Patient Care Quality Review Boards

File No. 11-0025

October 5, 2011

Dear Mr. and Mrs Rooney:

Re: Owen Rooney - Review Board Decision

The Interior Patient Care Quality Review Board (the Board), has completed our review of your complaint to the Interior Health Authority regarding the following matter:

Your son Owen Rooney is a 24-year-old Australian citizen who was visiting and working in British Columbia. On Friday August 13, 2010 he presented to Emergency Department (ED) at Boundary Hospital in Grand Forks, BC with facial injuries as the result of an assault. Owen was diagnosed with bruising to both sides of his face and ears and also his temple. The physician noted that both eardrums were hemorrhagic which he believed was due to barotrauma from being hit on the ears, rather than a fracture.

Owen had attended the Shambhala music festival in Salmo, BC from August 4th -9th and told the doctor while he was there he had consumed some hallucinogenic mushrooms which had made him paranoid. He indicated he had not slept for days and was noted to be quite teary, sad and quiet while in the ED. The doctor made the decision to admit Owen to observe his eyes for possible head injury, and the physician felt he could still be suffering from some paranoia from the mushrooms.

Owen remained at Boundary Hospital until approximately 6:15 p.m. the following evening when he went missing. He was last seen by staff sitting in a chair by a picnic table. His backpack was left in the ED and his jacket, cell phone, and glasses were left on the picnic table. The hospital contacted the RCMP who started a missing person's investigation. To date, Owen has not been found.

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You travelled to BC from Australia and allege that Owen was suffering from a head injury and was not properly diagnosed in the ED. You state you have independent witnesses who state that Owen was kicked in the head by two assailants. You also expressed concern that you did not receive cooperation from the hospital when you arrived from Australia to look for Owen.

The Board reviewed and considered all the information provided by both you and the health authority, and found the information in the attached list of documents to be most relevant.

Mr. and Mrs. Rooney the Board recognizes that Owen's disappearance has been a traumatic and tragic event for your entire family and the members are hopeful that this review will provide some clarity and the answers you are seeking.

The Board agreed with you that the Patient Care Quality Office (PCQO) should have been involved much earlier. Their involvement would have ensured that you were provided with assistance in communicating with the hospital administration and staff. The Board also commented that had the PCQO been involved from the beginning it is more likely that note taking of discussions and interviews would have been more thorough and comprehensive. Therefore, the Board recommended that the health authority remind all hospitals of the role of the Patient Care Quality Office and ensure that it is involved from the beginning in any future cases.

In reviewing the medical records the Board expressed concern regarding the poor documentation by both the nurses and physician at Boundary Hospital. For example, the Emergency Assessment record was not completed fully. Owen stated he had been assaulted yet there was no Glasgow Coma Scale score recorded either at the time he was admitted or later when he was assessed by the physician. The Board also noted that there was no past medical or mental health history taken, and no social history was completed on the intake form. The Board found that there were few observations documented by staff despite Owen being admitted for observation, and many of the notes that were provided were retrospective and provided well after the care was administered. The Board understands that the Interior Health Quality Improvement Review which was conducted in response to this complaint identified documentation as an area of concern and noted that the documentation in the patient's chart did not reflect the care as it was described in the interviews with staff. It was also noted that the charting did not meet the documentation standards of the College of Registered Nurses of British Columbia which states: "Nurses must document timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes". The Interior Health Quality Improvement Review recommended that quarterly audits be conducted specifically related to documentation and that there be mandatory education for staff at Boundary Hospital in the Legalities of Documentation, and a Charting workshop. The Board

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understands the education has now been completed and the first audit has been conducted, and additionally real time audits of charts are now being done on site. The Board recommended that the health authority share with you the results of the chart review as well as the Interior Health Quality Improvement Review and outcomes of the recommendations which were made.

In the documentation that was completed, and in the interviews with staff at a later date, there was no evidence Owen suffered from auditory or visual hallucinations at any time while he was a patient at Boundary Hospital. The Board found that the reports of hallucinations in the RCMP records are not substantiated in any of the medical or nursing records and the Board cannot explain how this information appeared in RCMP records.

With regard to your belief that Owen should have been sent for a CT scan the Board found that the medical management of Owen was appropriate, and that based on Owen's symptoms and presentation at the time, the ED physician's decision to observe him for 24 hours and then determine if a CT scan was necessary was a reasonable approach.

