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PRIVATE AND CONFIDENTIAL

March 10, 2023
David Dickson
david@dksdata.com

Dear David,

Thank you for contacting our Patient Relations Department regarding your concern with practice standards and communication of Diagnostic Imaging Staff. We appreciate your feedback and apologize that Alberta Health Services (AHS) did not meet your expectations. AHS takes all concerns very seriously and the feedback is valuable in our efforts to provide high quality care.

This concern was reviewed by [Redacted], Director [Redacted] Royal Alexandra Hospital, and relays:

Please let me start with an apology to Mr. Dickson and his family. It is evident that their experience was a negative one rift with stress, confusion, and unpleasant encounters. This is not how we want people to experience their visits and I am appreciative of the opportunity to use this example as a learning experience for our staff.

1. **After discussion and confirmation, the complainant requests leadership to review this concern.**

I have investigated this concern and included discussions with the Ultrasound Manager, Clerical Manager, Lead Cardiologist, Manager of the site screeners and Lead Infection Control Physician for the Edmonton Zone.

2. **Complainant asks if they were correct with informing the DI clerk of their mask exemptions prior to the appointment?**

Sharing this information with DI ahead of time was absolutely the correct thing to do and I ask that if there are appointments in the future to continue to do so. It is not apparent in the resulting experience the family encountered but organization was done for their visit beforehand. DI staff coordinated with the screeners in an effort to smooth the process and had to get permission for a designated support person to attend the visit. We (DI) understand the necessity for a support person in this case but COVID protocols still challenge having a second person come to the appointment.

3. **Complainant asks is there a process for the clerk to follow to inform the screeners, and various members of the team regarding the mask exemption?**

The manager personally spoke with the manager of the screeners to organize the visit. Information that was shared with her was that the patient would be arriving by ambulance not a private vehicle. This resulted in arriving at a different door than expected. She was also informed that there would only be one designated support person, not two. Mr. Dickson has explained clearly why two people were required, but this did add another unanticipated challenge.

4. **Complainant asks, why were they spoken to rudely by the clerk, through the two telephone interactions?**

   This is unacceptable and has been brought up with the clerical staff. We do not accept rude behavior.

5. **Complainant asks, why did the clerk chart he asked for the appointments to be combined, when he did not?**

   It is unclear why the clerk would chart this. It was in fact the US staff noted that there were two appointments on different days and thought they were helping the family out by consolidating it into one day. This was in an effort to save the family a trip and having to go through the screening process again. Mr. Dickson has explained how short notice changes in schedules like that can be stressful and cause more disruption than anticipated. Our staff should have asked if this would have been helpful, not assumed that they were doing a favor.

6. **Complainant asks why were they not informed earlier that the tests were combined to improve the logistics and planning for the family?**

   This was done with short notice, and it was not recognized as a challenge for the family as the patient was coming via ambulance.

7. **Complainant asks why were they not informed the tests moved to the same DI department prior to their appointment to prevent confusion and the time of several health care workers?**

   Assumptions were made that the patient was coming to the originally booked department by ambulance. It was intended to have two tests done on one day in one department. There was a communication breakdown in regards to the plan, how the patient was arriving, and this was compounded by the short notice.

8. **Complainant asks why were they placed in a positive Covid symptom area, when they were feeling well with no symptoms?**

   The person who sat them in that area was placing the family in an area away from other people waiting in the waiting room because they did not have masks on. The signs on the wall were outdated and from an old process where people were screened at the door and then told to sit in separate areas. I have personally removed the signs. I can see how this would cause concern and apologize. Please be assured that there were no COVID positive people in that area.

9. **Complainant asks why did the DI worker demand to see their exemption when they were already screened, treat them disrespectfully by raising her voice, and demonstrate a lack of customer service, or compassion?**

   The DI worker did not understand that they had been screened. It is unusual for people to not be wearing masks and the messaging to staff over the past three years is to inquire why they don't have a mask on. People have been known to bypass screeners by entering other facility doors or unfortunately be non-compliant when they arrive. The DI team is quite large, and it was not anticipated that you would have encountered this person. She was not aware of your arrival and exemption beforehand. The ultrasound sonographers and clerical staff were aware. It is unacceptable to be treated in a rude or disrespectful manner and this has been brought to the staff member's attention.

