

# ***Best Practices Review***

***Western Health Care Corporation***

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February 10, 2005

**HayGroup**

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## 6.0 Operations Analysis

Pressures to manage operating costs are challenging health service organizations to find new ways of doing things, while at the same time demanding that service quality be maintained and even improved. Service delivery is composed of three integrated components, as follows:

- Human Resources – staffing, organization, competencies, training and education
- Technology - “tools” used in delivering services (information systems, equipment, etc.)
- Process - methods and organization of how services are delivered.

One of the principal objectives of the ‘Best Practices Review of WHCC has been to identify potential opportunities where WHCC could improve the efficiency and cost effectiveness of its sites, services and functional centres.

### *On-Site Interviews and Observations*

On-site reviews and interviews were conducted in the following sites:

- Hospitals:
  - Western Memorial Regional Hospital
  - Sir Thomas Roddick Hospital
- Health Centres:
  - Calder Health Centre
  - Dr. Charles L. LeGrow Health Centre
  - Bonne Bay Health Centre
  - Rufus Guinchard Health Centre
- Long-Term Care Facilities:
  - Bay St. George Long Term Care Centre
  - Dr. J. I. O’Connell Centre
  - Interfaith Home for Senior Citizens

related to the following service areas:

- Special Care Areas (ED, ORs, PARRs, CCUs)
- Acute Care Nursing Units
- Long-Term Care Nursing Units
- Community Services

- Therapeutic Services
- Diagnostic Services
- Support Services
- Administrative Services

Functional centers and sites were visited when there was a reasonable expectation of achieving improvements in operating efficiency or when there were concerns that low staffing levels might be having a deleterious impact on service quality. The areas of focus during the on-site reviews were:

- Management processes
- Operations and procedures
- Inter-departmental coordination and processes
- Inter-site coordination and processes
- Facilities, Equipment and Supplies
- Productivity Review
- Opportunities for improvement, including redesign or reengineering of work processes, alternative service delivery approaches, improved use of information technology, etc.

The degree and magnitude of improvements in productivity and reductions in cost that the functional centres could achieve were determined through these on-site interviews, and observations and through follow-up data analyses and comparisons with the performance of peer hospitals and health care organizations.

***The performance of WHCC functional centres was compared to the performance of a peer comparator group consisting of Newfoundland and Labrador and Canadian hospitals and health regions.***

For purposes of this review it was agreed by the project's Steering Committee that the performance of the WHCC hospitals, health centres and functional centres would be compared against a peer comparator groups<sup>41</sup> comprised of the following Newfoundland and Labrador and Canadian hospitals and health regions:

- Comparators for Western Memorial Regional Hospital
  - Central Newfoundland Regional Health Center

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<sup>41</sup> Where organizational size might impact on productivity of a functional centre, comparators within the subgroups were employed. Where organizational size was not thought to be important to achievable productivity performance, the entire set of comparators was used in developing the range of peer performance.

- Carbonear General Hospital
- James Paton Memorial Hospital
- Ajax & Pickering General Hospital, Ontario
- Brantford General Hospital, Ontario
- Cambridge Memorial Hospital, Ontario
- Guelph General Hospital, Ontario
- St. Mary’s Hospital, Kitchener, Ontario
- Soldier’s Memorial Hospital, Orillia, Ontario
- St. Thomas Elgin General Hospital, Ontario
- Grey Bruce Health Services, Ontario
- Niagara Health System, Ontario
- Chinook Health Authority, Lethbridge Regional Hospital, Alberta
- Fraser Health Authority: Burnaby Hospital, B.C.
- Fraser Health Authority, Matsqui-Sumas-Abbotsford General Hospital, B.C.
- Interior Health Authority, Royal Inland Hospital, B.C.
- Interior Health Authority, Vernon Jubilee Hospital, B.C.
- Interior Health Authority, Penticton Regional Hospital, B.C.
- Comparators for Sir Thomas Roddick Hospital
  - Burin Peninsula Health Care Centre
  - Charles S Curtis Memorial Hospital, St. Anthony
  - Dr GB Cross Memorial Hospital, Clarenville
  - Stanton Territorial Health Authority, NT
  - Northern Lights Health Region, Alberta
  - Interior Health Authority, Kootenay Boundary Regional Hospital, BC
  - Interior Health Authority, East Kootenay Regional Hospital, BC
  - Interior Health Authority, Kootenay Lake District Hospital, BC
  - Interior Health Authority, Boundary, BC

- Interior Health Authority, South Okanagan General Hospital, BC
- Fraser Health Authority- Eagle Ridge Hospital, BC
- Fraser Health Authority, Ridge Meadows Hospital, BC
- Fraser Health Authority, Delta, BC
- Comparators for Health Centres
  - Bonne Bay Health Centre Norris Point
  - Calder Health Centre, Burgeo
  - Dr. Charles L LeGrow Health Centre, Port aux Basque
  - Rufus Guinchard Health Centre, Port Saunders
  - Strait of Belle Isle Health Care Centre, Flower's Cove
  - Southeast Labrador Health Care Centre, Forteau
  - White Bay Central Health Care Centre, Roddickton
  - Dr Walter Templeman Community Health Centre
  - Fogo Island Hospital
  - Connaigre Peninsula Health Centre
  - Willet Hospital, Paris Ontario
  - Chinook Health Authority, Cardston, Alberta
  - Chinook Health Authority, Pincher Creek, Alberta
  - Chinook Health Authority, Raymond, Alberta
  - Chinook Health Authority, Taber, Alberta
  - Chinook Health Authority, Border Counties, Alberta
  - Chinook Health Authority, Coaldale, Alberta
  - Chinook Health Authority, Magrath, Alberta
  - Chinook Health Authority, Picture Butte, Alberta
  - Interior Health Authority, Creston Valley Hospital, B.C.
  - Interior Health Authority, Elkford Health Care Ctr, B.C.
  - Interior Health Authority, Fernie District Hospital, B.C.
  - Interior Health Authority, Golden & District Gen Hospital, B.C.
  - Interior Health Authority, Invermere & District Hospital, B.C.

- Interior Health Authority, Kimberley & Dist Hospital, B.C.
- Interior Health Authority, Sparwood Healthcare Centre, B.C.
- Interior Health Authority, Arrow Lakes, B.C.
- Interior Health Authority, Slocan Community Hospital, B.C.
- Interior Health Authority, South Similkameen HC, B.C.
- Interior Health Authority, Pleasant Valley HC, B.C.
- Interior Health Authority, Princeton General, B.C.
- Interior Health Authority, Cariboo Memorial Hospital, B.C.
- Interior Health Authority, 100 Mile District Hospital, B.C.
- Fraser Health Authority, Mission Memorial Hospital, B.C.
- Fraser Health Authority, Fraser Canyon Hospital, B.C.

***Each of WHCC's functional centre's performance was compared to peer performance.***

Each of WHCC's functional centre's performance was compared to peer performance<sup>42</sup> in relation to the following parameters of the distribution of peer performance:

- Best quartile Performance Level
- Median Performance Level
- Mean Performance Level
- Worst Quartile Performance Level

The peer performance ranges were developed using each peer organization's reported 2002/03 data in accordance with the Canadian Management Information Systems (MIS) reporting

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<sup>42</sup> The only major exception to this is in Long Term Care. Significant differences in the organization of long-term care services among provinces makes inter-provincial comparisons of productivity in long-term care facilities quite difficult. Nursing home care in WHCC includes care that in other provinces might be considered chronic hospital care, nursing home care and personal care. We have drawn on our experience in working in LTC in other provinces to assess the staff workload relationship in WHCC.



***The best quartile is considered to be a reasonable surrogate for best practice performance.***

***Performance targets have been recommended for each functional centre based on both the comparative analyses and the on-site reviews.***

guidelines.<sup>43</sup> Comparisons of WHCC functional centres performance was primarily based on the WHCC 2003/04 performance as reported to the project team by the hospital<sup>44</sup>.

The best quartile is considered to be a reasonable surrogate for best practice performance and is a reasonable expectation for the level of performance for high performing functional centres in Canadian hospitals and health care organizations. It is generally thought that best productivity performance (the fewest hours/unit of workload) is not a reasonable target for the purposes of this type of comparison and for this type of operational/funding review. (However, it should be noted that many health care organizations are benchmarking and attempting to achieve best practice performance as part of their Continuous Quality Improvement Exercises.) Using the best quartile in place of the best productivity also ensures that the analysis excludes apparently extremely good performance results that might be based on errors in measurement and reporting rather than efficient processes.

The use of the best quartile performance level as the surrogate for best practice *does not imply* that this is the ideal, expected or achievable performance level for WHCC functional centres. In this project we have recommended performance targets for each functional centre based on both the comparative analyses and the on-site reviews<sup>45</sup>:

- For many functional centers we have recommended improvements in levels of performance to achieve best practice.
- In some functional centers there are factors that militate against achieving best practice performance. Poor

<sup>43</sup> While the MIS Guidelines provide a uniform set of reporting guidelines there continues to be vagaries in reporting of workload, staffing and costs among Canadian hospitals. The budget for this project did not allow for reviewing the reporting of comparator hospitals to confirm the accuracy of their data. However, given the number of comparators and the use of the best quartile rather than the 'best practice' performance level, the vagaries in reporting should not have a significant impact on the reasonableness of the performance targets established in this project.

<sup>44</sup> Prior to conducting the comparisons a data review and refinement exercise was undertaken with WHCC staff to address obvious errors/omissions identified in WHCC reported data.

<sup>45</sup> Although the NL DHCS suggests staffing levels for WHCC functional centres, the purpose of this study was to compare WHCC against Canadian 'best practice'. As a result, we have compared the performance of WHCC to the performance of the peer organizations. We have not compared or evaluated the standards established by the department.

facilities, inadequate technologies and low volumes are some of these factors. The suggested/targeted performance levels will leave the functional centre less productive than the best quartile performance level of the comparator organizations.

- In other areas current performance is better than the best quartile performance of the peer organizations. If quality was not an issue, in these functional centers the performance target was set at the current level of performance rather than the best quartile performance level of the peer group.

As WHCC moves forward with the recovery plan opportunities for further improvements in performance may be identified.

Functional centre performance targets and the reported workload were used to determine required staffing or costs. These were compared to the staffing and costs reported by WHCC to determine the potential savings were the organization to achieve the recommended performance targets<sup>46</sup>.

Also, it should be noted that the selected comparators for STRH and the Health Centres are relatively small, low volume organizations or sites. Like WHCC they too struggle to achieve efficiencies with small volumes and variable workload. As WHCC strives to improve its performance, it might consider the levels of efficiency achieved by larger organizations and health care sites. These likely would better reflect industry best practice.

## **6.1 Overarching Issues in Nursing Services**

### **6.1.1 Nursing Sick-time, Over-time and Call backs**

***There is significant sick time and over time usage at most of the sites.***

There is significant concern regarding the level of sick and overtime usage at most of the sites. This is a significant issue across the organization but is of special interest in nursing because of the number of nursing staff, the number of sick days expended and the number of these days that need to be replaced. There is an added cost of care when the sick time is replaced; but there is potential reduction in quality and safety

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<sup>46</sup> FTE Savings Potential =(Target productivity - actual productivity) \* workload  
 \* FTE/Worked Hour  
 \$ Potential = FTE Potential \* \$/FTE.

if the sick time is not replaced. There is concern regarding the sense of sick time ‘entitlement’ among the nursing staff. Findings and recommendations regarding the corporate approach to attendance management are made elsewhere in this report.

*If overtime were reduced by only 20% there would be an annual savings of approximately \$75,000.*

Most of the sites have little flexibility in back filling positions related to sick and vacation. This results in a significant use of overtime to provide replacement coverage. Overall, WHCC had overtime costs of \$1,120,734 or 0.92% of total labour cost in 2003/04 with \$585,000 in Nursing.

