CANADA
Province of Alberta

Report to the Minister of Justice and Attorney General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Provincial Court House

in the City (City, Town or Village) of Calgary (Name of City, Town, Village), in the Province of Alberta,

on the 5th day of September, 2007 (year), (and by adjournment

on the 6th and 7th days of September, 2007 (year)),

before Judge C.M. Skene, a Provincial Court Judge,

into the death of Irene Raffa (Name in Full) 80 (Age)

of 1512 – 8 Avenue NW, Calgary, Alberta, Canada (Residence) and the following findings were made:

Date and Time of Death: August 30, 2005

Place: Peter Lougheed Centre

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquiries Act, Section 1(d)).

Subdural Hematoma

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Accidental

Circumstances under which Death occurred:

A. Summary

On August 26, 2005, while being transferred from her nursing home bed to an EMS stretcher, Irene Raffa, fell from the hygienic sling attached to the mechanical lift being used to transfer her. She struck the back of her head on the base of the mechanical lift or floor and suffered a head injury and laceration. That fall caused Mrs. Raffa to suffer a subdural hematoma. She died in hospital on August 30, 2005.

B. Mrs. Irene Raffa

Mrs. Irene Raffa, born November 11, 1924, had been a resident of Extendicare (Canada) Inc.'s Hillcrest facility at 1512 – 8 Avenue NW, Calgary, Alberta since June 3, 2005, following an admission to the Peter Lougheed Centre.

She was not a healthy woman, having a number of medical ailments, including a history of congestive heart failure, insulin dependent diabetes, osteopenia, compression fractures of her spine, hypothyroidism and glaucoma. She was obese, being approximately 5 foot 3 inches tall and weighing 225 pounds.

Mrs. Raffa had limited mobility, spending most of her days at Hillcrest in her room, confined to her bed and secured in it with full side rails. She also spent some of the day in her room chair. She was dependent on Hillcrest staff for her care. She had no ability to assist the staff with her transfer from bed to chair or chair to bed. Her usual mode of transfer by her Personal Care Assistants was with a battery operated mechanical lift and full body sling.

C. Nursing Home

Extendicare Hillcrest is a privately owned, long term care facility, and a contracted facility of the Calgary Health Region.

Hillcrest employees who had direct contact with Mrs. Raffa on August 26, 2005 included Wayne Springer RN, a program manager for Hillcrest, and two Personal Care Assistants, also referred to in this Report as "PCAs or PCA."

PCAs attend school and receive on the job training programs. Their responsibilities at Hillcrest included attending to the needs of residents. PCAs are responsible for operating the mechanical lifts to transfer those residents requiring assistance from bed to toilet, bed to bath or bed to wheelchair or other chair and back again. Each PCA at Hillcrest successfully performs this duty numerous times each shift.

PCAs are the employees with the greatest direct contact with Hillcrest residents. Although their skills and services are essential to the care of the residents, they have the least amount of health care training and qualifications. Higher up the chain of command are Licenced Practical Nurses, Registered Nurses, and other administrative staff with health care qualifications and administration or management job descriptions. Wayne Springer RN would fall into this category.

D. Mechanical Lift and Sling

Residences or patients in long term care facilities often have to be transferred using a mechanical lift. Repetitive strain injuries have, in the past, taken a toll on the health and well

being of care staff. Some long term care facilities, including Hillcrest, have implemented policy forbidding staff members from physically lifting a resident or patient. Hillcrest staff are required to use mechanical lifts.

Mechanical lifts are common devices in nursing homes, hospitals and other institutions where residents and patients lack mobility to transfer safely from one location to another. Mrs. Raffa could not move from her bed to her chair or back again. She had limited mobility. Her transfer from bed to chair was facilitated by use of a mechanical lift with attached sling.

While a resident at Hillcrest, Mrs. Raffa was usually transferred using a full body sling. A hygienic or toileting sling had been used with Mrs. Raffa on occasion when she was placed on a toilet or bathed.

