LAKE OF THE WOODS DISTRICT HOSPITAL

LWDH Operational Review
Final Report Recommendations and Action Plan

Updated: February 7, 2020

COMPLETED	RECENTLY UPDATED	EVALUATED BUT NOT SUPPORTED	IN PROGRESS	NOT YET STARTED

	#	Recommendation	Priority Level High, Medium, Low, Evaluated but Not Supported	Person Responsible	Target Implementation Date	Extra Notes or Rationale if Not Implemented	Actual Implementation Date
Section 2.8	1	The CFO should ensure that sufficient operating credit facilities are in place, and approved by the Board and LHIN as required, to manage the anticipated negative working capital in 2017/18.	High	C. O'Flaherty	6/1/2018 Completed	Line of credit of $1.5M available with ability to expand it with bank as needed.	1-Jun-18
	2	The CEO and CFO should develop a maintenance and capital renewal plan sufficient to ensure that the hospital equipment and facilities meet the needs of the population served by LWDH.	High	CEO and C. O'Flaherty	June 30, 2019	The space review has been completed. There will be a realignment of outpatient services to the 4th floor which includes the relocation of Dialysis and Visiting Specialist Clinics to this floor; Telemedicine will be relocated to the 3rd floor; additional storage is being created on 3E; the beds are being reorganized on 2E to provide for a more efficient utilization of staff and space; spaces are being refreshed with new paint and updated furniture; multi-purpose spaces are being created to meet the needs of the departmental staff and physicians.	Dec-19
	3	The Medical Staff Association should immediately elect officers to both provide leadership to the MSA and represent the Physicians on the Board of LWDH.	High	MSA	Completed	President and Vice President of Medical Staff have been re-elected.	15-Feb-18
	4	The Board of Directors should implement a new governance model aligned with leading practice as outlined in the OHA Guide to Good Governance, 3rd Edition and relevant legislation in the Ontario hospital sector that includes the following three components: - Board and individual director accountabilities, roles, and responsibilities; - Board structures; - Board processes.	High	Board of Directors	Complete new model implementation by December 2018	The hospital Board has implemented a new leading practice governance model. New Standing Committees and Ad-Hoc Committees were approved in November. Committee Chair and membership appointments were made in December. A Board Charter was approved in September and establishes the governance framework and philosophy. OHA Guide to Good Governance was referenced for all governance changes.	Nov-19

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Section 3.1	5	That the Board of Directors consider amending Article 4.01(a) to increase the number of elected Directors from 9 to 12 to facilitate the annual rotation of Directors as required by the PHA, succession planning within the Board, and a more balanced distribution of Standing Committee assignments among the elected Directors.	High	Board of Directors	June 13, 2019	By-law re: number of elected Directors from 9 - 12 was Board approved (Feb 14, 2019) and approved at the Annual General Meeting in June. Had a lot of interest in vacant Board positions this year with 15 applications received.	13-Jun-19
	6	That the Board of Directors reduce the number of Standing Committees to align with its defined responsibilities, establish revised Terms of Reference and canvass all Directors for expression of interest in assuming Committee leadership and membership positions.	High	Board of Directors	1/1/2019 Completed	Terms of Reference for Board Standing Committees were approved at December's Board Meeting. Standing committee membership and Chair positions were approved at January's Board Meeting.	10-Jan-19
	7	That the Board of Directors operationalize its current by-law provision 8.03(g) to recruit non-Director members to selected Board Standing Committees to acquire additional skills and expertise as may be required and to serve as a potential pool for recruitment of future Directors.	High	Board of Directors	January 1, 2019	The following membership changes have been made to the Board's Standing Committees: Audit and Finance Committee: One (1) member at large with financial expertise; Quality Committee of the Board: Three (3) community members and one (1) member from the Patient and Family Advisory Committee; Community Engagement Committee: One (1) community member; and Patient and Family Advisory Committee: Nine (9) community members, one of whom co-chairs the committee.	21-Mar-19
	8	That the Board of Directors amend Section 6.01(b) to limit the position of the CEO to Secretary of the Board. In the event that the Board wishes to have a Treasurer, this should be an elected member of the Board. Alternatively, if the Board does not wish to have a Treasurer, the administrative and operational functions to support the Boards responsibility for financial oversight should be assigned to the Chief Financial Officer.	High	Board of Directors	Dec. 2018 Completed	Recommendation is fully supported by leadership. C. O'Flaherty, VP Corporate Services and CFO, is the Interim Treasurer until the Board recruits a Board Director with strong financial literacy. This was affirmed at the Annual General Meeting in June.	12-Dec-18