10. Complainant asks why was the echo cardiogram of poor quality?

I have had the Head Cardiologist review the images. The quality of the images are due to the patients [Redacted], in other words [Redacted]. Though challenging, adequate images were obtained to confirm left ventricle function and assessment of wall motion. The room and equipment did not affect the quality of the images. The sonographer did have to take more time trying to get the best pictures possible and was apologizing and explaining about the different room and equipment. I am sorry that this caused unnecessary concern around the quality of the exam.

11. What quality improvements have been identified.

As stated, before it is unacceptable for staff to conduct themselves in a rude and disrespectful manner. This is being discussed with all staff members as a whole and as mentioned has been addressed with the individual staff members involved in this concern. The managers tried to make this visit a smooth one but obviously fell short in communication and have learned some lessons for the future. We have asked the screeners to produce a visual cue like a sticker for patients who have been screened but are not wearing masks. I have asked for a review of the limitation of designated support people.

It is unknown how long masking requirements will be in place at AHS facilities or what the screening process will be in the future. I encourage Mr. Dickson to continue giving as much notice to the department as possible that he and or his family members will be coming and have exemptions in place. If there are future RAH Diagnostic Imaging appointments, he can contact me personally and I will arrange for myself or one of our management team to navigate him through the process in person.

Sincerely,
[Redacted]

Thank you again for contacting Patient Relations. We hope this feedback helps to address some of your questions from your experience. Please do not hesitate to contact us if you have further questions regarding your mother in laws health experience.

Kind regards,
[Redacted]

Patient Concerns Consultant

Dear [Redacted],

As promised, here is my initial response (while I await the information from Protective Services).

Note that the current AHS Policy HCS-267 does <u>NOT</u> require a medical exemption letter (and never did).

However, to the point *"It is unknown how long masking requirements will be in place at AHS facilities or what the screening process will be in the future."* you only have to look at the changes to HCS-267 on September 23rd, 2022, and March 6th, 2023 (along with the impending removal of screeners at AHS) to work out that the intention is for continuous masking to **never** go away. Masking has been removed though for executive or admin staff, and their special visitors.

September 23rd, 2022
Now HCS-267, after over 2 ½ years, is no longer restricted to COVID.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-use-of-masks-hcs-267.pdf

DIRECTIVE

TITLE	EFFECTIVE DATE	DOCUMENT #
USE OF MASKS DURING COVID-19	March 22, 2022	HCS-267

PRINCIPLES

Continuous masking can function either as source control (being worn to protect others) or part of **personal protective equipment (PPE)** (to protect the wearer) to prevent or control the spread of COVID-19. Working collaboratively, we shall ask all individuals to assist us in limiting the spread of COVID-19 through the use of masks/respirators in AHS facilities.

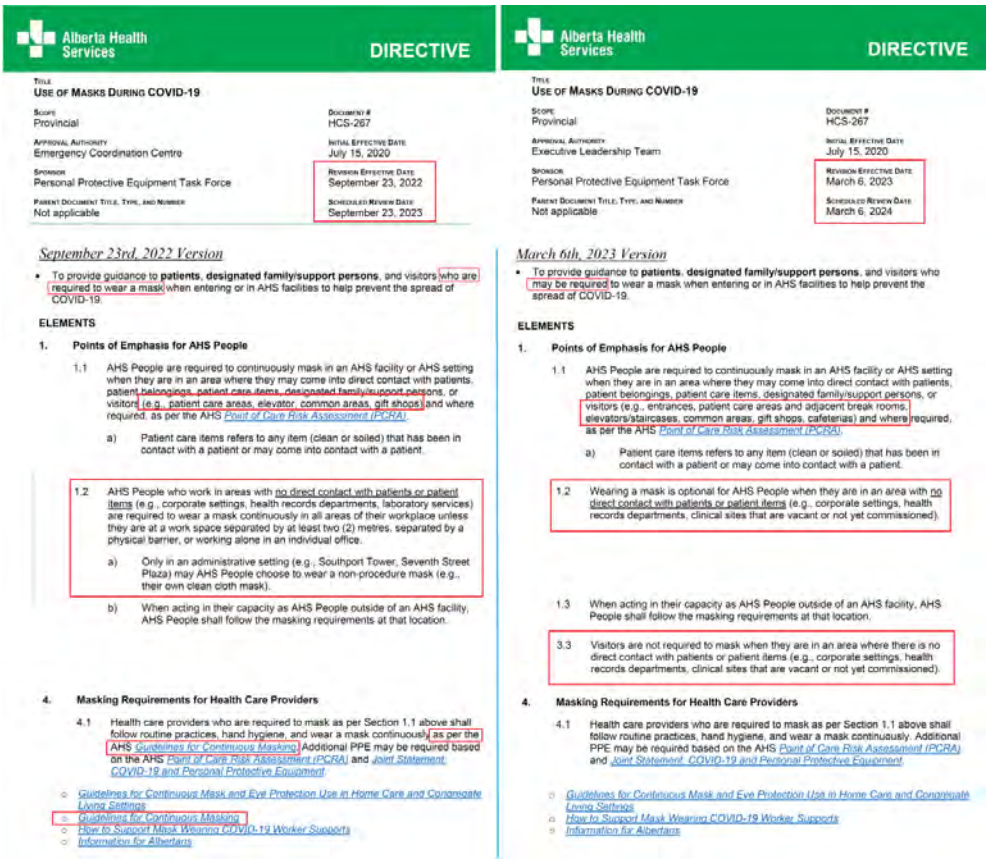
AHS requires continuous masking by **health care providers** who work in AHS facilities or AHS settings. AHS promotes education (e.g., AHS *Information for Albertans*), prevention strategies, and public awareness to prevent the spread of COVID-19 to health care providers, patients, designated family/support persons, and visitors.

