: s.22
Sent: Saturday, April 29, 2023 16:22
To: patientcarequalityoffice@islandhealth.ca
Subject: bad services for FN and Black patients

Dear Madam or Sir,

I hope you are well. I am writing to you today out of concern for the poor, and sometimes dangerous, level of care at s.22 This is not about one incident, but multiple incidents. The staff of this clinic clearly hold racial and other biases that need correction.

Immediately upon entry to this clinic front office staff treat BIPOC and lower SES white people differentially. They are treated less politely and as if they are less hygienic and dirtier than higher SES white people. They seem to assume that people do not care about Covid measures and will snap at people who do not move quickly enough to the hand sanitizer station and people are watched closely to make sure they are doing it right. If people say anything they are quickly labeled as hostile, abusive, and/or mentally ill, and possibly dangerous.

It seems to be a general assumption that all Indigenous people are drug seeking substance abusers, that Indigenous, Black, and poor people are less deserving of care, and entirely to blame for whatever condition they are in. The notion that BIPOC people do not feel pain the same way as white people persists. People are being subjected to many other negative stereotypes as well. People who are low income or on welfare are assumed to be lazy or 'milking the system'. People

with disabilities are assumed to be intellectually impaired, mentally ill, and malingering or exaggerating the difficulties they face. People who can't afford, or are physically unable, to follow a doctor's suggested treatment are labeled non-compliant and mentally ill. Marginalized people are often given very patronizing, unhelpful instructions like, "Get a better paying job", "You just need to learn to budget", "You have to learn to prioritize", "You just need to try harder", instead of doctors working collaboratively with them with the resources they have. They assume that all people have access to necessary resources, including the luxury of time, and just aren't managing them properly. Anyone who tries to discuss these issues with the doctor or other staff is labeled as difficult, abusive, resistant, avoidant, malingering, mentally ill, etc.

Marginalized people, particularly Indigenous and Black people, are assumed to be ignorant, unable, and unwilling to manage their health in a positive way, and not knowledgeable or aware of their own bodies and changes in health. Ironically doctors have expressed disbelief that systemic discrimination exists, that interpersonal discrimination is common, and that these things have serious physical and mental health impacts. Because of these negative, mostly implicit attitudes people are making multiple visits for the same concern, or are avoiding going to the doctor at all until they go to the emergency department. Sadly they are not receiving any better treatment at local hospitals, and are often chastised for not going to a doctor sooner. This all results in much poorer health outcomes and much higher costs to the system.

Often people who have gone to s.22 with serious concerns have been told that they are exaggerating or suffering from anxiety, and just need to eat a healthier diet and exercise more. Diagnostic tests beyond taking BP, listening to heartbeat, and reflex, are often not ordered as it is considered a waste of resources for these populations, but often liver enzyme and other tests of questionable usefulness are. Consequently people may suffer serious harms, such as cardiovascular incidents and kidney failure, that may be avoidable, or at least delayed. People who complain of pain are being subjected to deliberately inflicted, unnecessarily painful, and sometimes injurious, examination, as a form of punishment for their 'drug seeking' behaviors. Narcotic painkillers for legitimate conditions are not being prescribed for BIPOC people and that causes much unnecessary suffering. People who have never had substance abuse problems are resorting to excessive alcohol and marijuana consumption, and sometimes street drugs, out of desperation. Telling people they just need to "tough it out", "keep moving", and "it's all in your head", is not helpful when they literally can't stand without assistance, or urinate without catheterization.

s.22

s.22 There are too many incidents to list s.22 People are afraid to complain or report doctors because they fear that they will be treated even worse or banned from the clinic altogether. No one has confidence in any official complaints processes. s.22

s.22

s.22

s.22 I had already learned from experience to expect abuse, not care, in medical settings. At best I might get relatively benign neglect. s.22

s.22

s.22

s.22

With doctors like these I don't really care to get a family doctor. How would getting more of the same help me or my family and friends? For me, and many others, there isn't a shortage of doctors, there is a shortage of care. More doctors won't make that better.

