

**Report to the Honourable George Abbott
Minister of Health**

Re: Mrs. Frances Albo

February 28, 2006

Submitted by:

**Penny J. Ballem MD FRCP
Deputy Minister of Health**



Overview and Purpose of the Report

Under the authority of the Ministry of Health Act, the Minister of Health has asked me to deliver a report which relates to the recent death of Mrs. Fanny Albo of Rossland, British Columbia.

The purpose of the report is:

- to provide the Minister of Health with an overview of the circumstances of and decisions about the care of Mrs. Albo;
- to provide an assessment of whether what transpired was consistent with quality care; and
- to quickly bring forward recommendations to the Minister as to what needs to be done to ensure that any inconsistencies in the delivery of quality care and services to the Albo family are not a recurring issue for other patients and families.

This report is based on my interviews with staff and physicians at the Kootenay Boundary Regional Hospital starting on the afternoon of Wednesday, February 22, 2006 and finishing on Thursday morning, February 23, 2006. I also met with the husband of Mrs. Albo and her

two sons, Jerome and Jim, on the morning of February 23, 2006.

Health care is a complex business. Difficult choices and situations are faced every day in our health care system by patients, their families, providers, staff and managers as everyone strives to achieve the best outcomes. Every day, thousands of British Columbians receive compassionate and high quality care in our health system. But there are failures in the system, too. It takes courage, integrity and a strong commitment to quality improvement to undertake the difficult examination required to better understand how these failures happen.

I found all of these attributes – courage, integrity and commitment – throughout my interviews of care providers and managers involved in the case of Mrs. Albo. So too did Mrs. Albo's family members – her husband and her two sons – show great courage and grace during the interview they granted me and my colleague from Interior Health (IH). I thank them and respect their desire to help us learn from the experience of Mrs. Albo.

Summarized History of Mrs. Albo

Mrs. Frances Albo, 92 years of age, was a long time resident, with her husband of 70 years, of Rossland, B.C., a small community approximately 8 km from Trail. Over the last few years, she suffered from end-stage chronic congestive heart failure and mild confusion or dementia, possibly related to her heart disease and oxygen deprivation. In addition, she was hearing-impaired and suffered from a constellation of problems that are typical of the very frail elderly.

Mrs. Albo's two sons, one living in Osoyoos and the other in Rossland, were both very involved in overseeing and participating in the care of their elderly parents. Mr. Albo, at the age of 96, remained his wife's primary caregiver until the last few weeks of her life. However, over the few months prior to her death, his ability to care for her was diminishing significantly both because of her deteriorating health and both of their increasing frailness.

In December 2005, Mrs. Albo was admitted to the Kootenay Boundary Regional Hospital, very ill with heart failure. At that time it was determined by her family physician that she was near the end of her life and a candidate for palliative care. As is often the case, though, she rebounded to the point that, with commitments of home support from the Interior Health Kootenay Boundary home care program, she returned home to the care of her husband

and her son, who was home for a week over Christmas. However, the home support was insufficient in quality and time commitment, and at the same time, Mrs. Albo's clinical situation was worsening.

In January 2006, Mr. Albo suffered compression fractures of his vertebrae brought on by lifting. This is an extremely painful condition and he was admitted to hospital for treatment of the pain. Mrs. Albo, clearly unable to care for herself at home, was also admitted in severe heart failure with congestion of her lungs.

Over the first few days of the January admission, although Mrs. Albo improved somewhat and was able to stop intravenous therapy, she remained very ill and it was the sense of her family physician that her medical condition was fragile and she could die at any time. During the admission, she was assessed by the long-term care liaison nurse; consistent with her multiple problems, she met the criteria for complex care and was therefore eligible for a residential care bed. At that time, the family was advised that she would be eligible for the first available residential care bed. A number of meetings and family case conferences ensued during the January/February 2006 admission. Both Mrs. Albo's sons were very involved in overseeing the care of their elderly parents. The short notice of the family conferences in some cases made it very difficult for Mrs. Albo's son Jerome, living in Osoyoos, to attend. However

in a number of ways, by phone, through e-mail and letters sent to various IH staff and to her family physician, he ensured his concerns and observations about her condition were articulated. In addition, on a number of occasions he expressed his concern about the lack of any options for her ongoing care that would be acceptable to the family.