DIRECTIVE

TITLE	EFFECTIVE DATE	DOCUMENT #
USE OF MASKS DURING COVID-19	September 23, 2022	HCS-267

PRINCIPLES

Continuous masking can function either as source control (being worn to protect others) or part of **personal protective equipment (PPE)** (to protect the wearer) to prevent or control the spread of COVID-19 and other respiratory viruses. Working collaboratively, we shall ask all individuals to assist us in limiting the spread of COVID-19 and other viruses through the use of masks/respirators in AHS facilities.



Alberta Health Services — DIRECTIVE

TITLE: USE OF MASKS DURING COVID-19

SCOPE: Provincial
APPROVAL AUTHORITY: Emergency Coordination Centre
SPONSOR: Personal Protective Equipment Task Force
PARENT DOCUMENT TITLE, TYPE, AND NUMBER: Not applicable
DOCUMENT #: HCS-267
INITIAL EFFECTIVE DATE: July 15, 2020
REVISION EFFECTIVE DATE: September 23, 2022
SCHEDULED REVIEW DATE: September 23, 2023

September 23rd, 2022 Version

- To provide guidance to **patients**, **designated family/support persons**, and visitors who are required to wear a mask when entering or in AHS facilities to help prevent the spread of COVID-19.

ELEMENTS

1. Points of Emphasis for AHS People

1.1 AHS People are required to continuously mask in an AHS facility or AHS setting when they are in an area where they may come into direct contact with patients, patient belongings, patient care items, designated family/support persons, or visitors (e.g., patient care areas, elevator, common areas, gift shops) and where required, as per the AHS *Point of Care Risk Assessment (PCRA)*.

a) Patient care items refers to any item (clean or soiled) that has been in contact with a patient or may come into contact with a patient.

1.2 AHS People who work in areas with no direct contact with patients or patient items (e.g., corporate settings, health records departments, laboratory services) are required to wear a mask continuously in all areas of their workplace unless they are at a work space separated by at least two (2) metres, separated by a physical barrier, or working alone in an individual office.

a) Only in an administrative setting (e.g., Southport Tower, Seventh Street Plaza) may AHS People choose to wear a non-procedure mask (e.g., their own clean cloth mask).

b) When acting in their capacity as AHS People outside of an AHS facility, AHS People shall follow the masking requirements at that location.

4. Masking Requirements for Health Care Providers

4.1 Health care providers who are required to mask as per Section 1.1 above shall follow routine practices, hand hygiene, and wear a mask continuously as per the AHS *Guidelines for Continuous Masking*. Additional PPE may be required based on the AHS *Point of Care Risk Assessment (PCRA)* and *Joint Statement: COVID-19 and Personal Protective Equipment*.

- *Guidelines for Continuous Mask and Eye Protection Use in Home Care and Congregate Living Settings*
- *Guidelines for Continuous Masking*
- *How to Support Mask Wearing COVID-19 Worker Supports*
- *Information for Albertans*

Alberta Health Services — DIRECTIVE

TITLE: USE OF MASKS DURING COVID-19

SCOPE: Provincial
APPROVAL AUTHORITY: Executive Leadership Team
SPONSOR: Personal Protective Equipment Task Force
PARENT DOCUMENT TITLE, TYPE, AND NUMBER: Not applicable
DOCUMENT #: HCS-267
INITIAL EFFECTIVE DATE: July 15, 2020
REVISION EFFECTIVE DATE: March 6, 2023
SCHEDULED REVIEW DATE: March 6, 2024

March 6th, 2023 Version

- To provide guidance to **patients**, **designated family/support persons**, and visitors who may be required to wear a mask when entering or in AHS facilities to help prevent the spread of COVID-19.