The Corporation should establish policies to better control and reduce the use of overtime. If overtime were reduced by only 20% there would be an annual savings of approximately \$75,000 even if those hours were simply replaced by staff working at regular time.

#### **Recommendation:**

It is recommended that:

- (77) The Chief Nursing Officer and Directors of Nursing should develop and implement guidelines for the use of overtime.**

*WHCC had callback expenses of \$554,637 or 0.45% of its total labour cost.*

Although not only an issue for nursing, there also appears to be significant spending on call back. Overall, WHCC had callback of \$554,637 or 0.45% of total labour cost in 2003/04. Callbacks are often used for after hours diagnostic testing, for after hours procedures, to do transport within or outside the region or to fill positions while regular staff are transporting a patient.

The Corporation should develop guidelines to better control and ultimately reduce the use and cost of call back. It is recommended that call back initially be reduced by 20%, which would provide an annual savings, in Nursing, of approximately \$23,000.

#### **Recommendations:**

It is recommended that:

- (78) The Chief Nursing Officer and Chief of Staff should develop guidelines to control the use of callback.**
- (79) The Chief Nursing Officer should ensure that implementation of nursing callback guidelines**

**reduces expenditure by 20% from spending on nursing callback in 2003/04.**

### **6.1.2 Patient Escort**

The Department of Health has set guidelines outlining who can transport/escort patients. The guidelines are followed in order to ensure payment. However, these guidelines constrain the ability of the Region to use escorts appropriate to the actual need/acuity of the patient. It appears that, for the most part, RNs are used even when the patient condition may not warrant that level of support.

There should be guidelines by patient condition regarding the type of accompaniment that will be used. The physicians should be actively involved in the development of these standards as there appears to be variation of practice among the physician groups as well in the type of escort that is being used. The region/province should give more consideration to the appropriate use of LPNs and paramedics for transfers in place of RNs.

#### **Recommendations:**

It is recommended that:

- (80) The Department of Health and Community Services should revise its transport/escort guidelines such that care requirements determine who accompanies the patient.**
- (81) The Chief of Staff and the Chief Nursing Officer should develop and implement guidelines for assigning staff to patient escort based on patient need and acuity.**

### **6.1.3 Constant Observation**

The use of 'Constant Observation' is an issue affecting all acute care sites and occasionally the LTC sites. Use of 'Constant Observation' is having a significant impact on the cost of operations. There appears to be a significant use of constant observation beyond mental health patients. There are no standards or guidelines for the use of constant observation. When the policy of 'least restraint' was introduced there was a significant increase in the amount of constant observation used across the Corporation.

- The nursing services have been working on reducing the use of Constant Observation and costs have decreased in 03/04 from 02/03.
- In the past ‘sitters’ have generally been LPNs; the type of staff used for constant observation could be changed to reduce this cost.
- ‘Wander-guard’ mechanisms have been put in place on appropriate care areas.

In most medical/surgical areas in other jurisdictions, the decision regarding whether or not to use constant observation is a nursing decision. This policy was taken to the RMAC and rejected. The use of constant observation appears to be frequently driven by physician orders even though a nursing assessment would not indicate that it is necessary. The Corporation needs to develop standards and guidelines to guide decision-making for the use of constant observation.

**Recommendations:**

It is recommended that:

- (82) The Chief of Staff and the Chief Nursing Officer should establish and maintain standards and guidelines for the use of constant observation.**
- (83) The RMAC should reconsider its decision that constant care is a medical rather than a nursing decision.**

**6.1.4 Workload Measurement System**

There is concern across all areas that have acute care beds regarding the lack of a workload measurement system for use in determining required staffing levels in relation to patient care requirements. There is a need to have a system that can reflect changes in acuity. The organization used to have GRASP in place but it was not considered valid and has not been used in some time. The current approach to staffing is the application of the Department of Health guidelines on HPPD which are driven by the number of patients, but not their acuity or clinical characteristics. The issue of workload measurement appears to be a provincial concern as well. The CNO is working on a provincial committee addressing this issue.

**Recommendation:**

It is recommended that:

- (84) The CNO should acquire or develop an appropriate workload measurement system for use at WHCC.**

**6.2 *Western Memorial Regional Hospital Nursing***

**6.2.1 *Overview***

Western Memorial Regional Hospital (WMRH), located in Corner Brook, is the referral centre for the Western Region, providing the majority of secondary care services for the population base.

The Hospital has 178 designated beds. On April 1, 2003 there were 190 beds staffed and in operation (178 acute beds and 12 ALC beds). A summary of the patient care units as they were presented and observed during the site visits is provided in the table that follows. The number of beds presented here (reflecting the April 1, 2003 distribution) varies slightly from the number reported as staffed and in operation to DOHCS.

**Exhibit 6.1  
WMRH Beds by Service**

	Unit	Bed #	Service	Occupancy March 03 /April 04
LEVEL 4	4A	24	Urology & General Surgery	97.3%
	4B	8	Medicine Overflow	
	4CD	23 + 2 Emergency Beds	Mental Health	100.2
	ICU	12 Bed Unit + 2 Bed Overflow. 8 Beds Currently Open.	Medicine Surgery Paediatrics	103.3
	Renal Dialysis	12 Stations	Hemodialysis PD Program Progressive Renal Insufficiency Clinic Post Transplant Workup	
LEVEL 3	3A	28	HS Ventilation Cardiac Rehab General Medicine Pre & Post Pacemaker Care	95.7
	3B	28	General Medicine, Chemotherapy, CAPD	98.6
	3C	8	Palliative Care	75.9
	3D	12	Alternate Level of Care: Clients awaiting other services, such as, Long Term Care, Personal Care Homes. Most clients medically discharged.	
LEVEL 2	2C	15	Gynecology & General Surgery	93.3
	2D	17	Orthopedics, ENT, & General Surgery	91.9
	OR	6 available OR's 4 OR's Sept - July 3 OR's July - Sept	Dental Surgery, Ophthalmology, ENT, Orthopedics, Urology, Gynecology, General Surgery, Cardiovascular, Pacemaker Insertions	5257/year MOR 105/year Case Room
	PORR	12	As Above	4399/year
	Day Surgery	8	As Above	2802/year
LEVEL 1	1AB	11	Family Centered Care	63
	1CD	12	Paediatrics	68.4
	SDAC / PAC	9	Same Day Admission Surgery & Pre Admission Clinic	1778/yr PAC 1345/yr SDAS
GROUND LEVEL	EMERG			Total Visits ED: 23468 Clinic Non ER : 17413 Total: 40881
	OutPatient Non ER Clinic	Hours 1800-2200 M-F 1000-2200 S/S		
	Ambulance Dept.	Emergency Ambulance Service for Corner Brook and surrounding towns.		
	OPD / Procedure Rm	3 Procedure Rms.	Endoscopy, Minor OR, Urology/Gyne	See Attached
	OPD/RR	9 Stretchers	Medical Day Care Radiology Pre & Post Procedure Room Patients	See Attached
	Pain Control Clinic	2 Stretcher Spaces allocated from the 9 stretchers above in OPD/RR	Pain Control	384/yr
	Home Care Clinic		Change Dressings/Drains, etc., for Outpatients	3565/yr (excludes Ortho Clinic patients)
	Ortho Clinic		Assists Orthopedic Surgeons, Casting, etc., for inpatients/outpatients	7470/yr (excludes inpatients)

## 6.2.2 Issues in Management & Operations

### 6.2.2.1 Bed Utilization

*Use of over-flow beds is a significant issue.*

Use of “overflow beds” is a very significant issue for this organization. The administrative/nursing leadership appears to have very little ability or influence to address the situation.

The over-utilization of beds appears to be the result of a physician driven system within the organization.

The analysis of clinical efficiency indicates that some areas of the WMRH site are experiencing occupancy rates above 100%. It was reported during the site visits that beds are opened to accommodate patients waiting in the ER or to accommodate an elective admission often at the insistence of the attending physician<sup>47</sup>. Analysis of admission during periods of high occupancy could be undertaken to identify opportunities for improvement in specific clinical services.

There are over-flow beds and off –service patients spread throughout the hospital. This places tremendous pressure on the nursing organization to respond to the care demands of patients. It results in:

- multiple internal transfers – up to 35/day
- increase in patient/family dissatisfaction because of the frequent moving
- back-log in PARR
- increase length of stay in ICU
- issues of admissions late in the evening
- inefficient use of staff in small care units because of the need for minimum levels of staffing
- excessive workload for the nursing staff on units that are more than 100% occupied.

It was reported during the site visit that a number of initiatives have been undertaken to address these issues over the past, but all have met significant resistance from the medical staff. There is no ability to be able to control admissions. It was reported during the site visits to at least 2 of the consultants that cancellation of elective surgery is infrequent even though there is a shortage of beds.

It was reported that even when there are no beds available, elective surgery is seldom cancelled. Surgeons are booking major cases in the OR when there is a good likelihood that a critical care bed will be required but without first arranging

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<sup>47</sup> Additionally, the hospital has opened unfunded beds to care for ALC patients. The hospital reports that “until these beds were opened elective surgeries were regularly cancelled. WHCC felt that this situation could not be maintained and retain a surgical program and meet the surgical needs of the communities.”



for the bed. There appears to be no mechanism to control the inflow of patients to the OR and as a result there are frequent back-ups in the PARR because beds are not available on the nursing units. A more complete discussion regarding this issue can be found in the departmental report on the OR.

***New admission/discharge coordinator in place to facilitate flow.***

The Hospital recently put an admission/discharge coordinator in place to facilitate the flow of patients across the hospital. Previously, each Assistant Director of Nursing (ADN) did this function on a one week rotating basis in addition to managing their units. The Chiefs of Disciplines are to act as advisors to this role but there appears to be no policies regarding utilization monitoring.

***6.2.2.2 Alternate Level of Care***

It was reported during the site visits that there are a significant number of Alternate Level of Care (ALC) patients in the facility. Until recently, the organization has been under-reporting ALC.

There are patients occupying acute medical beds who clearly have ALC requirements, but who have not been declared ALC. There is a perception that physicians do not use ALC as they, incorrectly, fear that will automatically place the burden of co-payment on the family. Improved physician identification of medically discharged patients would enhance the ability of the region to identify its long term care requirements.

***LTC beds in Corner Brook have limitations on their use because of facility deficiencies.***

Managers in the acute setting reported that it was often difficult to access to LTC beds in Corner Brook. During the onsite visits we observed that the LTC beds in Corner Brook have limitations on their use because of facility deficiencies.

There have also been issues of process between Acute and LTC. There is currently a working group struck to streamline and improve the process of discharging patients from acute to long-term care. The organization is encouraged to support and implement process changes as soon as possible to facilitate the decrease in the number of ALC patients in acute care.

There are also issues associated with the policy of “1<sup>st</sup> available bed”. Work has been occurring on implementing such a policy but it has not moved forward as yet. If this policy or something that could achieve a similar result were implemented there would be some reduction of ALC in the acute care setting.

The average wait time in 2003/04 of 89 days in the region for permanent placement is higher than the provincial target of 69 days (to be achieved by 2007) established in the provincial strategic plan “Healthier Together”. The wait time in Corner Brook was 107 days in 2003/04.

***ALC patients should be clustered.***

These ALC patients would be better served if they were clustered in a more appropriate environment and an appropriate level and skill of nursing staff were assigned to them. There are a number of options for co-location of ALC patients. Expansion of the current 12 bed unit to 18 beds is underway but this will not fully address the issue. Consideration could be given to the creation of an ALC capacity at the Sir Thomas Roddick Hospital in Stephenville.

