

WAHA Clinical Review

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Preamble

Pursuant to the *Public Hospitals Act*, I was appointed as Lead Inspector to conduct a review of the clinical operations of WAHA. A team made up of 8 clinicians (physician, nurses, etc.) was assembled by the North-East LHIN and Health Sciences North to support this mandate and review specific clinical areas. The team reviewed the systems in place to ensure: **patient safety**, (infection control; incident reporting; equipment maintenance; hand hygiene; medication control, falls, medication reconciliation; chemical hazards; etc.) and **quality of care** (diagnostic tools; access to care; treatment; discharge and follow up; staff competence; etc.).

We conducted an onsite survey from October 31st to November 2nd and reviewed abundant documentation provided by WAHA officials, from whom we received full cooperation. This was a technical review that did not investigate specific complaints or examine particular cases, but rather verified if appropriate systems are in place to monitor and provide quality of care and maximise patient safety. In that context, with a few exceptions, we did not carry chart audits nor did we interview individual patients or community members. We also did not review governance and community relations.

Main Findings

The nine members of the team were unanimous in their assessment that physicians and staff are very dedicated, hard working, competent and generally do what they do well. We also found that the hospital has the right systems in place to monitor quality of care, provide quality care and ensure patient safety. We did not find any area of serious concern with the care provided.

There are nevertheless serious issues, not with what the hospital does, but rather what the hospital does not and cannot do because of its specific circumstances, including:

- obsolete IT infrastructure
- obsolete telephone system
- lack of and aging equipment
- run down facilities
- transportation problems between sites and out of the area
- recruitment and retention of staff and physicians
- focus on acute care, rather than prevention and primary care
- lack of equipment and facilities to support visiting specialists

Section 1: Quality Monitoring

WAHA staff has designed and implemented patient safety and quality monitoring programs that are similar to those in other Ontarian hospitals of the same size. Implementation is sometimes made difficult by communication problems between the sites, as well as deficient IT infrastructure. Communication with staff from the coastal sites tends to be by phone or OTN due to budget constraints.

Overall, in our opinion, WAHA is compliant with relevant legislation, including the *Public Hospital Act* and the *Excellent Care for All Act*.

- a) *Infection control*. The new Infection control (IC) coordinator is certified in infection control and has six years of relevant experience in this field. The IC program includes:
 - A hand hygiene program;
 - Regular revision of relevant policies;
 - Monitoring of C-difficile and MRSA infections;
 - Flu vaccination;
 - Regular environmental audits; and
 - An Infection prevention and control committee.
- b) *Incident reporting*. All incidents are reported to departmental managers and forwarded to the quality department on a standardized form. Daily data is integrated into a monthly report to the Board. An internal committee reviews incidents and analyses trends. No critical incidents have been identified over the last few years. A major weakness of the program is that reporting is on paper, due to the lack of an online system for reporting and data tracking.
- c) *Pharmacy*: WAHA has no staff pharmacist but has a contract (recently renewed) with a remote pharmacist who reviews all orders for in-patients and makes recommendations to physicians as required. However, WAHA coastal sites do not have access to pharmacist services within their community. As a result, WAHA is required to dispense medication on behalf of Northern Pharmacy in Fort Albany and Attawapiskat. This is problematic because the nurses who dispense the medication on site cannot always answer specific patient questions about their medication nor can they always provide advice.
- d) *Privacy*: In an area where most people know one another, privacy is always a concern and there have been a few breaches over the years. The privacy officer has good systems in place and follows up on any incident.
- e) *Patient records*. Because of the weakness of the IT infrastructure, charts of patients referred out from the remote communities have to be printed, which is labour intensive and costly, in addition to increasing the risks of errors and privacy breaches.
- f) *Physical environment*. Transportation of staff and patients between Moosonee and Moose Factory, as well as between Moosonee/Moose Factory and coastal locations, creates safety hazards, particularly during shoulder seasons and difficult climate conditions. In addition, the Moose Factory hospital does not accommodate those with disabilities or impairments. These problems cannot be resolved until a new hospital is built in Moosonee.