Interior Health, through a number of staff – the access manager, the social worker, the long-term care liaison, unit nursing staff and the patient advocate – laid out the options for the family as they pertained to Mrs. Albo:

- Transfer to the first available residential bed, with no guarantee that this would be in Trail;
- Home with IH home support, supplemented by private care paid by the family to achieve better 24-hour coverage;
- A private placement in a residential care facility closer to home paid by the family (it is not clear where that facility would be);
or
- Discharge to a temporary respite bed for 10 days with the above options for consideration.

During the 2006 admission to hospital, there was no mention of the option of palliative care. The family articulated on numerous occasions, in person and in writing, that transfer of Mrs. Albo a significant distance away was not in

their view a viable option given the fragility of her medical condition and the impact of a separation from her husband. Secondly, the financial resources of the family were not sufficient to support private care over the longer term either in home or in a facility.

The family doctor expressed to me her concern and disagreement with the concept of transferring Mrs. Albo to a residential care facility due to the instability of her medical condition and due to the hardship of being separated from her husband. However she advised that she did not document her concerns in the chart and did not write an order clarifying that she was not prepared to discharge her to residential care outside of the local region.

Nursing staff advised me that they were unaware of the family doctor's concerns in regard to Mrs. Albo's transfer. A decision was made to transfer Mrs. Albo to the first available bed, which in this case was outside the Trail local region. A number of staff were involved in discussions related to this decision: the social worker, nurse manager of the medical/rehab unit, liaison nurse from long-term care, the patient access co-ordinator and the patient advocate.

Discharge of any patient from a hospital in B.C. requires an order from the most responsible physician caring for the patient. In the case of Mrs. Albo this was her family doctor. When the most responsible physician is not available, a substitute physician be designated to assume care of the patient. When a bed became available in Grand Forks on February 17, 2006, the family doctor had signed over her patients to a locum physician colleague. He was aware that there was a long-term care patient awaiting transfer, and had been informed she was to have a chest X-ray prior to discharge. When contacted by phone, he asked if she was stable and whether a chest X-ray had been done; reassured that it had and was unchanged, and that she was stable, he gave a verbal order for the transfer.

On February 17, 2006, Mrs. Albo was transferred by the BC Ambulance Service to a residential care facility in Grand Forks, an hour and 40 minutes from Trail. As is often the case, this was done on short notice when the ambulance became available. The family told me of the devastating emotion of her departure. Both her husband and her son Jim were present and very distraught that this was happening. There was little time for them to talk to her or say goodbye. Her son Jerome was in Osoyoos at the time of her transfer, and visited her on Saturday in Grand Forks. His description of that visit relates the fact that she had deteriorated and was basically unresponsive to him. She died the next day. On being informed of Mrs. Albo's transfer to Grand Forks, her family physician contacted the attending physician in the Grand Forks facility to advise her of her concerns over the medical fragility of Mrs. Albo.

Other Relevant Information

This section of my report provides insight into a number of relevant issues beyond the actual care of Mrs. Albo.

- **The people of the Trail local health area:** The Trail local health area has a population of just over 20,000 people. Over the next five years, the population of youth and the middle-aged is projected to decline while the number of seniors, particularly those over the age of 85, is projected to increase significantly. There are currently approximately 1,200 residents over the age of 80.

Trail has a high incidence of mortality from circulatory disease (more than twice the provincial rate), combined with a higher hospitalization rate for these conditions than the provincial or Interior Health average.

Many people I talked to spoke to me about the unique cultural aspects of the community. Trail is a company town and there has been much pride in the partnerships over the years between the main employer, the local hospital and other health care facilities. Many people also spoke of the large Italian-Canadian community, proud of their heritage and characteristically a community that works hard to keep their elders at home and cared for by family members. A pattern, which to some extent was evident in the situation of Mrs. Albo, was that the family would often provide support

over a long period without any external resources from the health system until a given moment when the need for system involvement became suddenly acute.