The organization has also begun exploring a partnership arrangement with a Level I home. If arrangements could be made with this facility to ensure an adequate level of staffing for the ALC patients, this also may help to relieve the bed pressure at WMRH.

**Recommendations:**

It is recommended that:

- (85) The CEO and the VP-Medical Services should eliminate the use of overflow beds.**
- (86) The CEO and the VP-Medical Services should develop and implement a plan to co-locate WMRH ALC patients in a single nursing unit.**

***6.2.2.3 Community Services to Support Discharge***

There were issues reported related to a perceived lack of resources in community services to support early discharge. These resources are important to support the attainment of clinical efficiency targets. If patients require BID dressing changes, assistance with ambulation etc. they are kept in hospital because there is little/no support available from community services. There is a dressing clinic but it appears much of the activity in this clinic could be managed in the physician’s office; it does not seem to be providing the more complex treatments that are keeping patients in hospital.

A medical day care in the hospital does provide support for administration of IV antibiotics so patients are not kept in hospital.

#### 6.2.2.4 Professional Practices Issues

There are a number of professional practice issues that impact nursing services and can be discussed as part of the approach to professional practice:

Currently, most of the patient care units use a team nursing model. However, the lines of accountability for patient care are unclear in this model. The role and scope of practice of the LPN is limited within the team model; they should be enhanced.

There is a desire to move to Total Patient Care (TPC) at WMRH. As part of the movement toward this model of care, there has been a pilot of TPC on a unit at the WMRH. Many organizations use this model of care delivery as it improves continuity of care and reduction in a perception of nurses' job pressure.<sup>48</sup>

The Hospital is strongly encouraged to move toward this model by:

- Clarifying the role of the RN in the TPC model
- Supporting LPNs to function to the full scope of their practice. It is not necessary to wait for renovations to the physical environment on nursing units to improve the scope of practice of the LPN.
- Implementing the initiatives identified by the project team looking at the nursing care model.

#### **Recommendation:**

It is recommended that:

- (87) The VP Clinical Operations, the CNO, and the Director of Nursing for WMRH should advance the implementation of a model of total patient care on the inpatient units at WMRH.**

#### 6.2.2.5 Current Nursing Structure

*There should be a separate position of Chief Nursing Officer for the Corporation.*

As noted earlier in this report in the section on nursing services management in the region, there is a need for a separate position of Chief Nursing Officer for the Corporation.

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<sup>48</sup> McGillis Hall, Linda, & Irvine Doran, Diane, Study of the Impact of Nursing Staff Mix Models and Organizational Change Strategies on Patient, System and Nurse Outcomes. Canadian Health Services Research Foundation, March 2001.

Also, interviewees in this process expressed a concern that there is not a nurse on the senior team from the Corner Brook sites. Although the VP Clinical Operations represents nursing operations, there is a perception that because there is not a “nurse” to speak to the issues not all appropriate issues may be given adequate consideration in any discussions at the senior team concerning operations in Corner Brook

***There is inadequate support for the ADN role.***

The ADN role is essentially that of a front-line patient care manager of 2 or more patient care areas. Concern was expressed regarding this span of control and the current pressures on this role. This is not an uncommon structure and is seen in other organizations. However, there does not appear to be enough supports for this role in the form of clinical education/practice supports or clerical support.

There is limited clerical support available to the ADN to support the work the ADNs. This includes assignments related to Board and facility management such planning for facility changes, etc. The ADNs, together with the PCC are also often responsible for staff education on the nursing units. It is not common in other hospitals for managers to be responsible for delivering education on the unit. There is usually education support in the form of an educator shared across units, or some other level of advanced practice nursing role to support education of staff.

The organization should ensure the appropriate resources are provided to support these front-line managers so that they can assist the staff appropriately in the delivery of quality care and contribute to improvements in organizational efficiency.

***The authority of the PCC role to act should be recognized by the organization.***

There has been discussion regarding the role of the PCC and the fact that these positions are union and not management. The role of the PCC is to provide consistent coordination of day-to-day clinical activity on the patient care units. When these positions were implemented staff received these positions based on seniority. There was no ability to select based on experience in this type of role or suitability for the role. There is no rotation through the position.

The question is whether or not these positions should be union positions. In many organizations, these positions are part of the bargaining unit. As a result we believe that it should not be necessary for WMRH to change these to be administrative positions to fulfill the current role. However, were there to be a change in the work of this role, for example, taking

responsibility for performance management, then perhaps they should become exempt positions.

It appears issues are more related to variation in performance across the organization. Clear expectations should be established and performance monitored. The organization should work with the bargaining unit to establish a process to ensure the best candidate is in the position.

There are also issues with respect to lack of understanding by managers/supervisors in support service areas regarding the role of the PCC. Often ADNs are required to have communication with the departments because the manager/supervisor does not see the PCC has having responsibility for managing issues. Requisitions for maintenance done by the PCC are not responded to and the ADN must be involved.

This may be the result of the traditional or hierarchical nature of the organization. There is a need to ensure managers throughout the organization are aware of and accommodate the PCCs role. ADN should not be required to confirm appropriate initiatives of the PCCs.

***There is insufficient professional support for nurses and for nursing care.***

Currently the centralized education resources provide support for orientation, organization-wide initiatives, etc. There are 3 educators who are part of the regional education department. These educators provide general hospital orientation. It was reported that there are no nursing educators in the clinical areas to support education of staff regarding specific clinical/procedures changes, etc. If changes involve new equipment, training is usually obtained from the supplier. Education on the patient care units regarding any new procedure, policy, or practice, is currently primarily provided by the PCC and/or ADN. For an organization of this size there should be more resources available at the clinical level to ensure quality and consistency of care and practice.

As noted earlier, there is only one position for professional practice for nursing. This role is focused on policies and procedures across the region and it is seen as an important support. However, because the position is not located in Corner Brook there is a perception of limited access to staff at WMRH.

***There are limited mechanisms for the local nursing advisory committee to affect practice at WMRH.***

There is a local nursing advisory committee to support the development of nursing practice. However, there is often lack of communication between this council and program teams and no clear responsibility for the development and approval

of policies, procedures or for those changes that may affect nursing practice.

**Recommendations:**

It is recommended that:

**(88) The VP Clinical Operations and the Director of Nursing should improve the understanding and acceptance of the authority and responsibility of the PCC.**

**(89) The VP Clinical Operations and the Director of Nursing should ensure adequate clinical education/practice support for the ADNs.**

**6.2.2.6 Central Scheduling/Staffing**

There is a centralized scheduling/staffing office that manages the staffing and scheduling activities and the float pool for nursing. The Staffing Office currently reports to Human Resources. This reporting relationship is not common in hospitals across Canada. In most circumstances where there is a staffing office, we find that it reports within the nursing structure. This is seen to ensure effectiveness in communication and efficiency of operations. When there are issues and/or a need to make changes to processes/policies regarding staffing or staffing office functions, the nursing leaders need to involve another department rather than being able to implement the appropriate steps themselves. The separation of this responsibility from nursing limits its ability to respond to the needs of nursing and makes changes in staffing policy more cumbersome to implement. If strong communication processes are in place the current structure can provide the support required. We believe this function should be examined to determine the most effective reporting structure.

There is a centralized float pool that provides services for all units and is a centralized resource. Staff on the float pool are oriented to and able to support at least 2 nursing areas.

**6.2.2.7 Basic Unit Space and Equipment Issues**

There are some significant concerns regarding basic space and equipment for providing care. The units are basically built in a modified Friesen design. A number of them are so small as to be inherently inefficient. Even the larger units of 28 beds are less than an ideal size for efficiency of staffing.

Some of the spatial deficiencies of these areas cannot be fixed without major renovation. Redesign of a number of units has occurred in the past 2 years and will be implemented in the future to alleviate some of the inefficiencies of the patient care units.

There are inadequate storage facilities on the units for the type of supporting equipment currently used in the delivery of patient care. In addition, there is no workspace/nursing station, other than in corridors, for documentation and reporting. This raises concerns regarding confidentiality.

It was reported and observed during the site visit that there appears to be inadequate investment in basic equipment such as electric thermometers, blood pressure machines, geri-chairs etc. There are still a number of manual beds in the facility and most of these are in medicine where there are often the heaviest care and most frail patients. This area also has the highest rate of staff injury. These beds may have been put into use because of the creation of “overflow beds”, but their use creates significant problems for the delivery of nursing care. It also puts nurses at greater risk for workplace injuries.

There is a perception among the nursing managers that there does not seem to be an effective process for involving nursing in equipment decisions. Examples that were provided during the site visit included the acquisition of PCA pumps, wheelchairs, etc. and that these items arrive on the units with no provision for orientation/education of nursing staff.

There is a published process for the assessment of equipment needs through Local Nursing Advisory Councils with further assessment at the Regional Advisory Council with decisions occurring at the Senior Team. However, whatever this process is, it is not well understood at the front-line management level. There is a great deal of frustration with the challenges of supplies and or equipment arriving on the units that managers and staff know nothing about.

**Recommendations:**

It is recommended that:

- (90) The VP Clinical Operations should ensure that nursing is provided with the basic equipment for nursing care.**

- (91) The VP Clinical Operations should replace the manual beds in the medical program as soon as feasible.**
- (92) The VP Clinical Operations should ensure that nursing input is included in equipment acquisition decisions affecting nursing care.**
- (93) The VP Clinical Operations should ensure that there is adequate orientation to and training in the use of new equipment.**
- (94) The CEO should initiate a process to plan for and implement renovations of WMRH nursing units to provide for improvements in the efficiency and quality of nursing care.**

#### **6.2.2.8 Services That Support Patient Care Units**

Several issues were identified regarding support services that impact the ability of nursing to coordinate and deliver patient care. Many of these relate to the administrative structure and communication problems referred to earlier.

- **Housekeeping:**

This is a centralized resource. Housekeepers carry pagers but it is reported they are hard to find and to get to respond to calls. The organization has recently put an on-site supervisor in place to help address these issues. Cleaning of beds after hours continues to be a major issue and it is difficult to get cleaning of space such as shelves in specialized areas.

- **Laundry:**

This service appears to have been a problem for a number of years, particularly on Monday. Laundry is a 5 day/week service and the service is unable to meet the needs for laundry on the 7<sup>th</sup> day. Often the PCC must get the ADN involved to solve the problem. Nursing reports that it is not being involved in decisions regarding quotas etc.

#### **Recommendation:**

It is recommended that:

- (95) The VP Corporate Services, Regional Director of Environmental Services working with the VP Clinical Operations and Director of Nursing should**



**review and redesign work processes for laundry services to improve support for the patient care units.**

### **6.2.3 Medical Inpatient Services**

The Medicine Program provides primary and secondary care to medical patients from Corner Brook and those referred in from rest of the Western Region. The secondary services include Cardiology, Gastroenterology, Nephrology, Respiriology, Neurology, and Rheumatology.

The Medicine Program is comprised of 56 beds located on two nursing units. The program however expands when required into other services, i.e. overflow beds on surgical units. The total bed occupancy rate for the medicine program was reported during the site visit as 129% in 2002/03 and has averaged 126% in 2003/04.

#### **6.2.3.1 Unit 3A**

3A is a 28-bed general medicine unit that includes the following mix of patients:

- Cardiology including patients awaiting transfer to St. John's for cardiac catheterization
- Cardiac Rehabilitation Education Program – it was reported during the site visit that this includes standardized 4 and 6 day protocols and education
- HS Ventilation (for 2 patients on home ventilation who are admitted at night)
- Pre & Post-op Pacemaker Care

#### **6.2.3.2 Unit 3B**

3B is a 28-bed general medicine unit that includes the following mix of patients:

- General Medicine
- Chemotherapy
- Peritoneal Dialysis
- ALC and complex continuing care patients who have not been designated ALC. On average there are 6-8 ALC patients on this unit at all times.