Although there was little documentation by nurses, Owen was observed by the nursing staff during the day, and according to later interviews staff recalled that although Owen was disoriented and somewhat confused, staff did not associate behaviour with a significant head injury. In fact in the nursing notes it was observed that his cognitive function was improving. The Interior Health Quality Improvement Review identified that there was no clear plan of care with specific goals beyond a 24-hour period for Owen and this resulted in the staff treating him with "less vigilance and more as a social admission". The Interior Health Quality Improvement Review made three recommendations regarding the development of a pre-printed order set for observation patients which would include diagnosis, vital signs, and planned disposition. It also recommended that Boundary Hospital develop and pilot Nursing Guidelines/Practice Standards for Emergency Room observation and share this with the Interior Health Authority (IHA) Emergency Department Coordinating Committee. The Board understands that observation orders have now been developed, staff have been made aware of this, and the orders have been implemented.

Based on Owen's emotional state at the time of his admission, Social Services/Mental Health Services should have been called to assess him. Owen did not have a plan on how he would return to Kelowna, nor did he wish to contact his family for support or assistance. Had Social Services or Mental Health Services been contacted they may have been able to assist him with this and also conduct a more in depth interview/assessment to determine if he was suffering from a mental health issue. The Board concurred with the recommendations made as a result of the Interior Health Quality Improvement Review regarding increased access to Mental Health services after hours as well as additional training for staff and was pleased to learn that Mental Health services are now accessible Monday to Saturday from 8:00 a.m. to 5:00 p.m. at Boundary Hospital.

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You expressed concern that a toxicology screen was not done prior to administering the Ativan and Percocet to determine the level of residual narcotics in Owen's body. Toxicology screening for various drugs including narcotics and alcohol may have been helpful although the results would not have been provided immediately as these tests must be sent to Trail for processing. The Board noted that according to the U.S. National Institute on Drug Abuse the effects of psilocybin, the active ingredient in the mushrooms, last approximately eight hours. Given that Owen was at the music festival from August 4th - 9th and presented to the ED on August 13, 2010 it is unlikely he would have still been experiencing the direct affects of the mushrooms. This is when it would have been helpful to have had a Social Services/Mental Health assessment done.

The Board reviewed the Code Yellow protocol for Missing Persons at Boundary Hospital and determined that Owen's disappearance was handled appropriately. The hospital and grounds were searched, and the RCMP were notified, which was more than what the protocol called for as Owen was considered to be a low risk patient.

The Board discussed the attempts made by hospital staff to facilitate Owen's contact with his family by either phone or the internet and determined that their efforts were satisfactory. Owen declined both these offers as well as an offer for staff to contact family on his behalf. There was no evidence to suggest that Owen was not mentally capable of making a phone call.

This concludes our review of this matter. We appreciate the opportunity to respond to your concerns. Please note that the IHA is required to respond to the Board's recommendations within 30 business days and is also required to follow up with you. It is our hope that the conclusion of this process will bring you a satisfactory resolution to your concerns.

Yours truly,

Roger Sharman, Chair
Interior Patient Care Quality Review Board

pc: Honourable Michael de Jong, Minister of Health, Q.C.
Patient Care Quality Office, Interior Health Authority

## Relevant Documents

- Signed Review Request with attachments
  - PCQO confirmation and summary of complaint
  - Response letter from Susan Ogroske, IHA PCQO
  - Rooney family response to PCQO letter
  - Boundary RCMP dispatch and call log
  - Owen Rooney's Medical Chart
  - Meeting notes from interviews with staff
  - Code Yellow Search Protocol

- PCQO investigation file
- Response letter to Rooney family
- Boundary Hospital Pharmacy Record
- Ingrid Hampf's investigation notes
- Minutes from meetings with staff and Rooney family
- Owen's Medical Chart including Physician's notes, Emergency Department Interdisciplinary Notes, Emergency Assessment Record, Emergency/Outpatient Record, Imaging Consultation Report, Dr. Coleshill Emergency Room note.
- Request for additional information from Review Board Officer
- Quality Improvement Review
- Pre printed Order set
- Implementation schedule for recommendations
- IHA Incident Management Policy
- Code Yellow Search Protocol
- Canadian CT Head Rule
- Canadian Emergency Department Triage and Acuity Scale
- Glasgow Coma Scale