- g) *Client satisfaction and complaints.* WAHA conducts regular patient satisfaction surveys, the results of which are posted on the WAHA website and reported to Health Quality Ontario. Staff also monitor social media. There is also a process for filing and resolving complaints, which is available on the WAHA web site.
- h) *Physician services:* The credentialing process by the Medical Advisory Committee is satisfactory and similar to what is done in other hospitals. We heard two main complaints: 1- patients must often leave the region to see specialists, such as optometrist or dentist. 2- there is a constant turnover of physicians, which is problematic for continuity of care and patient-physician trust.
- i) *Transportation:* Transportation, especially ORNGE services, continues to be problematic and presents risks to patients, as well as high cost to WAHA. Some problems (e.g. non urgent transfers) will be resolved when the hospital site is transferred to the main land. In the meantime, WAHA must continue to work with ORNGE and the Ministry of Health and Long Term Care to improve the accessibility of ORNGE services
- j) *Recruitment and retention:* Recruitment and retention of staff and physicians constitutes a serious issue that has a significant impact on continuity of and access to care. There is no easy, short-term solution.
- k) *Staffing:* The current staffing in infection control and quality management is appropriate for a hospital like Moose factory. However, service provided to the coastal sites is limited and education of new staff is very demanding.

Section 2: Medical Services

WAHA Primary Care is largely staffed to deal with Acute Care in the Moose Factory hospital, with remote support to the satellite nursing stations or clinics. At this time, after these “core service” commitments are met, an average of only 2 physicians remain to provide Community Primary Care, resulting in low access to screening, prevention, wellness and chronic disease management in the communities.

It is an exceptionally challenging environment to practice Primary Care (PC), compared to the rest of the province. There are patient issues of cultural trust and familiarity, system issues of inadequate staffing resources for community PC. The hospital facility is far outdated, and much of the equipment is non-current. There is limited access to testing and treatment, with huge logistical challenges in referrals, as well as physician housing challenges, travel burdens and a lack of opportunities for family members.

Despite all this, the physicians have persevered and do an excellent job, and are to be commended for the work they do in such circumstances.

Section 3: Context of Care Delivery

The conclusion of the clinical review team is that the management team at WAHA is capable and dedicated. They are working hard to improve the delivery of care and the health of the people living in the James Bay coastal communities. However, their work is challenged by a political context characterized by unclear jurisdictional accountabilities, a historic inability to establish relationships of trust and a disconnected system of care delivery driven by individual and organizational mandates that are not focused or well aligned. The consequence is that patients are left with an antiquated

system of health care delivery, in which highly skilled professionals do their best to deliver high quality clinical care. There are not the resources, infrastructure or the required systems to make the improvements necessary for those working within the system and those relying on the system for their care.

WAHA does not have a formal Patient Advisory Committee or community engagement structure. Engaging patients and the community will help develop a sense of ownership and allow for system redesign that is more patient focused.

Section 4: Inpatient Care and Nursing

Given the lack of homogeneity of the patient population and the unpredictability of unit activity, there is the need to have 2 registered nurses at all times. If there is a labouring woman and a birth, this will consume the time of one full-time nurse for a significant period, leaving one nurse to manage the balance of patients on the unit. In the event of high acuity demands, there is the option of calling an additional nurse. The conclusion of the review team was that the unit was appropriately staffed for the work that was required.

The nurses and other inter-professional staff interviewed were engaging, energetic and rightly proud of the work they did every day. The team is dedicated and adaptable. They are very proud that all of their patients, including Long Term patients, are bathed daily and receive excellent skin care.

Section 5: Recruitment and Retention

Recruitment and retention of nursing and other professional staff is challenging, particularly in the community of Attawapiskat. One of the most significant barriers to staff recruitment and retention is housing.

WAHA is challenged with high staff turnover and vacancies, which make achieving a stable and consistent schedule a challenge. In addition, sick time is much higher than the provincial average, which creates a serious challenge for management.