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9	That as a priority pending the completion of new Board policies, the Board of Directors establish clear and transparent processes for: - Succession planning of existing Directors to assume leadership positions within the Board including Board Officers and Committee Chairs; - Annual evaluation of the performance of the Board as a whole and individual Directors and Board Officers.	Medium	Board of Directors	September 12, 2019	Agreed that Board officer succession will be articulated in new governance model and policies; committee chairs and Board officers need to be factored into Board succession planning	
10	That pending the completion of new Board policies, the Board of Directors establishes clear and transparent processes for comprehensive annual evaluation of the performance of the CEO.	High	Board of Directors	December 31, 2019	Target Q3 September to review committees and get them to agree to what the evaluation process will be for the CEO. Will then be implemented with the first appraisal complete by the end of the calendar year.	
11	That pending the completion of new Board policies, the Board of Directors establishes clear and transparent processes for comprehensive annual evaluation of the performance of the Chief of Staff.	High	Board of Directors	December 31, 2019	Target Q4 to outline the evaluation process for the Chief of Staff.	
12	The Board of Directors initiate the development of a new strategic plan to best position LWDH within the LHIN and sub-LHIN region.	High	Board of Directors	Q4 2019/20 planning June 2020 approval	Agreed. Strategy for generating new strategic plan will be discussed with the Board in Q3 2019. As noted in recommendation #13 and #22, as well as intent to improve engagement with staff, engagement must inform drafting of plan and will impact timing.	
13	The CEO and COS should develop and implement a formal ongoing multifaceted physician engagement strategy, the goal of which is to ensure LWDH physicians come to recognize that the Administration genuinely seeks a partnership with them, a partnership that will allow them to have a voice in policy and strategy development and implementation, and meaningful input into decisions with clinical implications.	High	CEO and Dr. J.K. MacDonald	10/31/2018 Completed	President and CEO now attending Medical Staff and Medical Advisory Committee Meetings and participating in physician recruitment and service planning/service issue discussions.	Oct-18
14	The CEO and Board of Directors should ensure that a commitment to full physician engagement is consistently expressed in internal and external communications.	High	CEO and Board	10/31/2018 Completed	Commitment has been made to physician engagement. The vote of non-confidence has been rescinded as per letter dated July 19, 2018.	19-Jul-18

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Section 3.2	15	The CEO and COS should identify and enlist the support of a temporary "guiding coalition" of credible physicians in Kenora with whom LWDH can work during the transition period. The CEO and COS should work with this Guiding Coalition, to put a process in place to create an effective Medical Organization Structure and implement a strategy to improve the culture and relations between Administration and the Medical Staff.	High	CEO and Dr. J.K. MacDonald	9/30/2018 Completed	Guiding Coalition formed and had their start-up launch meeting on December 10, 2018.	24-Oct-18
	16	The COS and Board of Directors should ensure that Chiefs / department heads are in place in the areas of Emergency, GP Extender / Internal Medicine and Surgery (at a minimum) to advise the MAC with respect to the quality of care (as required by the Public Hospitals Act).	High	Dr. J.K. MacDonald	30/5/2020	Special meeting of Professional Staff was held November 7th to review proposed new model. The model was supported. The Board reviewed the new model at their meeting held December 12, 2019 and supported proceeding with implementation. The Professional Staff was informed of the new model proceeding with implementation and were invited to submit an application to become a service lead (which is the name we are using for these service leadership roles).	
	17	The COS and MAC should establish a clear and transparent processes for comprehensive annual evaluation of the performance of the Medical Chiefs.	Medium	Dr. J.K. MacDonald and MAC	March 31, 2020		
	18	The CEO and COS should evaluate the LWDH approach to Clinical Quality to ensure that it fully aligns with Corporate Quality and is effectively reported to the Board as required under the PHA.	Medium	CEO and Dr. J.K. MacDonald	March 31, 2020		
	19	The CEO and COS, in partnership with the MOHLTC and the OMA (as required) should review / re-visit each AFP, ensuring that each is constructed in a fashion that fully supports LWDH and its responsibilities to its patient population.	High	CEO and Dr. J.K. MacDonald	June 30, 2020		
	20	The COS should report annually (at a minimum) to the Board on each AFP / APP and specifically on the status of the hospital obligations contained in each.	High	Dr. J.K. MacDonald and C. O'Flaherty	December 12, 2019		

