



PUBLIC INTEREST COMMISSIONER

Public Report

A report of the Public Interest Commissioner
regarding a finding of wrongdoing involving
Alberta Health Services- Correctional Health

Case: PIC-20-00108

October 25, 2023





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Foreword

An effective public service depends on the commitment of everyone who works in it to maintain the highest possible standards of honesty, integrity, and accountability. The *Public Interest Disclosure (Whistleblower Protection) Act* (the Act) applies to government departments, offices of the Legislature and public entities including provincial corporations, post-secondary institutions, school boards, charter schools, accredited private schools, and public health sector organizations. The Act creates a confidential avenue for employees to report serious and significant matters that they believe may be unlawful, dangerous, or injurious to the public interest, and provides legislative protections for doing so. Investigations by my office are extensive, thorough, and objective, with the purpose of identifying potential wrongdoing and recommending corrective measures to the effected entity. Doing so promotes public confidence in the administration of our public service. My larger aim is to promote a culture in the public sector where employees and managers share a common goal of reporting, investigating, and remedying wrongdoings.

In circumstances where I believe there is a public interest in disclosing the outcome of an investigation, I may make a public report. I do so not only to report on the wrongdoing found, but to inform the public of the corrective actions that have been taken by the effected public entity. I believe, in this case, it is necessary to publicly report the findings of the investigation and the corrective measures that were taken by Alberta Health Services.



Overview of Alberta Health Services - Correctional Health

In Alberta, healthcare services within provincial correctional centres are provided by Alberta Health Services (AHS), through their Correctional Health Services division (Correctional Health). Although correctional centres are operated by the Ministry of Public Safety and Emergency Services, Ministry employees are not involved in the provision of healthcare services. Medical staff within correctional centres are employees of AHS, and the policies and protocols relating to the provision of healthcare within correctional centres is the responsibility of AHS.

The public interest disclosure

A whistleblower came to my office concerned for the health and safety of persons incarcerated at a correctional centre. They reported that medical staff were failing to provide emergency medical care to patients who were in distress or in emergent situations, and patients with abnormal vital signs were not being properly monitored. Initially, the whistleblower identified five patients who had severe medical outcomes. Subsequently, the whistleblower contacted my office again to identify two additional patients. Of the seven patients identified by the whistleblower, four required hospitalization and two of the patients died.¹

After preliminary inquiries, my office commenced an investigation to determine whether medical staff at the correctional centre created a substantial and specific danger to the life, health, or safety of individuals – a wrongdoing as described in the Act.

For this report, the term “medical staff” refers to health care professionals, other than physicians, who are appointed by AHS to attend or treat individuals who are incarcerated at the correctional centre.

Findings of the investigation

The investigation examined the medical records and treatment history of the seven individuals identified by the whistleblower as allegedly having severe medical outcomes as the result of inadequate care provided by medical staff. An expert nursing consultant was also retained to review medical records of the five patients initially identified and provide an opinion on whether medical staff

¹ This investigation did not examine the cause of death - only the standard of care provided to patients within the correctional centre. In Alberta when a death occurs suddenly or it cannot be explained, the Office of the Chief Medical Examiner (OCME) investigates under the *Fatality Inquiries Act*.



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met the standard of care expected for nurses practicing in a correctional environment when providing treatment to those specific patients.

In a correctional facility, there is a shared responsibility between the most responsible prescribing provider (MRP) and nurses to assess patients. A MRP is the healthcare professional who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time. Standard practice is for nurses to apply their knowledge and skill to provide safe, competent, and ethical care. Since the MRP only sees patients periodically, a nurse's professional duty is to monitor patients for changes and report those changes to the MRP. This monitoring includes taking a history, taking vital signs from time to time, conducting physical examination as required, and keeping an accurate and complete record of the patient's treatment and history.

Based on the expert report of the nursing consultant, I found that for five of the individuals identified by the whistleblower, medical staff did not provide treatment that met the requisite standard of care. The expert nursing consultant identified several ways in which medical staff at the correctional centre did not meet the standard of care:

- Medical staff did not reassess, or conducted insufficient or infrequent reassessments of emerging symptoms for four patients relating to pain, shortness of breath, abnormal vital signs, or high temperature.
- In two of the cases examined, medical staff did not respond, advocate, or adequately manage pain concerns.
- Medical staff did not report the vital signs of three patients whose blood pressure was abnormal or unstable.
- In four cases, there were also gaps in documentation through untimed nursing entries or assessments, incomplete sets of vital signs, and failures to document physical assessments of patients.
- In one specific incident, it took two days for medical staff to begin treatment after noting a patient's toe was black and swollen with fluid.



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As the nursing consultant did not review the records of the two additional individuals identified by the whistleblower, I made no findings with respect to whether the standard of care was met in those cases. However, in response to a report outlining the preliminary investigative findings of my office, Corrections Health expressed concern that the standard of care was not met at the correctional centre with respect to all the seven individuals identified by the whistleblower.