The staff at s.22 and many other places, are in serious need of anti-bias training. Being exposed to racism causes health problems, in healthcare it is life threatening. While not every doctor at s.22 is bad, people don't get to choose, and the standard of care is generally unacceptable. No one has ever been injured by having to participate in effective anti-bias training even if unneeded. More important is that no one should be physically or psychologically injured, or suffer neglect, when seeking health care, and it definitely should not be so common as to be expected by BIPOC people. Discipline and other measures have not deterred or corrected the behavior, and are rarely applied. You can say "All lives matter", but clearly BIPOC lives are not being valued the same way. The 'In plain sight' and other similar reports have had no effect on the

behavior at this clinic or elsewhere. If they have bothered reading anything they don't believe it applies to them. It is time that remedial training be made mandatory at this clinic. Doctors might whine about not having time because they have too many patients, but they are not taking care of many of the patients they already have due to their ignorance. They would have much more time if they took people seriously the first visit rather than the 10th time for the same thing. Please make them take an anti-bias course of proven efficacy of at least 20 course-hours, followed by monthly bias testing, and more remedial training when necessary. One-and-done training is not effective and gives people the false sense that they are 'cured' of bias and know everything they need to. People have learned to be biased most of their lives; it will take just as long to unlearn it. Everyone has bias, it is what you do about it that counts.

Hoping for quality care for everyone,
s.22

Sent from Mail for Windows

From: s.22
To: OfficeofthePremier, Office PREM:EX (Premier@gov.bc.ca); Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: Doctor must be paid
Sent: 02/10/2023 07:16:22
Message Body:

HLTH MO fyi to HSWBS – ss – s.22

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https://www.vicnews.com/news/hitting-a-wall-victoria-doctor-eyes-leaving-b-c-after-ministry-fails-to-pay-her/

Shared via the Google app

Dear Minister Dix,

s.22 after s.22 years in this city, I have no doctor here. s.22 s.22 could not access an emergency care physician even though I tried the local clinics. s.22 But there was no doctor to assess or do a Cat Scan, or advise me. No doctors in s.22 No appointments at s.22 When I persevered at the s.22 I saw a nurse who got me a req for an xray...then, I spent the day finding an xray tech; most stayed home because of the snow.

Finally on s.22 I was able to speak with a doctor at the s.22 and I saw him on the following Sunday- in person! He s.22 ordered a series of tests. It was a huge relief! s.22 s.22

This is the short version of the story and the layers are just ridiculous. If it weren't so tragic, it would be laughable. I could write a story for the press and, as this drags on, I might. Thank goodness, I am strong enough to advocate for myself and could drive myself in the snow to the X-ray lab over on s.22 What does a really frail or mentally challenged person do?

So I have read this story about this doctor who is not getting paid. I read about the doctor in Port Hardy pleading for help, and now he is suspended by the apparently incompetent director in the northern part of the region. Regardless of the facts, the whole affair was very badly handled by Vancouver Island Health. It stinks!

Doctors in one Health Region (Island Health) cannot access tests or records done with VCH, resulting in the duplication of work, travel for me and a huge waste of time and money. s.22 s.22 s.22 This is a huge embarrassment for BC and Canada. The PM is right that this province needs to get these problems of data collection and sharing fixed. What a waste of the current health care budget! More money is needed, but it may be throwing good money down the drain of incompetence and red tape.

There are too many absolutely stupid roadblocks to the efficient delivery of health care. I think there are too many managers in this stuffy system who are protecting their fiefdoms. It is also apparent that the professional colleges are not helping the situation. Maybe provincial legislation can bring them into the tent.

Please advocate for this Victoria physician and urge her to stay. Make sure that she gets paid!

With respect,
s.22

From: s.22
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: 1257852 s.22 Incoming - Questions about Health care in Port Hardy
Sent: 04/25/2023 21:02:35
Message Body:

HLTH MO to HSWBS as Assign - jp

Hello,

Thank you for your attention, I am writing s.22 hopeful you can answer a couple of questions for me.

s.22

s.22 Island Health has somehow suspended Dr. Nosotros' right to practice in his clinic. s.22
s.22

I assume you are aware of the suspension of Dr. Nosotros' ER privileges by Island Health several months ago, and his subsequent efforts to open a community clinic and serve this community. In the past months Dr. Nosotros has seen dozens upon dozens of patients while he works tirelessly to build and open the new clinic. A feat he has accomplished with the overwhelming support of the community and Dr. Lee in Port McNeill.

My question is -- How and Why doe Island Health have the authority to deny Dr. Nosotros the right to clinical practice and deny this community medical care?

As far as the newspaper stories report, Dr. Nosotros was originally denied ER privileges based on two complaints from ER patients about his abrupt demeanor. It is difficult to believe that the North Island is denied medical care based on two complaints about attitude. I inquired via phone with Island Health, and the North island Gazette, and was told there is an investigation under way. The events that prompted Island Health to deny his ER privileges happened at least 3 months ago.