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Section 3.3	21	The CEO and Board of Directors COS should develop and implement a formal communication strategy with its health partners and the community about the operational review and its outcomes.	High	CEO, BOD, COS	Ongoing	The operational plan is being progressively implemented. Milestone achievements and planning targets are displayed in the public area of the hospital. Local discussions are proceeding at the staff level on recommendations pertaining to their areas. The Hospital will provide updates on the operational review at all public forums going forward. We will be communicating it through website and social media.	31-Jan-19
	22	The Board of Directors should include health partners and the community in the recommended development of a strategic plan for LWDH to ensure that issues of inclusiveness, transparency and trust and collaboration / integration are addressed.	High	BOD	Q1 2020 engagement and consultation phase		
Section 4.4	23	The VP Mental Health and Addictions should work with the LHIN and agree to report the psychiatric bed capacity that is actually available at the hospital.	High	B. Siciliano/C. O'Flaherty	6/30/2018 Completed	Bruce Siciliano and Denise Forsyth met with the LHIN on August 1, 2018 to officially inform them that the official Schedule 1 bed capacity is 17 beds.	15-Jul-18
	24	The VP Mental Health and Addictions should work with the LHIN to review the available mental health bed configuration to ensure that both appropriate capacity and facilities are available to meet the needs of the population served by LWDH.	Medium	B. Siciliano	6/1/2020 In Process	LWDH continues to meet on an ongoing basis with TBRHSC, SJCG, and the Northwest LHIN to discuss and to implement intermediate and long-term solutions, which will underpin a new model of psychiatry for Northwestern Ontario. A Regional Mental Health Design Event, (coordinated by these three hospitals, (on April 10th, 11th, and 12th), achieved an agreement that the 30 beds in In the Thunder Bay District and the 14 functional beds in the Kenora / Rainy River District would become “Regional Beds.” A new single point of access model for inpatient psychiatry is slated to be piloted commencing May 21, 2019. Also from this Design Event, an agreement in principle was reached whereby we would advocate as a region for SLMHC to become a 5 bed inpatient Schedule 1 Unit. On April 25, 2019 LWDH met with the MOHLTC to commence a review of the LWDH Psychiatry Alternate Payment Plan Agreement and to discuss opportunities from that agreement by which a Regional Model of Inpatient / Outpatient Psychiatry could be funded.	