Based on the nursing consultant's opinion, I also found medical staff did not properly implement protocols for two patients undergoing withdrawal, providing treatment that fell below the standard of care. In the case of one patient, medical staff did not use a withdrawal protocol at all and did not assess the patient's withdrawal symptoms given their drug use history. In another case, while a patient was placed on an opiate withdrawal protocol, there was no indication that medical staff used the protocol and there were gaps in documenting the administration of medication prescribed to treat withdrawal symptoms.

These significant lapses in the standard of care demonstrated a substantial and specific danger to the life, health, and safety of patients who received treatment at the correctional centre. This was serious and significant wrongdoing.

My office's investigation also discovered that in two circumstances, medical staff made healthcare decisions based on protocols that did not exist or practices that were inconsistent with the standards expected by AHS. Specifically:

- In two cases, patient charts indicated that medical staff followed the parameters of a "pain protocol" without providing any additional detail. However, Corrections Health indicated that no such protocol existed at the time when the patients in question received treatment.
- Medical staff denied a patient medical care after the patient reported vomiting because neither staff nor correctional officers had witnessed the vomiting. While this practice was standard in the centre, Corrections Health could not provide a rationale for this practice, indicating it did not conform with standards expected in other correctional centres.

Finally, the investigation focused on the application of policies and protocols for emergent care when patients showed abnormal or abnormally trending vital signs – specifically, the issue of charting practices that did not accord with AHS policies and procedures. As a result, the investigation did not



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examine the individual actions of medical staff, and I made no findings of individual wrongdoing under the Act.

Prior to my office receiving the public interest disclosure in this matter, Correctional Health introduced the Adult Vital Signs Record to track patient vital signs in correctional facilities. The Adult Vital Signs Record allowed medical staff to plot vital signs on a chart that identifies certain values as falling within the “Grey Zone” or the “Red Zone” depending on the severity. The Adult Vital Signs Record indicated that when there are acute changes in the “Grey Zone,” medical staff should complete a clinical review. If there is an acute change in the “Red Zone,” medical staff should consider calling a physician or nurse practitioner and consider a response team.

Along with the Adult Vital Signs Record, Correctional Health also distributed a Vital Signs Monitoring Guide for Provincial Correctional Institutions (the Guide). This Guide was intended to provide medical staff with guidance for monitoring and recording patient vital signs. Correctional Health informed my office that the Guide was not prescriptive, but rather considered an educational document for medical staff.

The Adult Vital Signs Record and the Guide were not in place for four of the seven patient incidents examined. Correctional Health informed my office that the Guide and Adult Vital Signs Record were introduced as a corrective measure following an incident at another correctional facility. However, I found that there was a lack of clarity as to whether complying with the steps outlined in the Guide were compulsory for medical staff, particularly when a patient’s vital signs were acute. In the three cases examined where the Guide was in place, medical staff failed to reference and comply with the Guide by not recording patient vital signs as required. While this evidence may not be sufficient to conclude that the failure to adhere to institutionally developed protocols is systemic, it is evidence of, at best, inconsistent and, at worst, arbitrary care.

Further, while the Guide instructed medical staff to provide the “necessary emergent care” based on acute vital signs, the Guide did not have a definition for the term “emergent care.” In the absence of a clear definition, what constitutes “emergent care” was open to broad interpretation. Such a broad interpretation may allow for variance in the treatment standards afforded to patients, which may lead to inconsistent or arbitrary health provision in correctional centres.

Given the lack of clarity surrounding institutional protocols, I did not view the wrongdoing as being solely the responsibility of any particular individual. Rather, based on my review of the circumstances of the seven individuals identified, I found there were systemic lapses in the medical care of



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incarcerated individuals at the correctional centre that stemmed from the lack of clarity surrounding the treatment standards expected when a patient shows abnormal or abnormally trending vital signs.

The corrective measures

During my office's investigation, it became apparent AHS was already aware of some issues regarding the care of incarcerated individuals and was in the process of taking corrective measures. These measures, supported and supplemented by my own recommendations, focus on the need for improvements to ensure incarcerated individuals receive appropriate medical care on a consistent basis. Based on my office's investigation, I recommended the following:

- AHS continue implementing corrective measures already underway to support staff in providing a high standard of patient care.
- AHS examine the circumstances of the specific cases reviewed by the Commissioner's office and determine whether it is appropriate to refer the matters to the regulatory and disciplinary bodies regarding the conduct of specific medical staff.
- AHS review and formalize the Adult Vital Signs Monitoring Guide into protocols or policies, as appropriate, to ensure clarity in the standard of care expected when incarcerated individuals require emergent care. Any policy or protocol implemented should include an audit component.
- AHS undertake a review to ensure that practices relied on by health care professionals in the correctional environment are consistent with AHS practices and protocol where appropriate.