### **6.2.3.3 Unit 3D**

3D is a 12 bed ALC unit opened as a temporary unit 2 years ago and still does not have permanent staff assigned.

Patients on this unit are either medically discharged and waiting placement to Long Term Care or personal care home or not medically discharged and waiting for rehab, home supports, etc. This unit is not large enough to accommodate all of the ALC patients that are usually in the Hospital at any one time.

This is a small unit that is inefficient and expensive to operate. The quality of care is a concern related to:

- Lack of consistent staffing. Generally, staff from the float pool are assigned to this unit.
- Lack of Equipment such as Geri chairs to get patients up daily.
- Lack of services such as Recreation Therapy, and Physiotherapy
- Lack of space for a common/central area.

Patients have been in this unit for an extended period of time without a long-term plan. Work is happening to improve the plan for these patients.

### **6.2.3.4 4B Overflow**

4B is an 8 bed unit opened as a temporary measure (it closes at Christmas and during the summer). The types of patients on this unit include those with COPD, PVD, Multiple Myeloma, Liver Failure, Diabetes out of control, etc.

This is a small unit and is very inefficient and expensive to operate. Minimum staffing must be maintained. In addition, quality of care and quality of work life are a concern:

- No continuity of nursing care as staff (usually from the float pool) are booked but then moved to other areas.
- This unit appears to have only manual beds and most of the patients are heavy care patients.

As noted earlier, all overflow beds should be removed as soon as possible from the system.

**Recommendation:**

It is recommended that:

- (96) The CEO and the VP-Medical Services should close 4B as soon as possible.**

Workload information provided by the corporation for the inpatient medicine program, excluding renal, is shown in the following exhibit.

**Exhibit 6.2  
Medical Inpatient Services – Patient Days & FTE<sup>49</sup>s**

	2002/03	2003/04
Total Patient Days	24,946	26,480
Total Worked Hours	140,609	147,630
FTE	91.82	94.40

**6.2.3.5 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.3  
Medical Inpatient Services - Productivity<sup>50</sup>**

	2002/03	2003/04
Wkd Hr/Pt Day	5.64	5.58
var NL non-drug \$/Pt Day	\$ 9.50	\$ 9.68

**Exhibit 6.4  
Medical Inpatient Services Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	17	4.52	5.25	5.85	5.52
var NL non-drug \$/Pt Day	17	\$ 9.80	\$ 11.12	\$ 15.57	\$ 13.00

Every effort must be made to eliminate the overflow beds that cause significant problems for efficient staffing. The physical space makes it almost impossible for this program to achieve best quartile performance.

<sup>49</sup> FTE (Full Time Equivalent) = (Worked Hours + Benefit Hours) / 1950

<sup>50</sup> var NL non-drug \$ = Variable non-labour non-drug costs. These are basically supplies costs excluding drugs. Equipment depreciation, leasing, and maintenance costs are also excluded.

To accommodate for the challenges of the physical environment it is recommended that the mean performance of 5.52 worked hours per patient day be used as the performance target for this program as a whole. The service is currently achieving close to the mean performance level. Given the number of small units, the larger units are probably already performing more efficiently than this target.

**Recommendation:**

It is recommended that:

**(97) The Director of Nursing should adjust staffing on the medical units at WMRH to achieve nursing productivity of 5.52 worked hours per patient day.**

#### **6.2.4 Surgical Services**

The discussion of surgical services is provided in the following key areas:

- Surgical service/specialty description
- Facilities and Equipment
- Booking Processes
- Urgent and After-hours Surgery
- OR Utilization
- Discharge Processes
- Surgical Service Departments – PAC/SDAS, OR, PARR, Endoscopy, Surgical Inpatient Units

##### **6.2.4.1 Surgical Service/Specialty Description**

WMRH is the main referral and treatment centre for surgery for the western region of the Province. The following services are available from a combination of salaried and fee for service (FFS) surgeons:

- General Surgery with vascular, plastic and limited thoracic surgery provided
- Orthopaedic Surgery including arthroplasty, general orthopaedics and spinal surgery

- ENT surgery<sup>51</sup>
- Ophthalmologic Surgery<sup>52</sup>
- Gynaecologic Surgery (and Obstetrics)
- Urologic Surgery (but the current urologist plans to leave the Province in August)

Staff retention has been a challenge as evidenced by urology. Recruitment is equally difficult. Locums for some disciplines like anaesthesia also have been particularly difficult to recruit.

#### **6.2.4.2 Facilities**

There are 5 ORs and 1 Orthopaedic room in the main Surgical Suite. There is a separate case room and labour and delivery area for delivery and C-sections. The hospital operates four of the ORs when there is sufficient anaesthesia coverage.

The surgical program reports that it suffers from equipment shortages. The monitors and lights are antiquated.

#### **6.2.4.3 Booking Processes**

Hospital ORs are generally booked to capacity. Late starting times, overtime procedures, and over booking are major issues that have a significant adverse effect on efficiency.

The chaotic booking practices have led to a general decline in discipline in the Department of Surgery. The rules for booking and scheduling cases are applied irregularly. There is no authority to enforce the rules; or no one with authority is enforcing the rules. And the rules are inadequate.

***Bed availability has not been a consideration in booking procedures.***

The booking and utilization of the surgical inpatient beds has been very poor. There has been no consistent coordination of patient care across each surgical service. Bed availability has not been a consideration in scheduling of surgery and admitting patients for procedures. As a result, post-operative patients often are held in the PARR waiting for a patient to be discharged.

<sup>51</sup> There is one salaried and one FFS physician. There appears to be insufficient publicly funded audiology so many patients must use the private sector or have very long waits.

<sup>52</sup> This service is functioning well with excellent cooperation between STRH & WMRH. It is a small source of revenue to the WMRH.

***Intensive care beds are not pre-booked.***

Especially troublesome is that the surgeons are not considering and ensuring the availability of an intensive care beds when scheduling and performing surgeries that will require the patient to be admitted to the ICU postoperatively. The Chief of Surgery should ensure a process whereby the operating surgeon performing a procedure that usually requires ICU support post operatively must clear the availability of an ICU bed with the charge nurse of the ICU before starting the case.

***A set number of beds should be reserved for emergency surgeries, the remainder should be available to accommodate elective surgical cases.***

In developing booking and scheduling processes, a mechanism must be in place to deal with a patient that develops a complication that delays discharge beyond an expected date of discharge and therefore causes a shortage of beds to care for the scheduled surgeries. Addressing this issue can be straight forward. If a patient cannot be discharged, the patient is moved to another bed that is normally used for emergencies. To start such a program it would be reasonable to assign a certain percentage of the surgical beds on each unit for elective (booked) cases and the remainder for emergencies. If there were sufficient volume of emergency cases, a specific ward could be set up to deal with these non-elective cases.

***Surgeons should be ensuring the availability of clinical support services for their patients.***

Patients are spending less time in the hospital and more care is being delivered on an ambulatory basis. This requires planning well in advance of any surgical intervention so that the care can be continuous, seamless and appropriate. Therefore, it is imperative that the various clinical support services be informed ahead of time in order to prepare for the delivery of the appropriate service in a timely fashion.

***Lack of clear rules for booking elective surgery.***

At the present time there are no clear rules being followed with respect to booking elective surgery. The lists are not available till the day before the surgery and are frequently changed during the evening hours. The last minute changes have made it impossible to organize staffing, and instruments ahead of time.

***Last minute booking of unprepared patients has been a serious problem at the WMRH.***

As noted above, frequently the OR list is changed the night before surgery. The impact of this results in:

- Confusion, delays and inefficiencies,
- Increased risk of errors,
- The instruments are not ready because of the changes,
- Delays in the start of surgery because the necessary documentation and investigation is not available.

***Estimates of procedure times are not accurate.***

There has been a consistent pattern, by some individual surgeons, of booking more procedures than time will allow. This has led to significant overtime expense and delays in doing urgent cases. Bookings have been arranged so that the longest case is scheduled in such a fashion that it will not be cancelled and yet it is clear at the time of booking that it will not be finished in the allotted time. This is irresponsible because it causes expense not only in the OR but also in the PARR. And, it can result in delays in starting emergent cases.

***Recommended Booking Processes***

There are a number of basic practices related to surgical booking that should be implemented at WMRH:

- The Chief of Surgery, with operational support from the VP Clinical Operations, should ensure elective surgical bookings are closed 5 days before the date of surgery<sup>53</sup>
- Each booking for surgery should include the following elements at a minimum:
  - name, address
  - hospital ID No.
  - date of surgery
  - surgical procedure
  - estimated duration of the procedure
  - preferred anaesthesia
  - laboratory investigation
  - consultation requests
  - additional information desired in the OR (e.g.: x-rays)
  - operating surgeon
  - referring physician
  - date of discharge
  - history & physical or consultation note of the surgeon
  - signed consent form

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<sup>53</sup> In instances where some surgeons are unable to fill their blocks within the period allowed for scheduling cases, the concept of a Wait List has been very effective. A “Wait List” can be established by the booking office to accept the names of patients that are ready for surgery but do not have an assigned time. Any unassigned time will be offered to surgeons that have placed patients on the “Wait List”. The time is to be offered to the surgeons in chronological order from that list at noon on the 5th day before the date of surgery.

- The Director of Nursing should ensure a process where all patients that are booked for surgery have their medical record checked for completeness 5 days before surgery. If there are any deficiencies, the surgeon shall be notified to correct the deficiencies or reschedule the patient.
- The VP Clinical Operations should ensure a process that notifies and books ancillary support services that are required after the surgical procedure.
- The VP-Medical Services and the Director of Nursing should establish a process in which the OR list is examined by the PCC to ensure that:
  - There is sufficient time in the block to complete the list
  - The order of the cases is appropriate
- The PCC should have authority to modify the schedule and inform the surgeon of the need to reduce or reorder the list.
- Disputes should be mediated by the Chief of Surgery & the VP-Medical Services.
- The Chief of Surgery and the VP Clinical Operations should establish and monitor a ‘waitlist’ process.
- Unfilled spaces in a surgical block will be made available to surgeons with patients on the wait list.
- Surgery should be initiated only if an appropriate bed is available.

It is absolutely essential to establish a monitoring system that includes:

- Evaluation of the appropriateness of admission of each surgical patient according to diagnosis with daily reports to the Chief of Surgery and a monthly report to the RMAC.
- Compliance with OR booking policies and procedures with a weekly report to the Chief of Surgery and a monthly report to the RMAC and Senior Management Team.

Together with a monitoring system there must be consequences for physicians that do not comply, particularly with the booking policies.



**Recommendation:**

It is recommended that:

- (98) The VP Medical Services should establish and implement an improved process for booking and scheduling surgical procedures.**

**6.2.4.4 Urgent & Emergency after hours surgery**

The first case of the day is almost invariably started late because the anaesthetist is waiting for the surgeon or the surgeon is waiting for the anaesthetist. And surgeons routinely exceed their allotted times, delaying the next block or the beginning of urgent cases. The overruns in the regularly scheduled surgery are causing delays to the start of the urgent surgery<sup>54</sup>.

*Many of the surgeries being performed on evenings and weekends are not urgent or emergent procedures.*

But, many of the surgeries being performed on evenings and weekends are for booked cases; they are not urgent or emergent procedures. This has caused a major and unnecessary use of overtime, has put undue stress on the nursing staff and is a cause of unnecessary spending by the Corporation.

It was reported during the onsite visits that tactics of intimidation have been used to force these extra cases to be done. There do not appear to be any criteria for defining what is urgent and emergent and what should be deferred until there is room in the surgeon's schedule.

In order to control the inappropriate use of the ORs for non-urgent cases on weekends, the Corporation will need to:

- Better control the availability and use of nursing staff.
- Defining criteria for determining whether a case is emergent or urgent requiring access to ORs after hours.
- Develop and implement policies and procedures for limiting access to ORs after hours to only emergent and urgent cases.