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Section 5.1	25	The VP Corporate Services & Chief Financial Officer should work with the LHIN and agree to report the bed capacity that is actually available at the hospital.	High	C. O'Flaherty	6/30/2018 Completed	Review of bed map completed. Small adjustment to psychiatric bed capacity will ensure all beds are reported accurately.	30-Jun-18
Section 5.4	26	The CEO should request, and the North West LHIN should support, the formal re-designation of 10 LWDH acute beds to Chronic beds. This should be done in conjunction with recommendation 43 (section 6.3) to review the entire bed map at LWDH to identify a bed configuration that will best meet the needs of patients.	Evaluated but Not Supported			Due to physical space and unit configurations, there is no capacity to adjust staffing levels and will not result in any savings. The bed map will be reviewed to determine whether the current service distribution is still appropriate from a quality, safety and fiscal perspective.	
	27	The North West LHIN, to support the implementation of its Rehabilitation and Complex Continuing Care Capacity plan, should ensure that Kenora residents have as equitable access to inpatient rehabilitation beds as residents of Thunder Bay.	Medium	D. Makowsky	June 1, 2019		
	28	LWDH should reduce legal fees by $100,000.	Medium	Senior Management	March 31, 2020	The hospital was on track to reduce legal fees until the hospital received notice that a delay claim was being levied by the general contractor for the surgical suite redevelopment project. The hospital has incurred legal fees for mediation discussions and will be proceeding to arbitration on the matter. Significant expenses have also been incurred by a disciplinary issue creating credentialing changes to an active physician.	
	29	The VP, Corporate Services and Finance should undertake a strategic review of Transcription Services, as well as considering a regional approach to transcription services.	Low	C. O'Flaherty	March 31, 2020	The transcription software was upgraded in July, 2019. There is on-going review of transcription services within the hospital and consideration of new software to improve the efficiency of this service.	
	30	The VP Corporate Services should either recruit a Manager of Plant Operations and Maintenance or establish a shared management service with another hospital for these services.	High	C. O'Flaherty	March 31, 2019	Hiring of Manager of Plant Operations and Maintenance has been completed.	3-Jun-19

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Section 6.2	31	The VP Corporate Services should realign the reporting of the Biomedical Engineering Department to Plant Operations and Maintenance.	High	C. O'Flaherty	April 1, 2019	The management of the Biomedical Engineering Department will remain under the Information Technology Department. A review of other hospitals was conducted and it was determined that the management varies. It was determined that it is best aligned with IT Dept. due to the nature of the equipment being serviced as well as the ability to remain patient focused.	
	32	The Manager of Finance and Manager of Housekeeping should ensure that all costs are being recovered for externally provided laundry services.	High	C. O'Flaherty	April 1, 2019	The managers of Finance and Environmental Services have reviewed the rates charged for laundry services and adjusted rates accordingly.	30-Jun-19
	33	The CEO should initiate a plan to provide appropriate on-site security services.	High	CEO	July 1, 2019	GardaWorld has been hired to provide a contracted security guard to the hospital. Limited service began on August 3, 2019, with expansion of service on August 19, 2019. It is anticipated that 24/7 coverage will be provided by the end of Q3 2019.	3-Aug-19
	34	The VP Corporate Services and Manager of Food Services should undertake a review of food services and develop a plan to reduce costs and/or increase revenues by $173,000 and achieve the peer median performance level of $51.23 per patient day.	High	C. O'Flaherty	9/30/2018 Completed	Cost savings for the department are significant due to process changes for nourishment supplies to the wards, a revised schedule for staff along with revised duty routines, the redeployment of 1.0 FTE dietary aide as of September 24/18, the discontinuation of meals to the clients of Pinecrest's Meals on Wheels program, as well as a change to a one-week menu for hospital patients. The cafeteria has implemented new menu offerings as well as new payment options, both of which have resulted in increases in revenue. The vending selections have also been enhanced, which has resulted in increased revenue. Further system improvements are being investigated for opportunities for cost savings and revenue enhancement.	30-Jun-18
	35	The VP Patient Care and the Manager should ensure a process to transition the Hospital Attendant Role to a PSW role.	Medium	D. Makowsky/Managers	March 31, 2020		
	36	The VP Patient Care and the Manager for the 3E should develop and implement a plan to achieve median productivity performance of 6.1 worked hours/patient day.	Medium	D. Makowsky	March 31, 2020	KPI to be developed for nursing departments for monitoring productivity.	
	37	The VP Patient Care and the VP Corporate Services Manager should ensure that nurse manager hours are reported or divided between all the units/departments that the manager covers.	High	D. Makowsky/C. O'Flaherty	6/30/2018 Completed	New cost distributions developed and applied	30-Jun-18