ELEMENTS

1. Points of Emphasis for AHS People

1.1 AHS People are required to continuously mask in an AHS facility or AHS setting when they are in an area where they may come into direct contact with patients, patient belongings, patient care items, designated family/support persons, or visitors (e.g., entrances, patient care areas and adjacent break rooms, elevators/staircases, common areas, gift shops, cafeterias) and where required, as per the AHS *Point of Care Risk Assessment (PCRA)*.

a) Patient care items refers to any item (clean or soiled) that has been in contact with a patient or may come into contact with a patient.

1.2 Wearing a mask is optional for AHS People when they are in an area with no direct contact with patients or patient items (e.g., corporate settings, health records departments, clinical sites that are vacant or not yet commissioned).

1.3 When acting in their capacity as AHS People outside of an AHS facility, AHS People shall follow the masking requirements at that location.

3.3 Visitors are not required to mask when they are in an area where there is no direct contact with patients or patient items (e.g., corporate settings, health records departments, clinical sites that are vacant or not yet commissioned).

4. Masking Requirements for Health Care Providers

4.1 Health care providers who are required to mask as per Section 1.1 above shall follow routine practices, hand hygiene, and wear a mask continuously. Additional PPE may be required based on the AHS *Point of Care Risk Assessment (PCRA)* and *Joint Statement: COVID-19 and Personal Protective Equipment*.

- *Guidelines for Continuous Mask and Eye Protection Use in Home Care and Congregate Living Settings*
- *How to Support Mask Wearing COVID-19 Worker Supports*
- *Information for Albertans*

Screeners have not 'screened' for some time. They are merely there to hand out masks, and escort the 'unmasked'. With the expansion of the mask required area ensuring patients, visitors and DSP's alike can't even get to a screener without a mask on, the screeners' position becomes moot. This is the approach already implemented in Care Homes for almost 6 months and at the Cross Cancer Hospital. Effectively, this will make the challenges I have documented so much worse. Just how will we get into a hospital now? Are we expected to pre arrange to be met at the door and only have escorted visits for health care now? Does AHS really have the excess staff and funds for this?

To open this response with the following comment was not a good start. It demonstrates a lack of understanding of the true impact to people like myself and [Redacted].

*"I encourage Mr. Dickson to continue giving **as much notice** to the department as possible that he and or his family members will be coming and have exemptions in place."*

What about a visit to the ER? What about an ambulance ride? EMS have stated they will refuse to transport a patient and/or DSP who cannot wear a mask (a breach of HCS-267 and worse). Considering this was written by an AHS Director who should be well aware of the AHS Directive, the response is more than disappointing, it is disturbing.

Since all CMOH Orders were withdrawn in July of 2022, the only official AHS policy/Directive in place is HCS-267, which far too many AHS staff seem not to have read or understood.

At that same time, the Scientific Advisory Group for AHS and the CMOH confirmed they had no

evidence to support the use of masks and some evidence to show the harms caused by mask wearing (psychological and physical). Yet these 'professionals' decided to extend the continuous masking policy (HCS-267). Even with that policy in place, no one should be being discriminated against (and continue to be treated this way by AHS and its staff.)

Further, this response goes directly against not just AHS Directive HCS-267 but Health Canada guidelines, OH&S regulations and the regulations of all healthcare professional Colleges. Health care professionals are required to do no harm and must ensure medical services are provided to all who need them without discrimination or obstruction.

From this incident, I still have no response from Protective Services, which is ironic as Protective Services central management were the ones to respond first to the incident at the Kaye Clinic in April of 2022. At that time, they apologized and sent the officers on a training course because of their behaviour, which was less egregious than what I experienced at the RAH. I was also assured that the April 2022 incident had been brought to the attention of senior management for AHS Protective Services so it would not happen again anywhere. So much for promises.

In response to the specific points above:

1. Considering the number of people spoken to, it is amazing how much is wrong in this response.

2. ***"Complainant asks if they were correct with informing the DI clerk of their mask exemptions prior to the appointment?"***

   This wasn't a question we asked but one that Patient Relations interjected. This really misses the point of the complaint. We should not have to do this, but we made the point that we did it **because** of the issues and discrimination we have experienced repeatedly. The point of the complaint was to bring an end to this behaviour, not make it a permanent expectation!