A full body sling or hammock sling was designed for the flaccid patient or resident and supports the resident's full body from head to knees. One witness described the sling as "cocoon-like." The resident or patient does not participate in the transfer. Care staff places the sling on the patient. The sling is secured to the lift. The lift is battery operated by controls on the lift or by remote control.

A hygienic sling, also known as a toileting sling is a strap sling attached to the resident or patient. It is a harness device where a strap wraps around the resident's back and under a resident's arm pits. The resident's arms go over that strap. Other attached straps support the resident's legs. The resident sits in the sling, with his or her buttocks clear of the obstruction. This allows the resident to be placed on a toilet or a toilet to be placed under the resident. It allows the resident's clothing to be removed to assist in the use of a toilet. The resident's genital area can be accessed for toileting and cleaning.

The resident or patient actively participates in the transfer using a hygienic sling by keeping his or her arms on the outside of the arm pit straps. The resident also assists by holding onto the straps with their hands.

There was no evidence in this Inquiry that suggested that the mechanical lift malfunctioned or that the hygienic sling did not function properly.

Graham Strong, of BHM Medical Inc., the manufacturer of the Ergo mechanical lift, the full body sling and hygienic sling used at Hillcrest, testified during the Inquiry.

The first point he emphasized was that the mechanical lift and sling is designed to be used to transfer a resident or patient. It was not intended to transport a patient.

He contrasted the use and suitability of a full body sling and the hygienic sling.

With a full body sling, the arms of the resident are on the inside of the sling, and no participation by the resident is required.

A hygienic sling does not supply the resident with similar support. It is distinguishable by its large opening at seat level. It is designed for toileting and is primarily used for placing a resident or patient on a toilet. It also permits easy changing of diapers. The sling is faster to apply or put on a resident. The resident's arms must be on the outside of the top straps and the resident must possess sufficient cognitive ability to understand that requirement and the need to continue to keep those straps under his or her arm pits. Further, the resident must possess sufficient arm and shoulder strength to hold his or her arms over the straps for the length of time it takes to transfer him or her from a bed to a toilet.

If a resident is unpredictable or not consistent in following instructions, or if a resident is cognitively weak or is physically unwell and does not have the strength in his or her arms and shoulders, the resident should not be placed in a hygienic sling. Some upper body control is required to hold onto the sling and to participate in the transfer.

Mr. Strong noted that PCAs are entry level care givers, with typically high turnover. Therefore, in his experience, it is not unusual to have inexperienced PCAs in a long term care facility. They are typically not highly skilled and have been educated and trained in basic care of residents who cannot care for themselves.

Another concern of Mr. Strong's is compliance. Even with training, a PCA, a Licenced Practical Nurse or RN may not possess the motivation to follow the instruction and policy of the institution. This not unique to this industry or this job description. It is a concern to all employers and in this case to the Hillcrest owners and administrators of the care facility.

E. Emergency Medical Services "EMS"

Two paramedics responded to the call from Hillcrest to attend and transfer a resident (Mrs. Raffa) from her Hillcrest room to the Peter Lougheed Centre.

Sarah MacLellan was the designated attending paramedic, responsible for Mrs. Raffa's care, filling out the Patient Care Report and communicating with the patient. Gordon Leigh was the driver of the EMS vehicle and assisted MacLellan with the transfer of Mrs. Raffa.

Gordon Leigh assumed the role of communicating with Hillcrest staff and obtained Mrs. Raffa's "green sheet", a document that contained a list of her medications.

F. Pre Fall Events

On August 26, 2005, Wayne Springer RN went into Mrs. Raffa's room to speak to her roommate. There he also found Mrs. Raffa with some of her family members. The family spoke to Springer telling him of their concern for Mrs. Raffa's health and well being as she was complaining of shortness of breath. Mrs. Raffa's medical condition had deteriorated with obvious symptoms of congestive heart failure. Some witnesses at the Inquiry reported noticing that Mrs. Raffa presented as cognitively confused.

It was determined that Mrs. Raffa's oxygen saturation level was low. Hillcrest staff placed Mrs. Raffa on oxygen. Shortly thereafter, Dr. Addison attended, being in the facility on another call, and assessed Mrs. Raffa. It was decided that the best course of action was to transfer Mrs. Raffa to the Peter Lougheed Centre and have her admitted to hospital for further assessment and care.