This is a serious and potentially deadly situation.

s.22

Thank you for your attention, I look forward to hearing from you.

s.22

From: s.22
To: OfficeofthePremier, Office PREM:EX (Premier@gov.bc.ca); Health, HLTH HLTH:EX (HLTH.Health@gov.bc.ca)
Cc: Babchuk.MLA, Michele LASS:EX (Michele.Babchuk.MLA@leg.bc.ca)
Subject: 1252236 s.22 Incoming | Sointula
Sent: 02/17/2023 15:11:21
Message Body:

HLTH MO to HSWBS as Assign – CV – s.22

[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.

Good morning Honourable Ministers,

It has come to light that Island Health intends to not renew an APP contract for this remote island community. s.22

By all accounts things have improved over the last 4 years with having an APP in creating stability of access and care provision to this community which has a number of frail and elderly community members s.22 s.22

I do not believe that the Island Health local executive or senior executive have an understanding of this community's care needs and place this vulnerable population at risk for not having an APP contract in place. s.22 instead punish this community (and others that you were made of: Zeballos truck fiasco, Port McNeill clinic set up,failed Port Hardy clinic, no Alert Bay help, no pooling of acute care resources....the list is long).

s.22

The senior IH executive telling the Minister that they are doing a good job and are competent custodians of care should not be enough. The voice of the public and people in the frontline s.22 have been asking for change for a while. The funding that you announced for the region will help but not without a change in the leadership.

s.22

I believe that the only way forward is a purge of current local and senior leadership to allow for success so that there is a more capable and receptive leadership team. Will the Minister respond in helping the people of our region?

s.22

From: s.22
To: Minister, HLTH HLTH:EX (HLTH.Minister@gov.bc.ca)
Subject: 1251340 s.22 Incoming -- Voicemail rec'd at Gov't Caucus reception
Sent: 02/13/2023 17:01:32
Message Body:

HLTH MO to HPHSD to Assign for Telephone Response - jp - s.13
s.13

Hi,

Over to you folks.

Voicemail
My name is s.22 The latest I am I'm hearing is that island health is suspending the doctor that called out the island health. Bureaucrat team.
If this isn't, if this is true, how is not in retaliation? I don't know, s.22
s.22
We're going to lose all doctors, all emergency, everything out of port Hardy, all because of some petty name calling and that going on between the bureaucrats.
The bureaucrats in this country are destroying this country. It's time that you politicians do something about it.
s.22

From: s.22
To: asktheboard@islandhealth.ca; Health, HLTH HLTH:EX (HLTH.Health@gov.bc.ca); info@bcombudsperson.ca; Babchuk.MLA, Michele LASS:EX (Michele.Babchuk.MLA@leg.bc.ca)
Subject: 1251340 s.22 2nd Incoming -- Medical Emergencies at Island Health Authority
Sent: 02/10/2023 19:38:11
Message Body:

HLTH MO fyi to HPHSD (PCR) - jp - s.22 ; upload to CLIFF and eApps; advise divisional coordinator and PCR team lead

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Dear, Board Members Island Health
Recently North Island Doctors have been speaking out about their serious concerns around patient safety. With this latest Doctor (Dr Alex Nataro) from Hardy to be suspended from practicing emergency medicine after calling for the resignation of Island Health senior health leaders!
This means there may well be **No Emergency Doctor Based in Hardy! Really????**
Apparently Island Health officials are saying that the suspension is due to a patient complaint. If this were the case, it is obvious s.22 that these doctors are being threatened, punished and silenced. In my worldly experience it looks highly suspicious and really bad on Island Health's part!
If one CEO, ten Vice Presidents, six Executive Medical Directors and eleven Directors can't do better managing health care in the North Island what are my wife's and my hopes of surviving a ***MEDICAL EMERGENCY***?
Note 1: *the above quantities are from the following Island Heath Organizational Charts "Island Health Medicine, Quality Research and Medical Affairs" and "Island Health Executive Team". Both charts updated December 2022.*
Note 2: *on the charts the only two names that appear on both are that of the "President and Chief Executive Officer" and "Vice President Medicine, Quality, Research and chief Medical Officer".*
What I believe is Island Health isn't just punishing doctors, they (you the "Board") are punishing us s.22 who may die due to lack of emergency services.
I ask that an investigation of what is happening on the North Island to be done and that such investigation be done by someone other than Island Health to ensure a proper, fair and timely report!
s.22