   "Sharing this information with DI ahead of time was absolutely the correct thing to do and I ask that if there are appointments in the future to continue to do so."

   This is not something we are required to do under the AHS Directive, so why are we continually being told to do this? In the event of an **emergency**, we would **not** be in a position to be able to do this, so what then?

   "had to get permission for a designated support person to attend the visit. ". - "We (DI) understand the necessity for a support person in this case but COVID protocols still challenge having a second person come to the appointment."

   I cover this in detail below. However, there is no restriction to a single DSP in HCS-267. In fact, quite the contrary (see below).

3. ***"Complainant asks is there a process for the clerk to follow to inform the screeners, and various members of the team regarding the mask exemption?"***

   This wasn't a question we asked but one that Patient Relations interjected as a result of the challenges we keep facing. This again misses the point of the complaint. This process should not

exist because as its existence demonstrates clear discrimination on the part of AHS, against HCS-267.

"Information that was shared with her was that the patient would be arriving by ambulance not a private vehicle."

This was one of the most shocking parts of the response. At **no** time was there any suggestion of [Redacted] arriving by ambulance. In fact, it was made very clear to everyone we spoke to that [Redacted] was being brought in by Karen and myself. I would like an explanation of where this apparent misinformation was started. All the way up to the last person we spoke to, everyone at RAH was made completely aware we were **not** arriving by ambulance. In fact, due to the ongoing and improper discrimination at AHS;

a) [Redacted] (like myself) can no longer travel by ambulance because;
    i. EMS are refusing to treat or transport patients who cannot wear a mask. This is despite Care Home residents **never** having been required to wear a mask in a Care Home. Note EMS and AHS staff do treat residents while in the Care Home, without requiring the resident to mask first. How does AHS explain this contradiction?
    ii. We have witnessed, first hand, incidents where paramedics have forced masks on residents (constituting an assault) since 2020. There are complaints on file regarding this. As such, being responsible for [Redacted]'s health and safety, we could not allow [Redacted] to travel unaccompanied in an ambulance.
    iii. EMS will not transport a patient with an unmasked or unvaccinated DSP (against AHS Directives). This was recently demonstrated when EMS abandoned a patient having an active stroke because her DSP was not vaccinated. In that case, the family were all wearing masks as the paramedics refused to even enter their home to triage until they were all masked. EMS management responded that this was their policy, followed by all staff. This is clearly not abiding by the AHS/EMS Directive or the respective College regulations.

b) If [Redacted] had been transported by an arranged ambulance, we would not have needed to be told which entrance to go to as the ambulance would have already been informed! This is not an Uber where the passenger provides directions to the driver.

"This resulted in arriving at a different door than expected."

We were specifically instructed to arrive at the Lois Hole entrance which [Redacted] and Karen did. I only came through the alternate door because of the instructions provided the night before, that it would be the closest exit for when [Redacted]'s second appointment was completed. This was a significant inconvenience in of itself as I am registered disabled and walk with a cane. However, parking closest to the second appointment location meant [Redacted] would be less inconvenienced and we would not have to walk across two buildings again as we left. Note that the screeners were NOT the issue on this occasion. I came in through the 'wrong' entrance but was treated with compassion and respect at all times by the screener. That was not because of anything DI did, but because the screener I experienced did not suffer from the same discriminatory mentality. I have to add the screener who kindly assisted Karen and [Redacted] also came to my aid when I was accosted by Protective Services near Diagnostic Imaging. Again, the issue was not the screeners on this occasion. It was DI and Protective

Services staff.

“She was also informed that there would only be one designated support person, not two.”

“Mr. Dickson has explained clearly why two people were required, but this did add another unanticipated challenge.”

What was explained to Patient Relations in the complaint is EXACTLY what was explained to all the DI staff in the calls the day before. This was not *“unanticipated”.*

At no time was anyone informed that there would only be one DSP. In fact, the calls all specifically outlined there being two people and the reasons why.

In the initial call to RAH diagnostic imaging, I spoke with [Redacted] (as [Redacted] was away from the desk).
In that call, I mentioned that;

- my mother-in-law had [Redacted].
- she was unable to wear a mask.
- I am her [Redacted].
- we both have written medical exemptions.
- we would both have our medical exemption letters with us.
- my wife, Karen (her daughter) is [[Redacted] (and primary caregiver).
- as per the above, we would **both** bringing [Redacted] in and had to accompany her for the visit.