Many staff I talked to spoke of their pride in the designation of the hospital in Trail as a regional centre. There was acknowledgement of the renovations which had been done throughout the hospital, the success in recruiting of new specialist physicians, planning for a new laboratory and other new equipment and programs – the new mobile MRI being one.

However, in spite of their pride in these improvements, there was also a sense expressed both by some staff and the Albo family that there was a disconnect with IH. There was a sense articulated that the vision for the role of Kootenay Boundary Regional Hospital and other health programs in the area was not inclusive of community input and didn't necessarily respond to some of the uniqueness of the communities being served. In other words, the local IH staff and community felt a lack of joint ownership with the health authority for the enterprise and they perceived a lack of understanding, concern and support by IH in regard to problems and challenges faced by the local health providers and institutions.

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- **Organizational structure:** The organizational chart of Kootenay Boundary Health Service Delivery Area (HSDA) from the website of Interior Health is appended to the report. The complexity of some of the reporting relationships is obvious. When I tried to clarify organizational accountability in the hospital with staff, I was unable to determine who had the authority to clarify the application of key policies such as the residential care access policy. During my interviews, I found that particularly in the area of quality of care, there appeared to be a confusing array of accountable people, including the community administrator (who is responsible for the hospital), the chief of the medical staff, members of the medical advisory committee (MAC) and staff onsite who were part of the corporate portfolio for performance management. All of these individuals had different reporting relationships in the organization and what appeared to be overlapping responsibilities. In addition, there was concern expressed about the lack of good data to support quality improvement processes.
 - **Medical Leadership:** Normally the senior medical leadership in health organizations such as a health authority are involved in the review of quality of care issues and patient safety issues. In the case of Interior Health, the two physicians

with such a role would be the medical director for Kootenay Boundary HSDA and or the medical director for IH. There was no evidence of involvement of either of these two individuals during my review of this case. The chief of staff for Kootenay Boundary Regional Hospital, a family physician supported one day per week in this role, was present at my visit and clearly understood her role and responsibility in reviewing the events that led to the situation.

- **Primary Care/Family Physicians:** During my visit to Trail, I met with three family physicians in relation to Mrs. Albo's case. I gained the impression that the family practice community felt a lack of involvement in the health authority "team." The three family physicians involved in my discussion about Mrs. Albo (including the chief of staff) also expressed their frustration about having insufficient access to flexible and appropriate home care resources for supporting their patients. They also talked about what they perceived as a complex array of rules and barriers to accessing resources, the unpredictability of commitments made for home care and home support, and the resulting difficulties associated with supporting patients and families.
- **Nursing Leadership:** Nursing leaders described for me the challenges in the Trail area of balancing access across community-based programs, hospital care and assisted living/residential care.

The managers reviewed with me the work being done on managing access to acute care beds. They described the interdisciplinary case conferences designed to do discharge planning for hospital patients. Physicians are not always able to be involved in these meetings, in part due to scheduling which is not always practical for physicians providing care in their offices.

An important message throughout my discussions with nursing leaders was their feeling that although there had been improvement, there is still more work to be done to enhance the use and development of community resources for patients of the Trail area. An issue they raised was the concern about a lack of readily available and understandable utilization data which would enable them to make better decisions in regard to the best distribution of resources in the community. They noted challenges in the relationship with the primary care community, particularly as it pertained to problem-solving around specific patients. Finally, they expressed concern about rigidity in the application of policy and in the allocation of financial resources with little ability to influence decisions made at the HSDA or corporate level in Interior Health.

As noted above, there was a lack of clarity regarding the accountability of the senior Medical Director of IH and the HSDA Medical Director for quality of care and the review of cases such as Mrs. Albo.

- **Home and Community Care:** Interior Health has undertaken a number of initiatives to improve facilities in the residential care sector in the Trail area. Overall, these changes have significantly enhanced the quality of complex care facilities and provided new options in the form of assisted living, where couples can live together. These initiatives have reduced the overall number of care beds over the last five years to a level more consistent with other health authorities around the province.