Mrs. Raffa, who had been sitting in her chair, was transferred to her bed using a mechanical lift and full body sling, the Hillcrest perception being that it would be easier to transfer Mrs. Raffa from her bed to the EMS stretcher than from her chair to the EMS stretcher, the latter option requiring the use of a mechanical lift.

Hillcrest employees testified that they assumed the EMS would do a bed slide transfer of Mrs. Raffa. That was the usual way a resident of Hillcrest would be moved from his or her bed to an EMS stretcher and EMS care.

EMS received a call on August 26, 2005 at 1445 (2:45 PM) requesting their attendance at Extendicare Hillcrest. The call was classified as a "6 Charlie" or a shortness of breath concern by someone at that location. Upon arrival EMS - MacLellan and Leigh - were escorted to Mrs.

Raffa's room by Wayne Springer RN. They brought their EMS stretcher and other equipment.

G. Mrs. Raffa's Fall

Mrs. Raffa's room was small. It contained two beds for two residents, and other furniture, including Mrs. Raffa's chair. Mrs. Raffa's bed was against one wall with the head of the bed against another wall. The available room for the EMS stretcher, two paramedics and Springer was limited.

EMS MacLellan spoke to Mrs. Raffa and assessed her. MacLellan shared Dr. Addison's opinion that Mrs. Raffa should be transported to Peter Lougheed Centre for admission and medical assessment and care. EMS MacLellan asked Mrs. Raffa "how she usually transfers" meaning how Mrs. Raffa usually moves from her bed to any other location, such as her chair. Mrs. Raffa responded that she did not transfer without assistance. MacLellan found Mrs. Raffa to be responsive and coherent. MacLellan asked Springer how Mrs. Raffa usually transferred. Springer advised MacLellan that Mrs. Raffa's transfer within the facility was with a mechanical lift.

MacLellan asked Springer to obtain a mechanical lift and Hillcrest personnel to transfer Mrs. Raffa from her bed to the EMS stretcher.

Springer called for assistance and PCA Asrat Eshetu responded. She in turned obtained help from PCA Mary Van Patten. Neither PCA was the PCA assigned to Mrs. Raffa for that shift, although they both had assisted Mrs. Raffa in the past. PCA Van Patten recalled that in the past she used a full body sling to transfer Mrs. Raffa. Mrs. Raffa's assigned PCA did not respond to Springer's request for assistance, although she was at Hillcrest at the time. PCA Eshetu had secured the use of a mechanical lift and had assisted Mrs. Raffa earlier when she was transferred from her chair to her bed. A full body sling was used and that full body sling was thereafter placed by PCA Eshetu in the hallway for others to access and use.

In response to being asked to transfer Mrs. Raffa from her bed to the EMS stretcher using a mechanical lift, PCA Eshetu obtained a mechanical lift and brought it into the small crowded room. When she went into the hallway to retrieve the full body sling she had used earlier, it was not there. PCA Eshetu searched for an available sling and found a hygienic sling.

She started to put the hygienic sling on Mrs. Raffa when PCA Van Patten came into the room. Van Patten told her and Springer that "we usually use a full body sling" on Mrs. Raffa. In response, she was advised that the hygienic sling was the only sling that PCA Eshetu could find. Eshetu understood that the transfer of Mrs. Raffa to the EMS stretcher was to be done immediately and without delay. Once Eshetu found a sling, albeit a hygienic sling, she did not look further for a full body sling. Springer stated that the urgency in transporting Mrs. Raffa was understood by him and his staff. Having been asked by EMS to transfer Mrs. Raffa from her bed to the stretcher, Hillcrest staff responded by complying as fast as they could.

EMS did not have the same sense of urgency. Mrs. Raffa needed to be transported; a hospital admission was required; but, it was not a life or death situation.