I received a call back from [Redacted] who, as per the complaint, was most unpleasant (as she had been in the call to Karen previously). In that call, [Redacted] noted both Karen and I said we would be accompanying [Redacted]. She tried to state (without listening) that only one person could accompany [Redacted] (contrary to HCS-267), but she was corrected on that point. We confirmed we would both be accompanying [Redacted]. I informed [Redacted] that we *“have letters of exemption”* (plural). Her response was that we should make sure we brought them to show them to the screeners and that was *“as much as I can do”*.

Later that evening, I received a call back from the RAH where I again confirmed both Karen and I would be accompanying [Redacted] and reiterated why. We were told to drive to the Lois Hole entrance of the hospital, come through that entrance and show our letters to the screener, so we could get in. No ambulance was mentioned at any time and there was no misunderstanding of [Redacted] being accompanied by two DSP’s, as is allowed under HCS-267.

For clarity;

HCS-267 April 8, 2021

"Designated support person means the individual(s) identified by the patient that they want involved in their health planning and decisions."

Again, Karen is [[Redacted] and I (David) am [Redacted]. We are both directly involved in her health planning, decisions and direct care. Note it states “*individual(s)”,* plural.

HCS-267 July 2020
s4. "Use of Masks in a Pediatric Outpatient Setting"
[nothing noted for Adult or disabled attendance]
s4.3 a)
*"AHS **advises** that only one (1) designated family/support person accompany a child to scheduled visits" [this is not a requirement, just advice, even at that time].*

By January 2021, the language had specifically changed to become plural to indicate MORE THAN ONE.
HCS-267 January 26, 2021
"Designated family/support persons and visitors"

April 2021, the wording is clarified to ensure A **MIMIMUM** of 1 **IN-PERSON** DSP.
HCS-267 April 8, 2021
s2.2
*"the importance of accommodating access to a **minimum** of one (1) in-person designated support person identified by the patient;"*
and:
"designated support persons" – Plural!

At the time of the visit, the September 23, 2022 revision was in effect.
HCS-267 September 23, 2022
"Designated family/support persons and visitors"

Again, clearly **plural** (more than one) and no mention of **any** restrictions throughout the Directive.

AHS Directive HCS-267 clearly states:
https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-use-of-masks-hcs-267.pdf.
Section 3.2
"Patients, designated family/support persons, and visitors are not required to mask when:
a) providing or receiving care or assistance where a mask would hinder that care or assistance;"
i.e. providing support and care/communication."

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-use-of-masks-hcs-267.pdf.
Section 8.4
"Patients requiring health care shall not be refused care if their designated family/support person or visitor is unable or refuses to mask."

Section 5.2 a), 8.4 a), 8.4 b)
https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-how-to-support-mask-wearing.pdf.
"No patient shall be denied service in AHS because they cannot or will not wear a mask."
(see https://dksdata.com/MASKS#AHSMasks).

4. I am glad to hear rude behaviour is not tolerated (as has always been the policy at AHS). Visitors

and patients are reminded of this constantly. However, this letter along with previous experiences is not giving me any confidence this will not continue as part of the clear life-threatening discrimination we are experiencing.

5. *"It is unclear why the clerk would chart this."*

I certainly don't know why the clerk would chart this. This, as a response, leaves a lot to be desired, considering it is in a letter responding to the complaint. Did anyone ask the clerk? If so, what was her response? Did she not know why she would chart a clearly false statement?

*"It was in fact the US staff noted that there were two appointments on different days and **thought** they were **helping the family out** by consolidating it into one day. This was in an effort to **save the family a trip** and having to **go through the screening process again**. Mr. Dickson has explained how **short notice** changes in schedules like that can be stressful and cause more disruption than anticipated. Our staff should have asked if this would have been helpful, not **assumed** that they were doing a favor."*

Short notice is an understatement. The initial notice that the second appointment (10 days later) had been combined to the same day was given barely 12 hours before the first appointment. Considering we had to arrange with Care Home staff to have [Redacted] woken early and drive from Devon to the North of Edmonton before heading downtown for the appointment, this was effectively **no notice**. In addition, [Redacted] had her regular physio booked later on the day of the appointment. This change without notice directly impacted her critical goals of care, the Care Home staff and her partner who attends her physio with her.