Two facilities have been closed – Mater Misericordia in Rossland and Kiro Manor in Trail. Both of these facilities were built many years ago, one in the late 1800s (Mater Misericordia). According to the provincial residential care inventory undertaken in 2001, both these facilities were deemed inadequate to meet the complex needs of patients now requiring residential care: wheelchair inaccessibility, small multi-bed rooms unsuitable for complex care, infrastructure inadequate to allow introduction of lifts and elevators. This resulted in a low rating for the ability to upgrade the facilities for complex care. Columbia View Lodge on the other hand had a number of the same problems but was rated medium in terms of the ability to enhance the physical infrastructure to provide complex care. It has subsequently

undergone a renovation to upgrade rooms to enable complex care. In addition to these changes, the brand new Rose Wood Village complex provides a combination of new residential care beds and assisted living units. Complementing these changes, 30 new supportive housing units have been built by BC Housing and a number of residents in this complex are served through the home care/home support program in Trail.

In Columbia View Lodge, there are seven beds which encompass one palliative care bed and six short stay/transitional/respice beds. These resources are available to assist clients who suddenly can no longer manage at home, for respice or for those who are ready to leave acute care but require more time to stabilize before returning home or to residential or assisted living care.

Placing a hospital patient requiring residential care in the first available bed has been a longstanding practice in this province. Not surprisingly, the ability to align a patient's choice of facility with available beds at the time of need is a challenge. Particularly for patients in acute care hospitals awaiting placement, it is often necessary that they be moved, first to an appropriate facility, and then to the facility of their choice as quickly as possible. Another option is

to discharge the patient and provide support at home with enhanced home care and family resources while waiting for the preferred facility. The challenge of matching patient need and preferences with available capacity is particularly difficult amongst the many small communities in Interior Health where providing access to the diverse continuum of options such as supportive housing, assisted living and residential care can be particularly difficult.

The first available bed policy is applied differently within each IH health service delivery area (HSDA). For example, in Kootenay Boundary, the first available bed could be anywhere in the HSDA; in the East Kootenay it could be anywhere within a two-hour drive from the person's home. This is not unique and over the years in rural areas of the province, seniors and family members have been travelling significant distances to visit their loved ones who require facility care.

The introduction of assisted living and increased access to purpose-built supportive housing with home care over the last few years is now allowing many dependent seniors to receive care and continue to live as couples as independently as possible. However, notwithstanding these innovations, and given the increase in seniors over the coming years, families and providers will continue to face difficult choices as the care needs of frail elderly couples change, often at different rates.

However, in discussions with staff and the family of Mrs. Albo, what was apparent was a perceived sense on their part of a lack of flexibility in the application of the first available bed policy. There appeared to be a sense that no one (at least among the people I interviewed) felt he or she had the authority to interpret the policy on a case-by-case basis taking into account the patient's personal needs.

In the Trail local health area, a number of innovations and partnerships with the local community have developed. The traditional meals on wheels program has been complemented by a frozen dinners program, which allows wider access for clients throughout the area. This program is now being used for both frail seniors and patients being discharged from hospital. The friendly visitors program provides volunteers who visit clients on home support to provide a social network. It has also been expanded to in-hospital patients.

In the area of home support and home care, there have been a number of significant changes. Much work appears to have been done to develop better programs to support patients leaving hospital – particularly in the area of mental health, addictions and volunteer programs for frail elderly. The managers I talked to spoke of the Health Connections Program, which provides subsidized transportation between Trail, Castlegar and Nelson, significantly improving access for patients and families.

Home support provides “personal care” for clients unable to fully complete the activities of daily living – such as bathing, taking medications and eating nutritious food. Home care provides professional nursing care or rehabilitation, often for patients who have just been discharged from hospital, have suffered a relapse of a medical condition, or have an ongoing chronic health condition requiring these services. Across the province the ability to support clients at home – even clients with significant disability – has increased as the public has signalled its desire to maintain independence as long as possible. Age adjusted rates for home support services in Trail continue to lag behind the provincial rate although they have increased significantly since 2002/03.