Since all surgical procedures on the weekend should be urgent or emergent, most will be coming from the Emergency Department. Assuming sufficient volumes of truly urgent and emergent cases, the corporation should first address scheduling of nursing staff. There should be sufficient staff

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<sup>54</sup> This was confirmed through data review.

on site for the afternoon shift to staff the expected volume of urgent and emergent cases. Most patients arrive in the emergency after noon and take time to be prepared for an operation and therefore typically are not ready for surgery until later in the day. Nursing staff should be on call to the OR and PAR for night shifts and for day and night shifts on Saturday, Sunday and holidays.

Strict criteria for the definition of emergent, urgent & semi-urgent types of cases should be established, implemented and used to control access to the ORs on nights and weekends. The HCCSJ has guidelines that could be used by WMRH as a guide:

- An emergent case is one that is life threatening or limb threatening requiring immediate intervention e.g., ruptured aneurysm or fetal distress.
- An urgent case requires intervention within 4-6 hours otherwise significant clinical deterioration might ensue e.g., compound fracture or acute appendicitis.
- A semi-urgent case requires intervention in less than 24 hrs e.g., fractured hip or gallstone pancreatitis. (See HCCSJ – Guidelines for Booking Emergency Surgery)

Urgent and semi-urgent cases must be done before 11:30 pm. Emergent cases can be done anytime and warrant calling in staff if necessary.

The VP-Medical Services and the Assistant Director of Nursing–Perioperative Program should establish a monitoring system to monitor the overruns in booked surgery and the after hours surgery. These data should be reported to the OR Committee and to the MAC on a monthly basis.

### **Recommendations:**

It is recommended that:

- (99) The VP Medical Services and the Chief of Surgery should establish definitions for the types of cases that may have access to the ORs at WMRH for after hours surgery.**
- (100) The VP Medical Services should establish policies and procedures for controlling after hours access to the ORs at WMRH.**

**(101) The VP Medical Services should establish a process for monitoring, reporting and enforcing the after-hours surgery rules at WMRH.**

**(102) The Chief of Surgery should ensure that the after hours surgery rules at WMRH are enforced.**

#### **6.2.4.5 Overtime in ORs and PARR**

As has been discussed inadequate controls in the booking process and misuse of after hours and weekend surgery has caused a significant amount of overtime in the ORs at WMRH:

- In 2002/03 3.73% of total worked hours in the ORs and 3.77% of total worked salaries for the ORs were devoted to overtime.
- In 2003/04 the situation deteriorated further, 6.13% of total worked hours in the ORs and 5.75% of total worked salaries for the ORs were devoted to overtime.

This equates to, on average, every FTE in the OR is working 1.5 to 2 hours of overtime every week.

Whereas across all of WHCC:

- In 2002/03 only 1.27% of total worked salaries were devoted to overtime.
- In 2003/04 only 0.92% of total worked salaries were devoted to overtime.

#### **6.2.4.6 Monitoring and Managing OR Utilization**

OR time can be wasted if there is no coordination of holiday and vacation time among the various groups that use this facility. OR time will go unused if surgeons go on vacation or holiday without giving others the opportunity to schedule the available time. Perhaps of greater concern, patients will wait unnecessarily for needed surgery. Information about vacations must be provided in advance so that the resource can be reallocated or closed. To date there does not appear to be any incentive to have the surgeons and anaesthetists provide this information in a timely fashion that can enhance the efficiency of the ORs. As a result, this information has not been forthcoming from the surgeons.

An approach that has been successful uses OR block time as a tool for encouraging compliance. Reasonable practice would have more than 85% utilization of an assigned surgical block.

A surgeon in any quarter falling below that level should be informed by letter from the OR Committee that a reassignment of OR time might be required if the deficiency continues.

If the surgeon does not inform the booking office, the Chiefs of Surgery and Anaesthesia and PCC of vacation time in writing 3 weeks before the scheduled time of the vacation the time not used will be considered unused and counted in the utilization statistics. This combination provides the incentive and fairness to achieve the goal of obtaining the necessary information.

The VP-Medical Services with the Patient Care Coordinator should prepare the utilization data and submit it to the Chief of Surgery and the OR Committee on a quarterly basis. The OR Committee should review OR utilization by each surgeon on a quarterly basis.

**Recommendation:**

It is recommended that:

**(103) The OR Committee should review OR utilization by each surgeon on a quarterly basis.**

**6.2.4.7 Discharge Processes**

The discharging of patients from WMRH has not been timely or predictable. The surgeons have discharged the patients at different times of the day and not provided leadership in the discharge planning. It was reported during the site visits, that patients are not being discharged from the surgical units in a timely fashion on the day of discharge. As a result, patients may wait in the PARR an extended time until a bed is vacated. It was reported and observed during the site visits that discharging of patients appears chaotic with no standards established or followed.

The organization does have a policy with respect to 11:00 hour discharge and a process has been developed to increase awareness across the region. It has also implemented a temporary discharge planning manager to assist in the process and improve discharge planning. Even with these efforts problems remain with discharging patients in a timely fashion. At least for surgical patients, it is feasible for discharge orders to be written the day before discharge so that even in the surgeon's absence, the patient can be discharged before 11:00.

**Recommendation:**

It is recommended that:

**(104) The VP-Medical Services should institute a clear discharge policy that requires all surgeons to have their patients discharged by 11:00 am daily.**

**6.2.4.8 Pre-Admission Clinic (PAC) and Same Day Admission Surgery (SDAS) Unit**

This unit is located on Level 1 and has 9 stretchers. It serves as the Pre-admission Clinic (PAC) and the site for the Same Day Admission Surgery (SDAS) program.

Delays in surgery occur before the patient gets to the operating room often because the patient and family have not been educated in what is to be expected. This requires an educational and evaluative process so that each patient is diagnosed and investigated appropriately before surgery. Preparation and investigation of the patient should be carried out in a separate out-patient area before the patient arrives at the hospital on the day of surgery. This requires a consistent comprehensive process that all patients go through, regardless of the surgical procedure. This assures that the patient is informed, documents are available, the ancillary services have been planned and notified, and that the patient is fit for surgery.

There is certain documentation that is required for all procedures and there are investigations and consultations that are required for a particular patient. A properly organized PAC will obviate many of the problems and reduce delays in the ORs.

The health of patients that are going to the OR must be evaluated by the appropriate personnel. It takes time to collate the information and have it ready for examination. The information must be available before the date of surgery. This means that the booking of elective surgery should be in advance of the date of surgery so there is time to correct any deficiencies. The problems with the booking processes at WMRH are addressed above.

***Poor pre-admission facilities  
at WMRH***

The facilities at WMRH are not well organized to deal with a proper PAC. There are 9 beds allotted for both the PAC and the Same Day Admission (SDAS) patients.

***There are confusion and delays related to PAC and SDAS being in same location.***

All “same day admit patients” are currently admitted on the day of surgery through the same unit as the PAC. That is, the nursing staff are performing two different functions on two populations of patients in the same geographical area. This causes confusion that may lead to errors. The Same Day Admission Surgical (SDAS) patients along with all other elective surgical patients should still be processed through the PAC, but on the day of surgery, they should be admitted through another venue.

The staff is coping in this difficult environment, but the likelihood of errors is significant because there are few rules or criteria for scheduling or for organizing the medical record prior to the patient arriving.

There are a number of recommendations related to establishing a separate PAC that include the following:

- The Chief of Anesthesia should ensure an anaesthetist be assigned to the PAC.
- The VP Clinical Operations should ensure ancillary services such as physiotherapy, respiratory therapists are an integral part of the team and available when necessary.
- The Chief of Surgery and the VP Clinical Operations should ensure that all patients having elective surgery at WMRH are seen and evaluated in the PAC not less than 5 days and not more than 30 days prior to surgery.

**Recommendation:**

It is recommended that:

**(105) The VP Clinical Operations should establish the PAC as a stand-alone unit dedicated only to the evaluation and education of patients for surgery.**

**6.2.4.9 Day Surgery**

The Day Surgery Service is provided in an 8-bed unit on Level 2 near the PARR and OR. It provides pre and post-operative nursing care to patients having surgery on an outpatient basis, as well as providing patients/families with education and discharge planning. The unit is staffed from 0700-1800 hours Monday to Friday.

Workload information provided by the corporation for Day Surgery (FC#713402560) is shown in the following exhibit.

**Exhibit 6.5**  
**Day Surgery – Visits & FTEs**

	2002/03	2003/04
Total Visits	2,853	2,664
Total Worked Hours	9,212	8,635
FTE	5.58	5.00

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (Wkd Hr/Visit). The peer hospital productivity range is also presented for comparison purposes.

**Exhibit 6.6**  
**Day Surgery – Productivity**

	2002/03	2003/04
Wkd Hr/Visit	3.23	3.24
var NL non-drug \$/Visit	\$ 3.65	\$ 3.32

**Exhibit 6.7**  
**Day Surgery – Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	7	1.19	1.86	2.12	1.69
var NL non-drug \$/Visit	7	\$ 2.97	\$ 8.03	\$ 8.94	\$ 6.05

***Staffing on the Same Day Surgery Unit at WMRH should be reduced to achieve nursing productivity of 1.86 worked hours per visit.***

This is not an efficient functional centre. Its productivity is worse than the worst quartile performance of its peers. In order to move toward median quartile performance at the current workload, the department needs to examine its staffing levels, hours of operation and/or number of days it provides service annually. Assuming 250 10-hour days of operation the department should be able to achieve the median level of peer performance with the current number of visits. The unit requires a minimum of 2 staff on duty during operating hours.

The Corporation should establish a productivity target of 1.86 worked hour per visit.

**Recommendation:**

It is recommended that:

- (106) The Director of Nursing should reduce staffing on the Same Day Surgery Unit at WMRH to achieve productivity of 1.86 worked hours per visit.**

### 6.2.4.10 Operating Room

#### Department Description and Operations

It was reported during the site visit that there are 6 ORs at WMRH. The organization has been running 4 ORs September to July and 3 ORs July to September.

There are 4 people assigned to cleaning the ORs and equipment between cases. Three nurses are assigned to each OR. This is more nurses assigned to each room than is normally seen in other North American jurisdictions. A common standard is 2.0 to 2.5 staff per room for an OR that handles primarily secondary and some tertiary cases.

#### *Anesthesia shortage*

There are 4 anaesthetists that allow for 4 rooms to be in operation when all the anaesthetists are available. The anaesthetists also cover the after hours work. This means that they may work the day following a night on-call in which they may have been up the majority of the night. This is not consistent with the Canadian Anaesthesiologist Society guidelines. This suggests that there is shortage of anaesthetists at WMRH.

There is limited space for the holding of patients awaiting surgery. The majority of patients are transported by porter on a stretcher. There is no ability to monitor patients awaiting surgery and there is no privacy.

#### *Improving OR Efficiency*

Long turn around times are a constant complaint and are exacerbated by frequent changes of the OR schedule. There are a number of changes in facilities, processes and systems that would improve efficiency of the OR at WMRH.

- The Director of Nursing, Acute Care should investigate and establish methods for patients to ambulate to the ORs and reduce the dependence upon porters for the transport of patients to the OR.
- The VP Clinical Operations should establish a program to replace the OR lights and anaesthetic machines which could include the harvesting of unused machines and equipment at the STRH and LeGrow.
- The Director of Nursing, Acute Care should investigate ways to deploy the cleaning staff in a more efficient fashion.
- The Director of Nursing, Acute Care should deploy the nursing staff more efficiently to conform to commonly accepted standards of staffing per room and per procedure.