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38	The VP Patient Care and the Manager for 2E should temporarily continue a staffing rotation that includes the hours of RPN that were added in 2017.	High	D. Makowsky/S. Grafham	6/1/2018 Completed		1-Jun-18
39	The VP Patient Care and the Manager for Birthing Services should explore and implement a process for cross training with surgical services rather than the medical service.	Medium	D. Makowsky/B. Winstanley/S. Grafham	December 31, 2019	Obstetrical staff currently assisting with Day Surgery Stay patients. Awaiting outcome of recommendation #43 prior to formalizing an orientation plan.	
40	The VP Patient Care and the Manager for Birthing Services should implement as soon as possible an agreement and process with a high volume obstetrical service to provide delivery experience for new staff as part of a retention strategy.	High	D. Makowsky/S. Grafham	6/30/2018 Completed	Agreement with Trillium-Credit Valley Hospital in Mississauga, a high volume centre to facilitate clinical placements for our staff.	Jun-18
41	The VP Patient Care and the Manager for Birthing Services should conduct an evaluation of the amalgamation of obstetrics and Medicine to determine what possibilities exist to ensure that improvements in the service can be made and determine what can be done to reduce risks that are apparent in the current situation.	High	D. Makowsky/S. Grafham	June 30, 2019	Indicators developed to evaluate the amalgamation of Obstetrics and Medicine. Indicators being monitored. Preparation for participation in an Accreditation Canada survey in Oct 2019, participation in the MOREOB program, development and utilization of Patient Order Sets, and Staff training supports Quality improvement. Feedback on identified risks are responded to. I.e.: review of unit admission criteria, movement of clients off unit when risk identified, staff recruitment, movement of doors to Obstetrical unit, key pass addition to Obstetrical door, etc.	
42	The CEO and VP Patient Care should develop a process to improve communication and collaboration across care areas.	High	CEO/D. Makowsky	December 31, 2019		
43	The CEO and VP Patient Care should develop a process to review the entire bed map at LWDH to identify a bed configuration that will best meet the needs of patients. This should be informed by the utilization data presented in chapters 4 and 5 and in conjunction with recommendations 26 and 27, Section 5.4.	Medium	CEO/D. Makowsky	December 31, 2019	A Bed Map review committee was formed with representation from front line Staff and Managers from 3E, ICU, 2E, Maternity and Surgical Services. Also participating on the Committee is a Physician representative, and the Executive Team. After reviewing four options for addressing space concerns, a preferred option of signed off by staff on October 31, 2019.	
44	The VP Mental Health and Addictions and the Manager Mental Health Services should evaluate the role of Hospital Attendant and RPN to determine the best role for patient care on this unit.	Medium	B. Siciliano	10/30/2019 In Process	As conversations continue to progress with TBRHSC, SJCG, and the Northwest LHIN, with respect to a new model of psychiatry for Northwestern Ontario, this will also assist in evaluating the new role of the Hospital Attendant and RPN.	