This change was not done to benefit [Redacted] or us as is clear by the chaos it caused. As the excuses provided are 'assumptions' with lies about charting a request that never happened, we can only assume malice in this change. The disruptive changes made with no effective notice (based on this response and the call in the evening) were as a result of the person charting the false statement ***"he asked for the appointments to be combined"*** immediately before she left for the day ([Redacted]). Again, it is hard not to attribute this to malice when combined with the manner in which we were treated by [Redacted] in multiple calls.

Then comes the second change on the morning we arrived which caused chaos, and contrary to the position of this letter, did not allow for an adequate scan. The result of that is further appointments for a repeat ultrasound and an urgent consult request with a Cardiologist from [Redacted]'s doctor. However, this letter suggests that may be unnecessary. If that report was updated, we will need to know immediately, as will [Redacted]'s doctor.

6. *"This was done with short notice, and it was not recognized as a challenge for the family as the patient was coming via ambulance."*

I have covered these two points in detail above. Both points being repeated in this response to excuse the whole incident are concerning.

7. *"**Assumptions were made** that the patient was coming to the originally booked department by ambulance." "and this was compounded by the short notice."*

I have covered the ambulance and short notice points in detail above. However, the reason

behind this being an 'assumption' is hard to fathom. Is this the only unacceptable assumption in the reality of what happened and this written response?

8. *"The signs on the wall were outdated and from an old process where people were screened at the door and then told to sit in separate areas."*

   Frankly, I find this response hard to believe based on our experience (and the proliferation of signs throughout this area in the department). I counted many signs including the pink *"POSITIVE SCREEN PATIENTS ONLY"* with the small text below *"NEGATIVE SCREEN PATIENTS PROCEED TO AREA BY TELEVISION"* (which was a contradiction). There were white signs with arrows on the walls and the desk marked *"NEGATIVE SCREEN AREA"* and *"POSITIVE SCREEN AREA"* and green NEGATIVE SCREEN PATIENTS ONLY" signs. Lastly, there was a sign in a holder stating *"if you have checked at the Main Reception desk PLEASE BE SEATED"* - which we had and did until we were rudely attacked.

   Even if it is an accurate statement that this was an old policy, it is concerning that the signs still existed. How long ago did this policy change? The signs suggesting it was still in effect were at the desk, all over the walls and were reinforced by the behaviour of staff. Further, this was not a case of separating patients and DSP's as we were sitting more than 6 feet away from the other persons wearing masks.

   "*The person who sat them in that area was placing the family in an area* ***away from other people waiting in the waiting room*** *because* ***they did not have masks on****."*

   Was it appropriate in this case to force two visibly disabled persons to move into another area? I thought we stopped that in society when 'get to the back of the bus!' became unacceptable. Again, the behavior of the staff member does not align with the supposition.

   We sat in the waiting area on the available seats (placed to allow people to be socially distanced) with my mother-in-law next to us in her wheelchair. Next, a nurse came out and advanced towards us, screaming *'You people need to move over there!'* She pointed at a lone chair on the other side of the waiting room. I indicated to her that there was only one chair. She responded with *'Then get another one!'* We moved over to this area not wanting any more confrontation or stress, especially for my disabled, elderly mother-in-law. Then the nurse demanded to know where our masks were. I explained we were exempt under HCS-267. She smirked and in a derisive tone spat '*Really, all three of you? Prove it!'*. I responded, now out of frustration, *'Do you really want to go there?'* She responded, *'Yes, I want to go there.'*

   Although correlation is certainly not causation, I was disheartened to discover a number of days later that I had developed my first chest infection (not COVID) in over three years that now required a doctor's visit, antibiotics and a stressful time recovering. So again, I ask, how long before had this *'old process'* been removed?

9. *"The DI worker did not understand that they had been screened." "the messaging to staff over the past three years is to* ***inquire*** *why they don't have a mask on".*

   She didn't even attempt to **'inquire'** or even call the screeners. She 'assumed' and attacked. **'Assumptions'** to the detriment of the patients and persons with clearly visible disabilities, in this case, are a recurring theme in this response.

As I pointed out above, even when I explained we were exempt under HCS-267, she smirked and in a derisive tone spat *"Really, all three of you? Prove it!"*. In what world, especially in health care, addressing visibly disabled persons, does this constitute **"inquire"**?

To be frank, based on her aggressive and discriminatory behaviour, I am not inclined to believe this response. This item may need to be referred to the College of Nurses for resolution.