- The Director of Nursing, Acute Care and the VP-Medical Services should ensure a process to reconfigure the pre-op holding area to accommodate ambulatory patients so that the patients that do require stretcher transportation can be monitored and have privacy.
- The Chief of Surgery should establish a process that provides the operating surgeon or assistant along with the anaesthetist accompanies/transport the patient to the PARR.
- The Director of Nursing should establish a process to investigate the introduction of a Surgi-lift System for the transportation of patients from the OR and the PARR.
- The Director of Nursing should ensure a process in which the operating schedule is published at least 72 hours before the day of surgery.

#### **Recommendations:**

It is recommended that:

- (107) The Assistant Director of Nursing Perioperative Program and the Chief of Surgery should establish a process to improve the start time and turn around times.**
- (108) The VP Medical Services and the Chief of Anaesthesia should develop a manpower plan to recruit sufficient additional anaesthetists to provide staffing for the PAC and to conform with accepted standards for on-call coverage.**
- (109) The Assistant Director of Nursing Perioperative Program and the Chief of Surgery should ensure implementation of the recommended processes to improve operating efficiencies.**

Workload information provided by the corporation for the Operating Room is shown in the following exhibit.

**Exhibit 6.8  
OR Cases and FTEs**

	<b>2002/03</b>	<b>2003/04</b>
Total Cases	4,989	5,257
Total Worked Hours	49,171	50,238
FTE	35.49	33.37

## Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient case (Wkd hr/case). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.9**  
**OR Productivity**

	2002/03	2003/04
Wkd Hr/Case	9.86	9.56
var NL non-drug \$/Case	\$ 436.11	\$ 443.55

**Exhibit 6.10**  
**OR Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Case	15	4.93	5.98	6.28	5.72
var NL non-drug \$/Case	15	\$ 278.37	\$ 285.99	\$ 368.33	\$ 307.17

As noted earlier, there are significant issues associated with booking practices which impact the efficiency of the OR staff. These issues must be addressed before it will be possible to achieve target performance.

It appears the department is staffing rooms with 3 RNs per room. Normal staffing in other organizations is 2.0 to 2.5 RNs per room with a PCC function. There may also be opportunity for the OR to achieve the target if it examines the role and use of cleaners, who porter patients to PARR etc.

Based on our analysis of the potential for efficiency in the ORs at WMRH we recommend that the productivity target be set at the median performance of the peer hospitals or 5.98 worked hours per case.

It is very important to note that achievement of this productivity target will not be possible until such time as issues associated with booking, OR utilization etc. noted here have been addressed.

### **Recommendation:**

It is recommended that:

- (110) The Director of Nursing Acute Care should reduce staffing of the ORs at WMRH to achieve a productivity of 5.98 worked hours per case at such time as the major issues associated with the OR have been addressed.**

### 6.2.4.11 Post Anesthetic Recovery Room (PARR)

#### Department Description and Operations

This is a 12 bed unit that provides nursing care to patients immediately following surgery and/or anaesthesia. This unit has 24 hour coverage, seven (7) days per week for elective and emergency patients.

The overtime, starting times and over-booking in the OR all have significant adverse effects on the PARR. Patients are frequently waiting in the PARR because there is no bed available in ICU or the inpatient surgery units.

Workload information provided by the corporation for the PARR is shown in the following exhibit.

**Exhibit 6.11  
PARR Cases and FTEs**

	2002/03	2003/04
Total Cases	4,637	4,887
Total Worked Hours	16,201	16,878
FTE	10.57	10.46

#### Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient case (Wkd Hr/case). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.12  
Productivity**

	2002/03	2003/04
Wkd Hr/Case	3.49	3.45
var NL non-drug \$/Case	\$ 10.41	\$ 12.90

**Exhibit 6.13  
Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Case	13	1.49	1.84	2.10	1.85
var NL non-drug \$/Case	13	\$ 2.50	\$ 3.72	\$ 5.73	\$ 4.17

As noted earlier, there are significant issues associated with booking practices that impact the efficiency of the PARR staff. The practice of holding patients in the PARR because of lack of beds also significantly impacts efficiency and requires additional staff resources. These issues must be addressed

before it will be possible to significantly improve the efficiency of this unit.

The recommended target is set at median peer performance of 1.84 worked hours per case. It is very important to note that achievement of this productivity target will not be possible until such time as the operational issues associated with the OR and PARR noted here have been addressed.

**Recommendation:**

It is recommended that:

**(111) The Director of Nursing Acute Care should reduce staffing of the PARR at WMRH to achieve productivity of 1.84 worked hours per case.**

**6.2.4.12 Endoscopy & OPD/RR**

There are three procedure rooms for endoscopy, minor procedures and urology/gyne procedures.

The endoscopy facilities are inadequate for the population served and there is little privacy. One room for endoscopy is very inefficient without the ability to have staff deployed to perform more than one task at a time. The hospital needs a dedicated unit for endoscopy with two procedure rooms adjoining an equipment cleaning room with an area for registration, waiting and recovery of the patients.

The booking of patients into the OPD/RR is chaotic. There are a wide variety of procedures performed from chemotherapy to post sedation recovery. This is too wide an array of tasks that requires knowledge in too many fields for staff to remain current. The organization should ensure a process to supervise booking practices of the OPD/RR such that bookings into the OPD/RR are restricted to a specific number of cases per day with built-in gaps in the bookings to allow for unexpected length of treatment and urgent cases.

**Recommendations:**

It is recommended that:

**(112) The VP Clinical Operations should develop and implement plans to redevelop the endoscopy suite at WMRH.**

**(113) The Director of Nursing Acute Care should review and revise booking processes for the OPD/RR at WMRH.**

#### **6.2.4.13 Inpatient Surgical Unit Operations**

***4A is a 24 bed general surgery and urology unit.***

4A is a 24 bed general surgery and urology unit. It has approximately 97 % occupancy reported during the site visit. This unit often accommodates medicine overflow patients.

A wound classification system has been developed and this unit would accommodate class III and IV which includes those that may be contaminated or have dirty/infected wounds.

Patients cared for on this unit include those with diagnoses of TURP, radical retropubic prostatectomy, nephrectomy, cholecystectomy, hernia repair, bowel resection, amputation, by-pass graft, etc.

There was a concern expressed that the types of patients on this unit require more intensive nursing care than patients on other units. There is a perception that the medical patients that overflow into this unit are also sicker than those that go to the other surgery units. It was reported that the large number of bed moves and higher care requirements of patients have resulted in many nurses asking to leave this area.

***2C is a 15 bed gynecological surgery unit with a reported average occupancy of 93 % during the site visit.***

2C is a 15 bed gynecological surgery unit with a reported average occupancy of 93 % during the site visit.

The types of patients cared for on this unit include those with total abdominal hysterectomy, mastectomy, bladder repair, hernia repair, etc. The issue of classification of patients is impacting the placement of patients. Because of close proximity to orthopedic care area there is a policy which states that this unit can only take Class 1 and Class 2 surgeries. This has created excessive bed moves (it has the most bed moves of all the floors).

This unit and the orthopedic unit are small and inefficient to operate. Currently, 1 PCC is shared between Gyne and Ortho but the staff are separate. Consideration should be given to consolidating the staff and centralizing the unit to be more efficient. However, to avoid infection of the orthopaedic patients, they should not be located in the same rooms as gynaecology patients and nurses will need to strictly follow infection control protocols.

***2D is a 17 bed orthopedic unit with an average occupancy of 92%.***

2D is a 17 bed orthopedic unit with an average occupancy of 92%.

Patients cared for on this unit include those with Hip Replacement, Total-knee Replacement, T & A, FESS, Corneal Transplant, etc.

Physiotherapy services are not routinely available on weekends. These services are only available to patients who meet the criteria for the use of therapists on the weekends. Only new orthopaedic post-operative patients such as TKR, THR or those who require first day ambulation are seen by therapists on the weekends. Therapy coverage on the weekend was reported as being provided as overtime hours for the therapists. Schedules should be developed for therapists that provide for weekend coverage for all patients. And these hours should be treated as regular time.

Workload information provided by the corporation for the inpatient surgical program, including days reported for medical/surgical inpatients, is shown in the following exhibits.

**Exhibit 6.14  
Surgical Inpatient – Patient Days & FTEs**

	2002/03	2003/04
Total Patient Days	18,836	18,442
Total Worked Hours	116,973	120,459
FTE	79.17	81.01

**Exhibit 6.15  
Medical/Surgical Inpatient – Patient Days & FTEs**

	2002/03	2003/04
Total Patient Days	345	289
Total Worked Hours	4,283	4,145
FTE	2.23	2.15

### **Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.16  
Surgical Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	6.21	6.53
var NL non-drug \$/Pt Day	\$ 17.53	\$ 19.79

**Exhibit 6.17**  
**Surgical Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	17	5.46	5.78	6.09	6.02
var NL non-drug \$/Pt Day	17	\$ 12.74	\$ 14.02	\$ 17.13	\$ 15.11

**Exhibit 6.18**  
**Medical/Surgical Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	12.41	14.34
var NL non-drug \$/Pt Day	\$ 17.53	\$ 19.79

**Exhibit 6.19**  
**Medical/Surgical Productivity**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	6	4.79	5.56	5.69	5.33
var NL non-drug \$/Pt Day	6	\$ 9.67	\$ 12.87	\$ 15.44	\$ 12.39

There are significant issues with the physical space and the unit sizes that make it almost impossible for this program to achieve best quartile performance of the peer hospitals. Comments on these issues have been made earlier in this report.

***Over the next two years the area should be able to achieve the median performance of its peer hospitals and achieve a productivity target of 5.78 worked hours per patient day.***

However the median performance of the peer hospitals should be achievable if issues associated with the surgical services noted here have been addressed. Also, as is discussed below, staff reductions will be possible and productivity improvements will be achieved when a short stay surgery unit is developed.

The unit should be able to move half-way to this target within a year, and we expect that the issues addressed here can be addressed and the median peer performance level can be achieved within 2 years.

Thus, the productivity for this area should be improved to achieve an immediate performance target of 6.38 worked hours/patient day. Over the next two years sufficient changes in operations should be implemented to allow the area to achieve the median performance of its peer hospitals and achieve a productivity target of 5.78 worked hours per patient day.

**Recommendation:**

It is recommended that:

- (114) The Director of Nursing Acute Care should adjust operations and staffing of inpatient surgery at WMRH to achieve a productivity target of 5.78 worked hours per patient day over the next two years.**

**6.2.4.14 Short Stay Surgical Unit**

*A Surgical Short Stay Unit will provide opportunities to significantly reduce costs of inpatient surgical care.*

We believe there may be opportunities to significantly reduce cost if the hospital created a Surgical Short Stay Unit (SSSU). The unit would close on Saturday and open Monday morning. This would save nursing hours. One hospital reports being able to save more than \$10,000 per month in staff costs.

The criterion for admission to the SSSU unit as an inpatient would be that the patient must be expected to and be discharged before 10:00 am Saturday morning. The surgical procedure is irrelevant for admission to the unit, the key criterion is expected length of stay. The allowable length of stay could be as long as 5 days if surgery is conducted on a Monday or as short as overnight for surgery on a Friday. A patient that has an unexpected complication that would extend the stay in hospital would be transferred to another surgical unit.

A SSSU that is open from 6:00 am Monday to 10:00 am Saturday could be used to process SDAS patients as well as accommodate short stay surgical patients. Many, if not most of the SDAS patients will be admitted to the SSSU after surgery. The SDAS patients would be admitted to the SSSU, go to the OR and return to the SSSU post-op if they are short stay patients; otherwise they would go to the appropriate unit for longer stay patients.

This approach would align 2 very similar services and take SDAS patients out of the area assigned to PAC. This change would allow the PAC to function more effectively and more efficiently. Staff will be able to concentrate on the evaluation and education of the patients prior to surgery.