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Section 6.3	45	The VP Mental Health and Addictions and the Manager Mental Health Services should evaluate the ratio of full-time to part-time staff to assist in recruitment.	Medium	B. Siciliano	10/30/2019 In Process	On August 1, 2018 Bruce Siciliano and Denise Forsyth reviewed our current staffing complement with the LHIN. Discussions will continue related to staffing ratio and increased funding for any additional staffing.	
	46	The CEO and the VP Mental Health and Addictions should work with the LHIN to review the accessibility to and potential need for Child and Adolescent psychiatric capacity and the potential ability for LWDH to meet such demands.	High	CEO/B. Siciliano	10/30/2019 In Process	Regional Schedule 1, St. Joseph's Care Group, and the NWLHIN meet every two (2) months. This recommendation is a recurring agenda item. 02/26/2019 progress update: Bruce Siciliano, Denise Forsyth, and Dr. Usama Zahlan met with the LHIN, TBRHSC, and St. Joseph's Care Group on August 1, 2018. During this meeting, it was acknowledged that LWDH does not have the capacity or facilities to appropriately accommodate youth with serious mental illness. TBRSC is currently working with the MOHLTC to support several child psychiatrists to serve the LHIN 14 catchment area. During this meeting the LHIN was informed that LWDH provided 270 days of patient care to 51 patients, between 15-17 years of age for the 17 / 18 fiscal year. Discussions will continue with LWDH Senior Management, TBRHSC, SJCG, and the LHIN on this matter. 04/29/2019 UPDATE - OBTAIN FROM BRUCE	
	47	The CEO and the VP Mental Health and Addictions should investigate with the LHIN the requirements for both youth and adult crisis response capacity.	High	B. Siciliano/LHIN	September 30, 2019	In August 2019 LWDH met with a contingency of cross-sector service providers to discuss the creation of a new after-hours community-based mental health mobile crisis response service for the Kenora area. The mobile crisis response service will serve both youth and adults. The current model is a contingency service (due to the earlier collapse of a regional service model) provided by an LWDH Mental Health Therapist, Nurse, and Physician within the Emergency Department. This contingency plan was originally planned to run from April 1st to September 30th, 2019 but has been extended to Nov 30, 2019 to provide timing for a new model to be implemented. The vast majority of work during the contingency period has involved suicide risk assessment and safety planning. Over the period of April – Aug 2019 113 patients have been served in the after-hours period.	

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	48	The Manager for the ED should develop and implement a plan to achieve median productivity performance of 1.2421 worked hrs/equivalent visit.	Medium	C. Tycholiz	March 31, 2020	Minimally staffed at night; may get efficiencies during the day. Manager will continue to monitor time of day volumes to see where the greatest volume is. This will help decide if schedule change or shifting of hours would be required. KPI to be developed for nursing departments for monitoring productivity.	
	49	The CEO and VP Nursing should work with the NW LHIN to secure permanent funding for the General Ambulatory Clinic.	High	CEO/D. Makowsky	September 1, 2019	Has been discussed with LHIN but LHIN unable to approve. Will be part of a base funding appeal by LWDH to the Ministry in Q3 2019.	
	50	The VP Patient Services should develop a process to eliminate the presence of the nursing supervisor on days.	Low	D. Makowsky	3/31/2020 Completed	Looked at saving on manager salary instead. Management position was eliminated as of July 12, 2018. Patient management work re-distributed to Day Shift Supervisor.	12-Jul-18
	51	The VP Patient Service and VP Corporate Services should ensure that hours for Unit Producing Personnel (UPP) recorded in Nursing Administration, are instead recorded where the associated staff are working.	High	D. Makowsky/C. O'Flaherty	6/30/2018 Completed	Looking at redistribution of wages of NRT to nursing functional centres.	30-Jun-18
Section 6.4	52	The Laboratory Manager should undertake a review of workload collection practices and ensure that workload is collected accurately and comprehensively.	Medium	L. Hoppe	3/31/2019 Completed	Lori reviewed the lab recommendation and indicated that it was a limitation of Meditech that created the comment by the auditors. Verification of workload management system was undertaken and confirmed that system is current with standards.	30-Jun-18
	53	The Diagnostic Imaging Manager should undertake a review of workload collection practices and ensure that workload is collected accurately and comprehensively.	Medium	A. Schussler	3/31/2019 Completed	A. Schussler reviewed the workload for DI and it was discovered that transport and Isolation units were not counted . A report will now be generated and submitted to Finance to ensure workload is being properly collected and reported.	30-Jun-18
	54	The Diagnostic Imaging Manager should develop and implement a plan to achieve median productivity performance of 0.0360 worked hours per Patient Care Workload Unit.	Medium	A. Schussler	June 30, 2019	04/29/2019 progress update: statistics will be reviewed for 2018/19 to evaluate productivity performance. Utilization of service will also be reviewed during the next quarter.	
	55	The Diagnostic Imaging Manager should investigate an integrated PACS with the other NW Ontario hospitals.	Medium	A. Schussler	March 31, 2020	Integrated PACS is being investigated with a final report pending. Is on the Capital List for 2020/2021.	
Section 7.1	56	The CEO and VP Patient Services should immediately establish a Perioperative Executive Committee (PEC) with representation from surgery, nursing, and anesthesiology and a mandate to manage perioperative resources, enforce policies, resolve conflicts, and act as the executives of the surgery program.	High	Donna/CEO(incoming)/Surgical Services Committee or PEC	12/31/2018 Completed	Committed to meet initially every two (2) weeks	10-Jan-19