*"The DI team is quite large, and it was not anticipated that you would have encountered **this person**."*

The waiting area is between the main entrance and the working areas so it is highly likely any member of staff going for a break or to another area would encounter us. I am very familiar with this area due to many procedures prior to COVID from multiple thoracentesis, CT scans, and even a complex ultrasound-guided percutaneous drainage procedure. This clear attempt at a deflection is not acceptable. What is even more disturbing is the reference to ***"this person"***. Should we *'assume'* that this is not an isolated incident with this staff member? There should be **NO PERSON** in AHS's employee who is a concern interacting with **anyone** let alone **a disabled person** such as [Redacted] and myself.

Note that the staff member mentioned here walked past me **twice** afterwards going through the main entrance door to get to another department or go on a break, as mentioned earlier. So, again, how were we **not** expected to come in contact with ***"this person"***, or any other member of staff during our time at the hospital? And why would that even be a concern?

"Please be assured that there were no COVID positive people in that area."

Based on the AHS back to work policy where symptomatic staff get to 'hide behind the mask' after 5 days, as long as *'symptoms are improving'*, how can you make this statement?

https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-return-to-work-guide-ahs-healthcare-worker.pdf
*"you must be work restricted for **5 days** after onset of symptoms, or **until symptoms have improved** AND you have gone 24 hours without a fever, without the use of fever-reducing medications"*

Recently, in [Redacted]'s care home a member of AHS staff, working directly outside [Redacted]'s room and handling residents' food daily was symptomatic for over two months, hidden behind her mask.

10. *"The quality of the images are due to the patients imaging [Redacted], in other words **[Redacted]**"*.

I am having a hard time processing that this statement would have been written down in this response. Effectively, this is nothing less than an attempt at [Redacted] stroke patient in an attempt to excuse the issues created above. Please note that this response was not mentioned by the sonographer at the time. This statement is not just inaccurate, it is deplorable. The sonographer mentioned difficulty moving [Redacted] due to the stroke, which is not *[Redacted]*.

"Though challenging, adequate images were obtained to confirm left ventricle function and

assessment of wall motion."

The responses here and the report to [Redacted]'s doctor do not appear to align. Why mention *[Redacted]* to excuse a bad scan then state the scan was adequate for purpose (contrary to [Redacted]'s doctor's findings in the report he received)? From the actual report to the explanations to the apologies and excuses at the time by the technologist, the impression is such that a repeat of the same procedure is urgently required. As explained above, the result of that is further appointments for a repeat ultrasound and urgent consult request with a Cardiologist. However, this letter suggests that may be unnecessary. If that report was updated, we will need to know immediately, as will [Redacted]'s doctor.

Further, based on the [Redacted] comment, what would be the point of repeating the ultrasound if [Redacted]'s "*[Redacted]"* is such an obstacle? It is a good job that this isn't a reality in my personal experience, or I would never have been able to have any scans completed since my disability from a police injury on duty many years ago.

11. This last paragraph is nothing less than horrifying. Apart from contradicting the actual AHS Directive that does not require masking patients or DSP's, the following statement is abhorrent.

    *"We have asked the screeners to **produce a visual cue like a sticker** for patients who have been screened but are not wearing masks."*

    Maybe a yellow badge or pink triangle would be something they could consider. Apart from the distressing historical connotations of this suggestion, this would only enhance the discrimination which is not being caused by anything other than the willful ignorance and distressing discriminatory bias of AHS staff as regards the written AHS Directive HCS-267.

    In closing, I would like definitive assurance that the issues raised around masking are to be addressed at an organizational level immediately. Once this is completed, it needs to be communicated in a way that the public in general can trust that this active discrimination has been stopped. Anyone found in breach of the AHS directive or Human Rights must be dealt with accordingly.

    *"I encourage Mr. Dickson to continue giving **as much notice** to the department as possible that he and or his family members will be coming and have exemptions in place."*

    This **IS NOT** and **WILL NEVER** be an appropriate response from an organization that provides **EMERGENCY MEDICAL SERVICES**!

For your information, I am attaching a redacted response made earlier to an overlapping complaint for the RAH. This contains information that will provide additional context. *[note this has been left out of this redacted copy as it is already available].*

We look forward to your prompt response.

David Dickson
Karen Dickson

See related:
https://dksdata.com/PatientRelations/letter-RAHPhy_Redacted.pdf

https://dksdata.com/PatientRelations/letter-Kaye_Redacted%20ops.pdf
https://dksdata.com/PatientRelations/letter-PS_Redacted.pdf
https://dksdata.com/PatientRelations/letter-kaye%20phy_Redacted.pdf