Creation of the SSSU will allow nursing to better match staffing to inpatient workload for surgical patients. The census can be predicted with relative certainty because the booking rules will require the slate to be established 5 days in advance and the expected length of stay established for each



patient. Nurse staffing can thus be planned in relation to census and anticipated acuity with relative certainty. Acuity will be more predictable because these patients, like all elective surgical patients, would have passed through the PAC.

## **6.2.5 Intensive Care Unit (ICU)**

### **6.2.5.1 Department Description and Operations**

The ICU at WMRH is the Regional Referral Center for Intensive Care. The unit has capacity for 12 beds plus 2 overflow beds. There are 8 beds currently open. Average occupancy in 03/04 for these 8 beds was about 103%. The unit provides services for cardiac, respiratory, surgery, general medicine, orthopedics, trauma and paediatric care.

The unit does care for pediatric patients: it will stabilize and transfer them to the Janeway Hospital in St. John's as appropriate.

***The ICU does not have negative pressure capability for patient isolation.***

There is no negative pressure capability for patient isolation in the ICU. This is a concern for the care of seriously ill patients with contagious respiratory diseases and others.

There is PCC and ward clerk support Monday to Friday for 8 hours each day. Although there is a Medical Director of the Intensive Care Unit, the unit is not closed: all specialists may admit to the units and are responsible for the care of their patients while they are on the unit.

***ICU resources should be requested at the time of booking a procedure, and confirmed before initiating the procedure.***

As has been discussed, there is a significant problem with the appearance of cases from the OR with no advance notice. Surgeons are booking/starting cases with no advance notice to the ICU or without checking with ICU regarding the availability of a bed. This has created significant staffing problems and put patients and the organization at risk. A system must be established that requires a surgeon to book ICU resources at the time of booking the case and then a check with ICU prior to starting the case to ensure that a bed and staff will be available for the patient when the procedure is completed.

There are 8 telemetry units in the hospital monitored by the ICU staff and this will be increasing to 12 in the autumn of 04 when a new monitoring system is installed.

Staff receive a 10 week orientation to ICU which is supported by staff education.

Workload information provided by the corporation for the ICU is shown in the following exhibit.

**Exhibit 6.20  
ICU Patient Days & FTEs**

	2002/03	2003/04
Total Patient Days	2,735	3,026
Total Worked Hours	51,148	56,742
FTE	34.97	36.66

#### 6.2.5.2 Productivity and staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.21  
ICU Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	18.70	18.75
var NL non-drug \$/Pt Day	\$ 49.68	\$ 55.12

**Exhibit 6.22  
ICU Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	18	15.03	17.41	19.71	17.84
var NL non-drug \$/Pt Day	18	\$ 38.61	\$ 49.46	\$ 55.83	\$ 50.20

The issues associated with booked beds for surgical patients must be addressed to assist in achieving more efficient operations of the ICU.

***The median performance of the ICUs in the peer hospitals should be used as the productivity target for the ICU at WMRH.***

Because patient acuity is so important in determining appropriate staffing levels in the ICU and these data are not available to this study for WMRH or its peers, it is inappropriate to recommend best quartile productivity performance for WMRH based only on these comparisons. Rather, based on our interviews, observations, data analysis and the comparisons of performance with peer hospitals, we recommend that the median performance of the ICUs in the peer hospitals be used as the productivity target for the ICU at WMRH. As soon as possible staffing should be reduced to allow the ICU to achieve the median performance of its peer hospitals and achieve productivity of 17.41 worked hours per patient day.

**Recommendation:**

It is recommended that:

- (115) The Director of Nursing should reduce staffing in the ICU at WMRH to achieve nursing productivity of 17.41 worked hours per patient day.**

**6.2.6 Birthing Program****6.2.6.1 Department Description & Operations**

The Maternal/Newborn programs provides Level I and II family centered maternity care within the Western Region. Included in these programs are outpatient prenatal care, inpatient antepartum, intrapartum, postpartum and neonatal care as well as some ambulatory care encompassing outpatient diagnostic testing, i.e., non-stress tests, ultrasonography, amniocentesis, etc. Patient education services are provided through a collaborative effort between Western Health Care Corporation and Health and Community Services Western, i.e., New Life Program (prenatal education) and Post Partum Parent Support Program (postnatal education). Other collaborative efforts from a regional prospective include the involvement of regional representatives on the Breastfeeding Promotion Committee.

There are a total of 11 beds for birthing which include 5 birthing rooms and 6 regular post-partum beds. There is a triage area for assessment with 2 stretchers. Non-stress testing is also done in the triage area.

There are fewer than 600 births annually. OR staff attend C-sections. There were 105 C-sections in 2003/04. There is sufficient capacity to consolidate all obstetrical services for the region to this site

Workload information provided by the corporation for the Birthing program is shown in the following exhibit.

**Exhibit 6.23  
Birthing - Patient Days & FTEs**

	<b>2002/03</b>	<b>2003/04</b>
Total Patient Days (adult)	2,638	2,331
Total Patient Days (newborn)	1,558	1,634
Total Worked Hours	45,929	46,365
FTE	30.87	29.63

### 6.2.6.2 Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). Like other low volume birthing units, staff of the inpatient unit provide support for a range of outpatient services in addition to inpatient care<sup>55</sup>. The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.24  
Birthing Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	10.95	11.69
var NL non-drug \$/Pt Day	\$ 22.47	\$ 28.40

**Exhibit 6.25  
Birthing Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	17	8.08	9.04	10.04	9.09
var NL non-drug \$/Pt Day	16	\$ 18.25	\$ 26.58	\$ 31.01	\$ 25.46

***Productivity of WMRH birthing is dramatically worse than performance of its peer hospitals.***

Based on the worked hours and workload information provided to us by the region, in 2003/04, this functional centre's productivity is worse than the worst quartile level of performance of its peer group for birthing.

It is suggested that core staffing be changed to 3 RNs on days and nights (this assumes 12 hour shifts). This should be considered the minimum staffing required for station-fill. It will be more than sufficient to accommodate the requirements of the current workload. Although infrequent, there may be peaks in census and acuity that generate workload that exceeds the capacity of this minimum level of staffing and the hospital will need to, and need to be able to adjust staffing accordingly. Additional RNs should be on-call to provide support should more mothers be in labor than the available staff can safely manage.

It is recommended that the median performance of 9.04 worked hours per patient day be used as the target.

<sup>55</sup> For low volume birthing units, patient days is used as a surrogate for the combination of inpatient and outpatient workload. The ratio between inpatient and outpatient workload accommodated by unit staff is relatively constant among these low volume birthing units.

**Recommendation:**

It is recommended that:

- (116) The Director of Nursing should reduce staffing for Birthing at WMRH to achieve productivity of 9.04 worked hours per patient day.**

**6.2.7 Pediatrics****6.2.7.1 Department Description & Operations**

The Paediatric inpatient services at WMRH are provided on a 12-bed unit. Like most general hospital paediatric units, the admission criteria include all medical, surgical, and mental health diagnosis for ages between 28 days and 18 years.

The program at WMRH provides primary, secondary and limited tertiary care. All other sites in the Western Region see children and admit for observation or send to WMRH for more specialized Paediatric Care. The program also provides respite care. This is offered to families of children with mental/physical disabilities up to a maximum of 30 days per year per child. The Paediatric Program can offer respite care to one client at a time year round.

The program also provides an outpatient service to children who do not require admission but need short-term intervention, i.e., blood pressure checks, weight checks, chemotherapy, etc.

A multidisciplinary team is available to provide services in the inpatient area. There is a play therapist available 1600-2000 Monday to Friday.

There are issues associated with physician coverage. The WMRH Chief of Staff is currently acting as Chief of Pediatrics as there is no one in this role at present. There are currently 4 pediatricians but 1 will be retiring in the near future.

Like many communities across Canada, adolescent mental health has been a concern. There has been lack of physician coordination for the mental health staff.

Workload information provided by the corporation for pediatrics is shown in the following exhibit.

**Exhibit 6.26  
Paediatric Patient Days & FTEs**

	2002/03	2003/04
Total Patient Days	3,278	2,993
Total Worked Hours	35,658	35,017
FTE	23.87	23.59

### 6.2.7.2 Productivity and staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The peer hospital productivity range for comparison purposes is also presented

**Exhibit 6.27  
Paediatrics Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	10.88	11.70
var NL non-drug \$/Pt Day	\$ 10.83	\$ 13.84

**Exhibit 6.28  
Paediatrics Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	12	7.74	7.94	8.29	9.07
var NL non-drug \$/Pt Day	10	\$ 12.80	\$ 14.43	\$ 21.17	\$ 17.48

The size of this unit makes it difficult to achieve efficiencies. It should be staffed with the minimum number of staff to ensure the safety and care of the patients. Where possible efforts should be made to cross-train staff with family-centred care program so that both programs might benefit from sharing staff.

The minimum reasonable and safe staffing for the paediatric unit would provide 3 RNs on days and 2 staff on nights with at least 1 of these being an RN<sup>56</sup>. This staffing will generally exceed the number of staff necessary to meet the care requirements of patients on the unit; but fewer staff would not be safe.

It is recommended that the median performance of the peer hospitals of 7.94 worked hours per patient day be used as the productivity performance target for paediatric nursing at WMRH.

<sup>56</sup> The unit nursing staff will also require clerical and clinical support at approximately 10 worked hours per day.

The fact that there are mental health patients should not change the target or minimum staffing. Most general hospitals accommodate paediatric (to age 18) mental health patients on their paediatric units. Moreover, WMRH has a multi-disciplinary team available to this unit. The unit would have to use all usual measures if these patients were in crisis (for example, additional staff for short period.) If some of these patients are more critical they should be transferred to the paediatric/adolescent mental health services in St. John's. There is currently a problem with physician coverage for these patients but that should not significantly impact the required nursing worked hours.

**Recommendation:**

It is recommended that:

**(117) The Director of Nursing should reduce staffing for paediatric nursing at WMRH to the recommended minimum staffing levels until such time as workload increases beyond the capacity for workload of this level of staffing and then 7.94 worked hours per patient day should be used as the productivity target.**

**6.2.8 Mental Health**

**6.2.8.1 Department Description and Operations**

The Mental Health Program at WMRH provides inpatient care on a 23 bed acute care unit which serves the Western Region of Newfoundland. The admission criteria includes all diagnosis covered in the DSM IV including alcohol and drug detoxification prior to clients being referred to the addiction rehabilitation service. The program is focused on providing a safe, therapeutic and caring milieu for persons experiencing emotional, behavioral, aging and addictive disorders through a multidisciplinary team approach.

Another component of the Mental Health program provided at Western Memorial Regional Hospital is an outpatient rehabilitation program. This program provides follow-up counseling through group therapy, one on one sessions and a neuroleptic clinic. Clients who attend are maintained in the community and the support provided enables them to lead productive lives.

There is a collaborative effort between institution and community to provide public education on Mental Health issues. This is accomplished through the Mental Health

Promotion Committee. The continuum of care is recognized between the two agencies.

Other issues such as recruitment and retention of psychiatrists and issues related to the child and adolescent population is jointly recognized.

Workload information provided by the corporation for psychiatry is shown in the following exhibit.

**Exhibit 6.29**  
**Psychiatry Patient Days & FTEs**

	2002/03	2003/04
Total Patient Days	6,741	7,694
Total Worked Hours	54,683	41,526
FTE	34.26	27.90

#### 6.2.8.2 Productivity and Staffing

*Productivity on the psychiatric nursing unit has improved by 33% from 2002/03 to 2003/04.*

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). As can be seen, based on the data provided to this study, productivity on the psychiatric nursing unit has improved by 33% from 2002/03 to 2003/04. The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.30**  
**Psychiatry Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	8.11	5.40
var NL non-drug \$/Pt Day	\$ 2.54	\$ 2.27

**Exhibit 6.31**  
**Psychiatry Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	11	5.24	5.59	5.88	5.71
var NL non-drug \$/Pt Day	10	\$ 3.38	\$ 4.59	\$ 7.17	\$ 5.09

The physical environment presents challenges for this unit with respect to programming space, secure observation, etc. It was reported during the site visit that there is also significant use of constant care. The organization has worked to reduce the amount of constant care in the past year. Every effort needs to be made to establish standards for the use of constant care to reduce the resource used for this activity.