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Section 7.2	57	The VP Patient Services should relocate the office of the Manager, Surgical Services and MDRD to be proximal to the OR, and ensure the manager has significant visibility and interaction with the perioperative staff.	High	Donna/Blair	Renovation completion or sooner if possible Completed	Surgical Services Manager's office permanently relocated to 2nd floor near the OR.	12-Jul-18
	58	The VP Patient Services should require that the role of Manager, Surgical Services and MDRD implements: - Weekly staff meetings / in-services; - Daily Huddles; and - Daily rounds.	High	Blair w/ feedback from front-line staff	Completed	Daily huddles q a.m. Informal staff meetings every 3rd Thursday, in-services all other Thursdays. Blair checks in with the charge nurse daily at 1400.	24-Apr-18
	59	The VP Patient Services and Manager, Surgical Services and MDRD, should redefine the OR Team Leader role to be that of a Control Desk Coordinator, and develop daily functions and expectations for this role to ensure consistency and reliability to ensure proper and efficient flow of patients throughout the perioperative process, and troubleshoot when issues arise.	High	Donna/Blair/Debbie	June 30, 2019	Revisions to the Team Lead job description are complete. Since the Educator role was embedded in the Team Lead job description, a separate Flow Coordinator role/duties will be developed. As with Scrub, Circulating, and Recovery Room assignment, the Flow Coordinator would be assigned within the Surgical Services staff	8-Jul-19
	60	The VP Patient Services and Manager, Surgical Services and MDRD, should eliminate the co-manager role.	High	Donna	Completed	Completed. Position has been eliminated.	24-Apr-18
	61	The VP Patient Services and the Manager, Surgical Services and MDRD should target median performance of peer hospitals to achieve 5.8 worked hours per case.	High	Donna/Blair/Surgical Services Committee or PEC	March 31, 2020	Performance is determined by total number of cases divided by worked hours. Would have to first make quality improvements and measure over time. Finance is currently building reports to assist us with tracking.	
	62	The VP Patient Services and the Manager, Surgical Services and MDRD should consider booking endoscopy and dental cases on specific days, and change the staffing compliment to match the industry requirement.	High	Donna/Blair/Surgical Services Committee or PEC	Potential Endoscopy and Dental slate (booking on specific days) Sept 2018; Research of staffing industry requirements October 2018 Completed	Industry standards were investigated. When endoscopy services are offered out of an operating room, the staffing levels remain at the operating room required level. Other hospitals in the Region follow the same practice. The comparators listed in the Operational Review are specific to endoscopy suites located outside of an operating room, where practice standards are different.	Sep-18
	63	The VP Patient Services and the Manager, Surgical Services and MDRD should formally change the RPN position performing booking and pre-surgical testing from 0.6 FTEs to 1.0 FTEs.	High	Donna/Blair/Human Resources/Union	Decisions re: posting as soon as possible Completed	Created and filled a 0.4 PT to make coverage a total of 1.0 FTE	24-Sep-18