Once Mrs. Raffa was properly placed in the hygienic sling and the sling was properly attached to the mechanical lift, PCA Van Patten took responsibility for operating the mechanical lift. Her role was to lift Mrs. Raffa off her bed, turn and pivot the mechanical lift and move Mrs. Raffa from a spot over her bed to a location over the stretcher. Her plan was then to lower Mrs. Raffa onto the stretcher. PCA Eshetu took responsibility for monitoring the resident, ensuring that she transferred safely.

PCA Van Patten recalls being instructed by Wayne Springer to start lifting Mrs. Raffa. Springer

does not recall ordering that. Springer did not assume a role in transferring Mrs. Raffa. He was fulfilling the role of Hillcrest administration escorting EMS, giving EMS Mrs. Raffa's medical information and responding to their requests. At best, he was a passive observer in the room. He was conversing with EMS Leigh and providing Leigh with Mrs. Raffa's green sheet containing a list of her medications. EMS MacLellan did not have a role in operating the mechanical lift. When Mrs. Raffa was lifted off the bed, neither MacLellan, Leigh, nor Springer were aware that the lift and transfer had started.

EMS was not ready to receive Mrs. Raffa on their stretcher. EMS was not advised that Hillcrest was going to start lifting Mrs. Raffa. Hillcrest was not advised that EMS was not ready. Hillcrest employees were attempting to comply with their direction to transfer Mrs. Raffa and they were doing so as quickly as they could, in response to their understanding or assumption that this transfer was urgent.

MacLellan, Leigh and Springer started paying attention to Mrs. Raffa, and became aware that she was in the middle of being transferred, when she was up in the air, having been lifted up off her bed, pivoted off the bed and over the concrete floor. The EMS stretcher may have been in close proximity to her. In her small room everything was close to everything else. The EMS stretcher had been brought into Mrs. Raffa's room with the head of the stretcher beside the head of Mrs. Raffa's bed. The mechanical lift was between the bed and the stretcher. Surprised by seeing Mrs. Raffa already lifted by the Hillcrest staff and hovering over the floor, EMS noticed that Mrs. Raffa's body position was now turned 180 degrees, and had she been lowered onto the stretcher right then, her head would have been at the foot of the stretcher, and her feet would have been at the head of the stretcher.

EMS MacLellan instructed EMS Leigh and Springer to turn the stretcher around. Because the room was small, the stretcher had be wheeled out of the room, turned around and brought back in. Before the stretcher was able to be positioned underneath Mrs. Raffa, she moved her arms to the inside of the hygienic sling. The strap was no longer under her arm pits; it was on the outside of her upper arms. That caused the back strap to slide up Mrs. Raffa's back and over her head. Mrs. Raffa's head and torso fell backwards and onto the floor. Mrs. Raffa hit her head on the floor or on the base of the mechanical lift, causing a significant gash to the back of her head.

EMS MacLellan assisted Mrs. Raffa and dressed her head wound. PCA Eshetu left the room and found a full body sling. Mrs. Raffa was placed into the full body sling, and transferred from the floor to the EMS stretcher for transport to the Peter Lougheed Centre. Mrs. Raffa verbally indicated to everyone that despite falling and hitting her head, she was okay.

H. What Went Wrong

The findings of fact show that there was a failure to communicate. Further, all health care staff made certain assumptions and did not ask for clarification.

Hillcrest staff originally assumed EMS would transfer Mrs. Raffa using a blanket slide from her bed to their stretcher. EMS asked Hillcrest staff to transfer Mrs. Raffa the usual way she was transferred at Hillcrest.

Hillcrest staff thought Mrs. Raffa needed to be lifted and transferred immediately and thought EMS was ready to receive Mrs. Raffa on their stretcher. EMS did not require Mrs. Raffa to be lifted before they were ready and before the stretcher was ready to receive her. EMS was not aware that Mrs. Raffa had been lifted up and off her bed.

EMS assumed the stretcher was placed appropriately in the room. The mechanical lift turned Mrs. Raffa 180 degrees and therefore EMS MacLellan determined the stretcher was required to

be turned as well.

EMS having little familiarity with the operation of the mechanical lift and sling did not appreciate or address their minds to the possibility that Mrs. Raffa could fall out of the sling if she lifted her arms and put them inside the hygienic sling straps. EMS was unaware of that risk.