Section 6: Transportation

Access to appropriate transportation for unscheduled care remains the most significant issue impeding access to acute care. Coordinating transportation with ORNGE consumes inordinate amounts of organizational energy at all levels of the organization. There is a strong view among the staff that there is an absence of proactive communication on the part of ORNGE.

Section 7: Diabetes

WAHA has an engaged Diabetic Education Team. The service can be characterized as excellent. The team has an improvement mindset, each year setting a target for improvement. Delivering care across broad geographic distances places limitations on access to their service.

There is no formal screening program for diabetes. Most patients are identified when they become symptomatic. Reducing prevalence requires screening, a strong connection to primary care and community engagement and ownership. This would require more resources than a single small program.

Section 8: Surgical Services

Surgical care is provided by locum dental and general surgeons. The surgeon typically spends a two-week period in the community and is essentially on continuous call for the entire period. There are no major surgical interventions performed except in an emergency and when transfer is not possible. Surgical volumes are low and comprised mostly of dental surgery and endoscopies (gastrostomies and colonoscopies), with an assortment of lower volume relatively low risk surgical procedures. All other scheduled surgical care is generally referred to Timmins, Kingston and Sudbury. Regular ophthalmology care would be helpful to avoid patients having to travel for cataract surgery. This would require the addition of new equipment. With updated instruments and equipment, the range of surgical services provided at WAHA could be expanded.

The existing physical facilities are outdated. The operating room, while generous in size, does not meet basic standards for operating room ventilation or humidity control. This is not an easily remedied problem. Much of the equipment observed was outdated and required updating. Replacing aging equipment and instruments should be seen as a priority.

Section 9: Mental Health

There are currently 12 FTE funded clinical positions, an interim program manager and 1 FTE clerical. Additionally, all communities are supported by a visiting psychiatrist. Some staff are recent grads with little or no mental health experience. More senior staff have life experience and some speak Cree. However, they have little or no formal education or training in the provision of mental health services, sometimes leaving them unprepared to provide effective clinical treatment.

Coastal staff offer a variety of services in the community to all age groups with no consistency from one community to another. The mandate of the program often does not match up with the expectations of chief and band, and this can cause conflict, confusion and frustration on both parts as well as a sense they are being ineffective despite best efforts.

Much of staff time is spent managing crisis in all community locations. The current model of service delivery makes it difficult for regional clinicians to see clients consistently and to provide effective treatment. Phone calls are the preferred method of follow-up for staff when they are not on site. However, due to connectivity challenges and unreliable equipment, there are times when staff has no access for follow-up. Many clients present only when in crisis and do not attend scheduled treatment appointments.

Currently, there is no formal integration of care providers in all locations. There can be many services involved in care but little planning or integration to offer a seamless system of care that does not overlap or duplicate. Staff did state that politics often influence care decisions rather than what is best for the client. This can result in fatigue on the part of clients and families who have to tell their stories multiple times to multiple providers. This often results in no agreement on treatment planning.

Reports of domestic violence, neglect and sexual abuse are not consistently brought to the attention of child welfare authorities by clinicians. There is fear of the consequences of fulfilling this obligation. This reinforces a culture of silence in many communities. This is especially concerning for regulated health professionals whose colleges clearly outline responsibility of reporting suspected neglect or abuse, and for clients who continue to live in these conditions with little hope of change.

Staff worry about their security and have concerns about working in isolation. Limited safety protocols/checks are in place to address safety concerns. Nishnawbe-Aski Police Service (NAPS) are not always available. Physical layout of offices/location is not ideal. Panic alarms do not secure a formal response when they are set-off. There is no security on site. No workplace inspection or formal safety procedures are used consistently and effectively.

Section 10: Elder Care

WAHA does not have a specific geriatric care program for its elderly population but rather relies on the resources from its discharge team, community supports, diabetes care services and rehab team.

Older Adults are most likely to present to emergency department because of complexities related to their chronic disease or failure to cope. Approximately 60% of emergency visits are by seniors. In the community, there are limited resources for 24/7 care; so most of the care required by older adults falls back on family members and caregivers. Caregiver fatigue is common and results in patients presenting to the emergency department for respite care.