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Section 7.3	64	The VP Patient Services should consider the development of a perioperative educator role to support all areas in the perioperative environment including OR, pre-op, PACU, and MDRD.	High	Donna/Blair in collaboration with staff and clinical educator.	Tabled; Revisit in October. Completed	The peri-operative educator role was incorporated into the Team Lead job description.	19-Mar-19
	65	The VP Patient Services and Manager, Surgical Services and MDRD, should develop a competency-based orientation program for all perioperative areas.	High	Sonia completed; Donna/Blair to review	March 31, 2019 Completed	Peri-Op 101 is used to train new staff in the OR. The Team Lead will facilitate the in-house training fro new staff in the OR. We have specific skills checklists developed for the OR, Pre-op clinic, and PACU. The Team Lead will assist with routine education so staff can maintain skills and competencies, and familiarity with OR specific equipment.	31-Mar-19
	66	The VP Patient Services and Manager, Surgical Services and MDRD, should review standards of practice in all areas and develop qualification standards for staff to perform competently in those areas (i.e. ACLS for all nurse who rotate through PACU).	High	Donna/Blair in collaboration with staff, union and clinical educator.	ACLS - March 31, 2019 (fiscal year end); Standards of Practice review is ongoing.	Surgical Services Committee strongly supports having OR nurses ACLS trained. 04/29/2019 update: all permanent staff have attended an ACLS course; monitoring of certification and recertification will be ongoing.	Apr-19
Section 7.4	67	The VP Patient Services should charge the Perioperative Executive Committee with the development of policies defining the scheduling process, schedule administration, and block schedule management and utilization.	High	Donna/Blair/Surgical Services Committee or PEC/Pre-Op Clinic	March 31, 2020		
	68	The Manager, Surgical Services and MDRD, should develop an urgent emergent policy and case classification system.	High	Donna/Blair/Surgical Services Committee or PEC	10/1/2018 Completed		10-Jan-19
	69	The Manager, Surgical Services and MDRD, and the OR Team Lead should establish a daily huddle to review the next day's surgery slate, and to review the schedules of cases five days out.	High	Blair/Debbie in collaboration with staff	9/1/2018 Completed	Established daily huddles	13-Nov-18
	69				September 1, 2019	Still working on review of cases up to five (5) days out. Will need to have booking policies in places	
	70	The Manager, Surgical Services and MDRD, should charge the OR Team Lead role with primary responsibility for managing efficiency and patient flow throughout the OR, with the visible support of the Manager.	High	Blair/Debbie/OR staff/Surgical Services Committee	March 31, 2019	A separate Flow Coordinator role & duties has been developed and implemented.	8-Jul-19

	#	Recommendation	Priority Level High, Medium, Low, Evaluated but Not Supported	Person Responsible	Target Implementation Date	Extra Notes or Rationale if Not Implemented	Actual Implementation Date
	71	The VP Patient Services and Manager, Surgical Services and MDRD, should develop an online patient questionnaire to provide patients with the opportunity to pre-fill out required information prior to the telephone screening, thus creating a verification process versus an information collection process.	Medium	Donna/Blair/Anesthesia/Surgeons	March 31, 2020	We have to research feasibility for our community.	
Section 7.5	72	The Manager, Surgical Services and MDRD, should implement use of the ORM preference card module, and utilize that module to plan resources, pick cases, intraoperatively record items used/develop a bill of materials, and perform case costing.	Low	Blair/Donna	April 1, 2019	Requested demo from Meditech. Noted that TBRHSC is the only regional hospital to use this module. There is a cost to implement the module, we would have to apply for funding. 04/29/2019 progress update: TBRHSC finds little value in this module, no funding available to implement.	
	73	The Manager, Surgical Services and MDRD, should proceed with the plan to implement an exchange cart system for OR theatre supply replenishment.	High	Blair	10/1/2018 Completed	Case carts now being picked up by MDRD to improve efficiency.	2-Jan-19
	74	The Manager, Surgical Services and MDRD, should ensure that stores items amalgamated during construction should remain in one location, to minimize inventory and decrease restocking of multiple locations.	High	Blair	June 30, 2019	Stock and inventory review complete. All unissued inventory will be kept permanently in Stores. Only Operating Room specific supplies will be kept in MDRD. As we move toward barcoding supplies, the process for stocking the units and unit inventory is also under review and a LEAN exercise has taken place.	30-Jun-19