Hillcrest staff may not have appreciated the deterioration of Mrs. Raffa's physical condition and mental condition. If they did, Hillcrest staff did not consider how that deterioration may impact the appropriateness of transporting Mrs. Raffa using a hygienic sling. PCA Eshetu should have been in position to assist Mrs. Raffa or break her fall if she fell out of the hygienic sling.

This transfer of Mrs. Raffa took longer than expected by either Hillcrest staff or EMS personnel. It is unclear whether Mrs. Raffa experienced fatigue which resulted in her moving her arms inside the straps, or whether she did not appreciate that she had to keep her arms on the outside of the straps, due to her state of confusion, if any.

I. Peter Lougheed Centre

Mrs. Raffa was transported to the Peter Lougheed Centre and admitted. Her symptoms of congestive heart failure resolved within 12 hours of her admission. She suffered brain damage due to the subdural hematoma, caused by her fall and head injury. She died of those injuries on August 30, 2005.

J. Post Fall Investigation

Hillcrest administration staff took immediate action and extensively investigated the incident. The steps Extendicare Hillcrest staff took were impressive and extremely thorough.

Extendicare Hillcrest reenacted the transfer and fall with Joan Hopp, Program Director being placed in the hygienic sling and lifted. PCA Van Patten was at one reenactment. PCA Eshetu was at another.

During the reenactments of the incident, It was discovered that when Hopp moved her arms from outside the sling (with the straps under her arm pits) to inside the sling, the back strap of the sling would slide up her back, over her head, and her head and torso would fall backward out of the sling.

A report was made to the Calgary Health Region. Recommendations were proposed. The incident and recommendations were shared with other long term facilities in the Region.

Hillcrest met with staff and formulated policy changes applicable to the transfer of patients and instituted additional educational seminars, retraining and certification for their staff. Compliance with policy is also monitored and non-compliance results in sanctions by Hillcrest administration. Health care funding was spent on purchasing more slings. Extendicare policy for transfer to EMS was developed and put in place.

All PCAs at Hillcrest transfer residents during their shifts numerous times. It has always been a two PCA job and the fall, injury and resulting death of Mrs. Raffa was an isolated incident. The PCAs at Hillcrest did not usually transfer a resident to an EMS stretcher. That typically was done by EMS using a blanket slide technique. Regardless, each Hillcrest transfer team now uses a checklist which is attached to the mechanical lifts that the PCAs use. The checklist requires communication with the resident being transferred and communication with their co-worker. No mechanical lift is started until the sling is ready, the lift is ready, the PCAs are ready and the receiving chair, bed or other device is ready.

Hillcrest 6 Point Checklist

1. Resident is able to participate
2. Resident ready
3. Sling applied properly
4. Sling attached to lift properly
5. Lift path is clear
6. Staff ready and in position

Mr. Strong of BHM Medical Inc. suggested a 7th point be added: "Proper sling being used." Another suggestion made during the Inquiry is that the Checklist should include a reference to the receiving chair, bed, toilet or stretcher being positioned properly and ready.

Hillcrest met with EMS and asked for their input.

Immediately after the incident, EMS MacLellan prepared an incident report and reported the fall to her supervisors.

Recommendations for the prevention of similar deaths:

Recommendation 1: The transfer of a resident or a patient by any classification of health care worker, including PCAs and EMS, require the health care workers participating in the transfer to communicate with each and determine the role each worker shall have in the transfer. They should act as a team. The transfer should not start until all participants are ready and that readiness has been communicated to the other members of the transfer team.

Recommendation 2: The method of transfer of a resident or a patient should include a consideration of the safest method of transfer for both the health care workers and the resident or patient. That should include a consideration of the resident's mental and physical health.

Recommendation 3: A hygienic sling should only be used for the purpose intended, which is the hygiene of a resident or patient, including toileting. A hygienic sling should not be used on a resident or patient with insufficient upper body strength or cognitive awareness to properly participate in the transfer.

DATED January 31 ,2008

at Calgary , Alberta.

Judge C.M. Skene
A Judge of the Provincial Court of Alberta