Availability of home support workers has become a constraining factor across the province in the delivery of home-based care programs. This is an issue being addressed in a number of venues, and if not effectively addressed will constrain our ability to deliver much needed home-based services.

I conclude that the system did not deliver quality care to Mrs. Albo. There were inconsistencies in the care she received which need attention so that her experience and that of her family is not repeated.

We must take the situation surrounding Mrs. Albo's care and use what we learn as a basis for lessons that can be applied widely.

Summary of Issues

My suggestions are outlined below. The full support of the Ministry is available to Interior Health to enable moving ahead quickly to address these issues. I have no doubt that everyone involved would willingly become immediately engaged in putting these initiatives in place.

In regard to the specific case of Mrs. Albo:

My review of the situation strongly suggests that Mrs. Albo was very close to the end of her life at the time of her transfer to Grand Forks. It is difficult to know exactly what impact the transfer played in her death. In the following ways, quality care was not delivered:

- Mrs. Albo's discharge from hospital to a residential care facility in Grand Forks did not constitute quality care for the following reasons:
 - Her heart condition was end-stage and she was medically fragile;
 - She was a more appropriate candidate for palliative care rather than residential care; and
 - Transferring her to a facility so distant from her home was imprudent given her advanced age, the fact that her frail and very elderly husband had been her long-term primary care-giver, and there had been no time to prepare either of them for their separation.
- The lack of attempts by providers and senior staff involved in her case to take responsibility for a "pause and think" decision, which might have resulted in different and more creative options, did not constitute quality care.
- The lack of integration of key information from concerned family members into the options offered to her and her family did not constitute quality care.

Other Key findings:

- There is a need for better alignment of home and community care and primary care resources with the health needs of the community, as evidenced by demographic data and burden of illness data available through health status information and health system utilization data.
- There appears to be a trend toward declining engagement of family physicians in the overall health system in the Trail local health area, and particularly in regard to issues related to quality of care and system utilization.
- There is insufficient support and involvement of senior medical leaders from the Kootenay Boundary Health Service Delivery Area and corporate Interior Health in the area of quality of care and critical incident investigation.
- There is a need for improved coherence and clarity of accountability for quality of care, and this needs to involve senior medical leadership as well as the director of performance management.
- There is a need for improved engagement of the local community by the health authority to allow better understanding of community needs, the development of a better relationship and the development of viable shared solutions to address these needs.

Recommendations

My recommendation to the Minister is that he direct the Interior Health Authority to:

1. Undertake an expedited process involving senior medical leaders across the health authority to ensure all medical staff, including locums, are aware of their responsibilities in regard to ensuring safe and appropriate discharge of patients from hospital.
2. Conduct a comprehensive review of the application of the first available bed policy to better clarify criteria for decision-making in regard to:
 - a. the feasibility of a family's ability to remain connected in the case of patients being placed outside their home community;
 - b. any special considerations which should be taken into account in regard to ongoing medical care;
 - c. identification of the key decision-makers and an appeal process for families who disagree with the decision.
3. Develop:
 - a. a more robust palliative care program, with a particular emphasis on patients dying of circulatory diseases due to the high incidence of this chronic condition in the area;
 - b. more robust transitional resources for patients who are able to leave hospital or are suddenly unable to cope at home but whose final destination is still unclear.
4. Implement, in conjunction with the Ministry of Health, a trial program in the Trail local health area modeled on the concept of primary care "practice commissioning" from the UK. This would be led by leaders in the

family physician community and involve key nurse managers from the hospital and the home and community care programs and key municipal staff.

"Practice commissioning" allows a health care provider group to purchase patient-centred services to better serve and support frail patients in the community. Emphasis in this instance, should be on chronic disease management, particularly patients with chronic heart disease. The goal of the initiative is to enhance outcomes for patients through: engagement and accountability of family physicians; development of innovative patient-centred approaches for the care of the frail elderly which are responsive to the unique characteristics of this community; a breaking down of barriers across acute care, home and community care and the community at large.