In addition, I made two observations for AHS's consideration when implementing my recommendations:

- The broad understanding of "emergent care" and the absence of a general emergency response protocol when a patient does not fit within established specific protocols may have contributed to inconsistent or arbitrary medical care within the centre and other correctional facilities.



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- Medical records in correctional facilities are handwritten, which resulted in issues with legibility and clarity. Digitizing the records would reasonably improve patient care.

Following the investigation and the report of my findings and recommendations, AHS indicated that it had implemented corrective measures to address all my recommendations and observations. My office confirmed that the following corrective measures have been initiated:

- Reviews were conducted with the medical staff involved in the patient care incidents investigated by my office, and appropriate action was taken on an individual basis. These actions included discipline, coaching, completing mandatory training or education, and performance reviews including reviewing professional practice requirements for their role.
- Improvements were made for monitoring of the performance of medical staff in correctional centres. Enhanced chart audits and file reviews are now conducted in response to critical incidents and monthly random audits are conducted. Targeted audits are also conducted twice annually based on new initiatives, fatality inquiries, or quality assurance review recommendations. I have been advised that these newly instituted reviews and audits have since resulted in workplace investigations resulting in coaching discussions, letters of warning and terms of suspension, in addition to identifying individual and program educational needs. In some circumstances, reports have also been made to the College of Registered Nurses of Alberta for review. I accept these outcomes as being indicators that the reviews and enhanced audits are successfully identifying and remediating performance-related concerns.
- A second layer of review has been added to supplement the formal initial review of all critical incidents. While the first review is conducted by an AHS manager at the correctional centre where the incident occurred, a second review is conducted by a manager from a different correctional centre or by the Director of Correctional Health Services. Following patient safety events, the outcome will be entered into a tracking database for analysis and to determine if there are any trends. This process has been built into the operational procedure for managers to ensure there is consistent practice when incidents occur.
- AHS has also updated and implemented the Vital Signs Monitoring Guide to ensure staff are correctly recording vital signs in the Vital Signs Monitoring Record. The use of the Guide is now compulsory and is monitored through regular audits.



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- In October 2022, and prior to the conclusion of my office’s investigation, AHS completed a comprehensive Provincial Correctional Health Services policy compliance audit to ensure that the care provided in correctional institutions aligned with broader AHS policies and procedure and protocols. This audit is intended to be conducted annually by AHS, and more frequently when there is a significant change in policy at AHS. AHS has also undertaken to review all current correctional-specific policies and procedures with the intent of adding new policies as needed. Further, AHS has retained a consultant whose role and responsibilities will be to ensure up-to-date policies and practices are in place, and ensuring review, communication, and assessment of practice standards.
- AHS has a Provincial Correctional Health Services Quality Council. The mandate of this council is to focus on improving quality of care resulting from patient feedback, audits, and other mechanisms of identifying patient safety and quality concerns. This council has facility-specific sub-councils. AHS has initiated facility-specific trending reports to identify overall gaps in service and care provisions identified through audits and data gathering.
- A new process has also been implemented to improve the response to patient concerns. This includes a dedicated communication channel between the correctional centre health unit and AHS Patient Relations, an audit and review of outstanding patient concerns, and other quality improvement initiatives that are derived from trending areas of patient concerns.
- Finally, AHS advised it will be implementing Connect Care Electronic Medical Record in the Fall of 2024. This system will digitize records kept by medical staff in correctional settings and will include a protocol with prompts for vital signs monitoring, recording, and flags. The implementation of this system will be a significant step to ensure the integrity and clarity of patient records and will assist medical staff in their delivery of medical care.

Afterword

AHS was fully cooperative during the investigation. It was evident that AHS had a desire to understand what had transpired and to ensure that a proper standard of patient care was being provided in correctional centres. Indeed, AHS was already aware of certain incidents and was already in the process of remedying issues when my investigation began. AHS’s approach to this investigation and response to my findings is a model for what the Act is intended to achieve – a whistleblower safely and



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confidentially bringing forward concerns, and the affected organization taking substantial and meaningful steps to remedy the wrongdoing.

The effectiveness of the corrective measures can only be assessed over time. However, I believe that the corrective measures being taken by AHS will address concerns raised by my findings and reduce the risk of future occurrences of inadequate standards of care in correctional centres. I will monitor any new complaints that are received by my office relating to similar circumstances and will continue to monitor the ongoing corrective measures that require time for implementation. In particular, I will monitor the application of Connect Care Electronic Medical Records within correctional centres.

This investigation, and the subsequent changes implemented within AHS, are the result of a whistleblower who had the confidence to use the Act to report wrongdoing to my office. I commend the whistleblower for serving the public interest, and for their concern with the safety and well-being of patients within correctional centres.