There is no Long Term Care facility in the coastal communities, resulting in a continued and growing reliance on the hospital sites for older adult long term care.

The high rate of turnover among primary care providers results in a lack of care continuity for older adults, leading to frequent changes in care and treatment plans.

Travel to appointments for specialist care is a hardship, especially for those with mobility issues. If the older adult patients cannot walk, they cannot get on planes and need to use medi vac for appointments or care. The elderly population is frequently supporting young children or other family members, which makes it even more difficult to attend appointments or access health care services.

Section 11: Maternal Care

There are several challenges in providing maternal and newborn care along the coastal communities. The challenges related to location, weather and transportation are amplified for pregnant and labouring mothers living in the coastal communities. This challenge is present even in Moosonee, where there have been 7 deliveries at the Moosonee clinic this year due to challenges with transportation to Moose Factory Hospital site.

Due to potential travel challenges, mothers from the coastal communities are admitted to Moose Factory site 2-3 weeks prior to delivery. Only one support person is allowed to accompany the expectant mother. These rooms are not family friendly, consisting mainly of a bed in a room in the administrative hallway of the building. Families have nothing to do during this 2-3 week confinement.

In terms of service delivery, all labouring mothers receive 1:1 nursing services. The monitoring equipment is very outdated. Post-delivery, all families are offered skin to skin contact. Rooming is available and offered to all families.

A gynecologist will occasionally visit the community through the visiting specialist program. There is no longer any paediatric visiting specialist - all paediatric patients (inpatient and outpatient visits) must be transferred to Timmins, Kingston or Sudbury. The decrease in the number of specialist visits is mainly related to a lack of equipment.

Section 12: Nephrology

The eligibility criterion for hemodialysis limits patients from the area receiving treatment in their home community. There is no housing or transportation support available for patients that would enable them to receive care in Moose Factory. Access to appropriate transportation and housing is a major barrier to care. Patients are excluded from care at WAHA if they have any physical disability that does not permit patients to transfer on their own to a chair.

The current wait list is 6 months to 1 year to get into the unit for those who qualify. The patient must otherwise receive care from outside of their community until a spot is available. This usually means the patient must relocate.

The patients serviced by the renal satellite are well cared for and receive excellent hemodialysis care. The satellite staff and management are focused on the provision of quality renal care to their patients, resulting in absolutely no concerns related to the care provided.

Section 13: Emergency Services

The ED at the Moose Factory site is small, poorly designed and functionally disconnected, with narrow hallways. Accessibility into triage, acute/sub-acute areas is challenging, and navigating with a stretcher or wheelchair is difficult. A particular health and safety challenge is the ramp, which is the only means of transferring stretchers and wheelchairs in and out of the building. Triage rooms are not set up to allow nurses to easily leave if a patient demonstrates violent behaviour. The physical environment presents several safety risks to staff and physicians. The monitoring equipment and defibrillator are older models except for programmable IV Smart Pumps that are relatively new.

The Moosonee Health Centre environment is small but well organized.

The review team had no concerns with the quality of care being delivered

Section 14: Information Technology

The telephone system is extremely outdated.

There are no maintenance contracts. Hardware failure is a common occurrence and is repaired by IT staff. Parts to address failures take days to weeks to arrive. Critical services are running on servers with age related issues.

In November 2013, WAHA implemented the Meditech Hospital Information System. However, WAHA has no local Meditech expertise beyond the knowledge of how to use the system. This has led to the absence of local champions who have a fulsome understanding of the Meditech functionality and the available opportunities to leverage the system to support and enhance local processes and clinical care.

Lack of local Meditech expertise and system champions, coupled with strong local physician support for PS Suite (the medical system that existed prior to the implementation of Meditech) has led to uncontrolled growth in use of PS Suite beyond what it is designed for as a primary care system. As a result, there is a marked under-utilization of Meditech for documentation of hospital based acute and ambulatory services and care. The result is a disjointed patient record, making it difficult to compile information which accurately reflects care and services provided.