5. Undertake an immediate review of its quality of care structure with a view to improving coherence across the various components and strengthening the relationship to senior medical leadership.
6. Proceed with initiatives to effectively engage the communities in Kootenay Boundary in their health system.

I recommend the Interior Health Authority return to the Ministry by March 31, 2006 with an update on implementation of this direction.

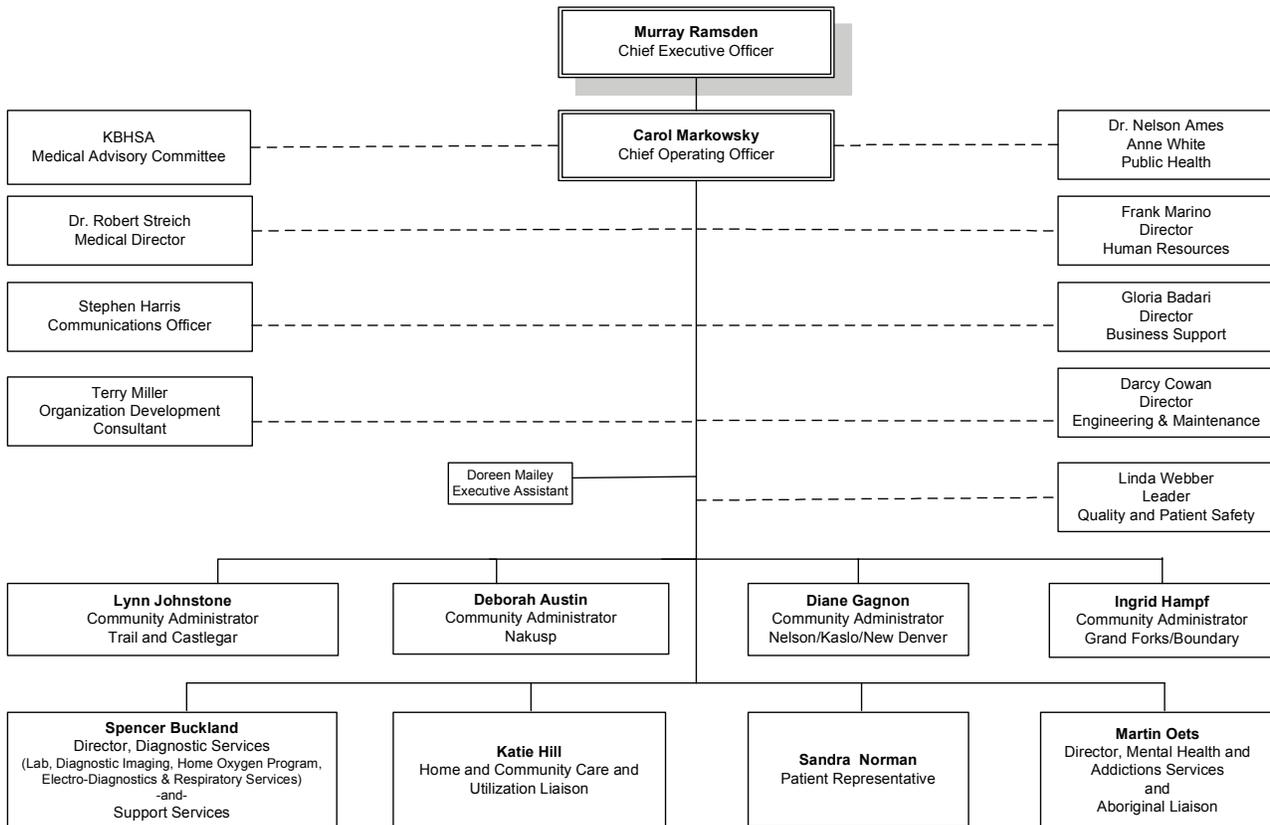


Penny J. Ballem, MD, FRCP
Deputy Minister of Health

Appendix



Kootenay Boundary Senior Leadership Team



Last Revised: August 11, 2005