The current productivity is between the best and median performance levels. Unit productivity does not seem to be



having a negative impact on the quality of care. The current level of staffing is satisfactory. We recommend the unit maintain its current productivity performance level of 5.40 worked hours per patient day.

**Recommendation:**

It is recommended that:

**(118) The Director of Nursing should maintain the current productivity performance of 5.40 worked hours per patient day of the Psychiatry Unit at WMRH.**

**6.2.9 Palliative Care**

**6.2.9.1 Operations**

3C holds an 8 bed palliative care unit that opened in 2002. It is running about 76% occupancy. There are significant inefficiencies with this size of unit and minimum staffing of 2 on days and nights must be maintained regardless of how few patients may be on the unit. The unit leaves 1 bed vacant at all times to accommodate a potential community admission. Regional Programs include an End-of-Life Program that is a community program (defined as death within 6-8 weeks) and Symptom Management Program. Admission can be to the program and/or admission to the unit.

The criteria for admission to the unit are strict, confusing and/or inconsistent applied. Nursing staff and physicians from other areas need more information and education related to the admission criteria. Consideration could also be given to expanding the criteria to provide care to other palliative patients occupying acute medical beds and who could benefit from the care provided. This would increase the occupancy as well as staff productivity and still allow for admissions from the community.

Workload information provided by the corporation for the palliative unit is shown in the following exhibit.

**Exhibit 6.32  
Palliative Care Patient Days & FTEs**

	2002/03	2003/04
Total Patient Days	2,208	2,222
Total Worked Hours	21,331	19,148
FTE	13.67	11.65

### 6.2.9.2 Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.33**  
**Palliative Care Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	9.66	8.62
var NL non-drug \$/Pt Day	\$ 21.50	\$ 17.40

**Exhibit 6.34**  
**Palliative Care Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	2	5.60	5.82	6.04	5.82
var NL non-drug \$/Pt Day	2	\$ 12.54	\$ 13.90	\$ 15.26	\$ 13.90

***Both of the comparators with palliative care units used fewer hours per patient day than did WMRH.***

It should be noted that only 2 peer comparators reported productivity information for a palliative care unit. As a result the performance parameters are not meaningful. However, it should also be noted that both of the comparators with palliative care units used fewer hours per patient day than did WMRH.

It was recommended above that efforts should be made to increase the patient days in this unit and provide access for a broader range of patients. This will also assist in achieving improved productivity for the staff on the unit.

The size of this unit and average occupancy requires minimum staffing levels of 2 on days and nights (or 48 worked hours per day). Given the small number of comparators it is recommended that the mean productivity of the comparators, 5.82 worked hours per patient day be used as the performance target

#### **Recommendation:**

It is recommended that:

- (119) The Director of Nursing should reduce staffing for palliative care at WMRH to the recommended minimum staffing levels until such time as workload increases beyond the capacity for workload of this staffing and then 5.82 worked hours per patient day should be used as the productivity target.**

## 6.2.10 Emergency Department

### 6.2.10.1 Department Description and Operations

This department provides 24/7 full range emergency services to Corner Brook and surrounding areas. The department functions with triage area, resuscitation room, 5 individual exam rooms, and an observation/treatment room with 3 stretchers. There is a PCC Monday to Friday 0800-1600. Ward clerk coverage is available for 16 hours and the department staffs with 3 RNs on nights and days. Paramedics provide assistance up to their scope of practice when they are on site.

There is 1 ED doctor 24/7 and a 2nd doctor 1100 - 1700 daily Monday to Friday.

The Department also runs what is called a Non-Emergency Clinic. This is an outpatient clinic staffed by a Family Practice Physician from Corner Brook. The hours of operation are Monday to Friday 18:00 – 22:00 hours and Saturday & Sunday 10:00 – 22:00 hours. The clinic is staffed with a Personal Care Attendant. All patients are triaged by the Emergency Triage Nurse before being seen in this clinic

The department averages about 110 visits per day and about 40% of these are seen in the Non-emergency Clinic.

Workload information provided by the corporation for the ED is shown in the following exhibit.

**Exhibit 6.35  
Emergency Visits & FTEs**

	2002/03	2003/04
Total Visits	38,851	40,881
Total Worked Hours	39,709	38,650
FTE	26.89	24.77

### 6.2.10.2 Productivity and staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient visit (Wkd Hr/visit). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.36  
Emergency Productivity**

	2002/03	2003/04
Wkd Hr/Visit	1.02	0.95
var NL non-drug \$/Visit	\$ 5.82	\$ 6.04

**Exhibit 6.37**  
**Emergency Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	15	1.22	1.28	1.67	1.41
var NL non-drug \$/Visit	15	\$ 5.52	\$ 6.53	\$ 7.86	\$ 7.24

There are issues associated with the layout of the department and the distance between the main department and the non-emergency clinic. There is shared space with outpatients which cause problems with traffic flow etc. The WMRH has submitted a proposal to the DOHCS for improvement in the physical facilities. These space issues do impact efficiency.

This unit is performing better than best quartile of the peer hospitals with respect to staff productivity. Unit productivity does not seem to be having a negative impact on the quality of care. The current level of staffing is satisfactory and it is recommended that this department maintain its current level of performance.

**Recommendation:**

It is recommended that:

**(120) The Director of Nursing should maintain the current productivity performance of 1.0 worked hour per visit of the ED at WMRH.**

### **6.2.11 Renal Program**

#### **6.2.11.1 Department Description and Operations**

The Renal Care Program provides treatment for patients in end stage renal disease in the Western Region. The program provides the following services:

- 12 station hemodialysis unit for chronic/acute dialysis
- Post Kidney Transplant Clinic (also provides donor and recipient transplant work-up)
- Progressive Renal Insufficiency Clinic (Education and follow-up)
- Peritoneal Dialysis Program
- Clinical Management of the 4 bed Satellite Dialysis Unit at Sir Thomas Roddick Hospital

Services are provided 0800 - 2000 hours Monday to Saturday, with standby services when the unit is closed.

Workload data was not provided in the corporate MIS report for this program. The program reported the following patient volume statistics:

- 6,650 Hemodialysis Treatments/Year
- Average Census - 46 Hemodialysis Patients
- 10 Peritoneal Dialysis Patients
- 75 Progressive Renal Insufficiency Patients
- 50 Kidney Transplant Patients

#### ***6.2.11.2 Productivity & Staffing***

There is no comparative productivity data available for this service. They are currently staffing at approximately 3.3 hours per treatment and this is common practice in other organizations where the range is often 3-3.5 hours per treatment.

#### ***6.2.12 Medical Day Care/Outpatient Recovery***

This nine (9) bed unit located on the ground level provides services to patients accessing the Outpatient Procedure Rooms and patients requiring pre and post-procedure nursing care following Diagnostic Imaging procedures. The unit operates 0730 - 1600 hours Monday to Friday.

Medical procedures and treatments performed in the unit include such things as liver biopsies, blood transfusions, etc. A Pain Clinic service is also provided one day per week, 0800 to 2000 hours and uses 2 of the 9 stretchers.

There are 44 physicians who use this service.

There are significant space and location issues for this unit that are affecting both the efficiency and quality of patient care. This area shares clean and soiled rooms with ED. There is very limited storage space. There are significant issues with respect to traffic, congestion and ultimately confidentiality.

This unit often gets the overflow of admitted patients from the ED waiting for a bed on an inpatient unit. It does not have the appropriate level of staffing to provide care for these patients. The physical environment is not appropriate for providing inpatient care. This is already an over-utilized space with level of ambulatory activity. Having inpatients in this area makes it almost impossible to provide for all of the needs of the ambulatory care patients.

With the previously recommended approach to creating a short stay unit, there may be some space freed up from the integration of the SDAS into a surgical short stay unit. Options for improving the space for Medical Day Care activity should be explored.

**Recommendations:**

It is recommended that:

- (121) The VP Clinical Operations and the VP Medical Services should eliminate the practice of holding admitted patients in the Medical Day Care Area.**
- (122) VP Clinical Operations should explore alternative locations for Medical Day Care to ensure a better quality of patient care.**

Workload information provided by the corporation for Medical Day Care is shown in the following exhibit<sup>57</sup>.

**Exhibit 6.38  
Medical Day Care Visits & FTEs**

	2002/03	2003/04
Total Visits	8,851	10,201
Total Worked Hours	20,359	21,355
FTE	13.20	13.63

**6.2.12.1 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient visit (Wkd Hr/Visit). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.39  
Medical Day Care Productivity**

	2002/03	2003/04
Wkd Hr/Visit	2.30	2.09
var NL non-drug \$/Visit	\$ 6.22	\$ 5.52

<sup>57</sup> Data provided included the Orthopaedic Clinic, an area not normally reported as part of Medical Day Care. We have removed 1.0 FTE and 7000 visits so that Medical Day Care performance can be compared with the peers.

**Exhibit 6.40**  
**Medical Day Care Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	3	2.51	3.28	3.80	3.11
var NL non-drug \$/Visit	2	\$ 18.50	\$ 30.91	\$ 43.32	\$ 30.91

It should be noted that there are only 3 comparators for this area. This unit is functioning better than the best quartile but concerns have been noted above with respect to the delivery of service in this area. If the organization eliminates admitted patients from the ED being held in the Day Care area then the current level of staffing may be sufficient. If there is no change in this situation, staffing levels will continue to need to be augmented from the inpatient areas. Assuming the organization can contain the activity in this area we recommend that the current performance level of 2.09 worked hours per visit be maintained.

**Recommendation:**

It is recommended that:

**(123) The Director of Nursing should maintain the current productivity performance of 2.09 Worked Hour/Visit of the Medical Day Care Unit at WMRH.**

**6.2.13 Other Ambulatory Activity**

*The Home Care Clinic (Dressing clinic) is dealing with activity that is not usually seen in an acute care facility.*

The Home Care Clinic (Dressing clinic) is busy dealing with minor procedures such as suture removal and routine post-operative follow up of surgical patients. This activity is not usually seen in an acute care facility. These are procedures that are part of the normal postoperative course of care for a patient and are usually dealt with in a physician's office or in the home. It was reported during the site visits that home care is limited and this has resulted in the establishment of this clinic. It is not the responsibility of the hospital to provide this type of follow-up surgical services. Most if not all of these patients live within the catchment area of the WMRH and therefore should have access to their surgeon or primary care physician. These services should be provided by the physician's office practice.

**Recommendation:**

It is recommended that:

**(124) The VP-Medical Services and the Director of Nursing should discontinue the Home Care (Dressing) Clinic at the WMRH.**

There is an Orthopedic Clinic providing services for inpatients and outpatients.

There is a Urodynamic/vascular clinic supporting both inpatient and outpatient activity. The technician provides assistance on the inpatient units for difficult catheterizations. There is concern regarding the computer and software being used in this clinic, as tests have to be repeated a number of times because of computer malfunction. The use of on-call status for the technician should be re-examined. In total the technician was required to attend in off hours only about 35 times in 03/04. Paying for on-call status for a service that is required this infrequently is questionable; alternate mechanisms should be explored.

Workload information provided by the corporation for the functional centre External Clinic Visits is shown in the following exhibit.

**Exhibit 6.41  
External Clinics Visits & FTEs**

	2002/03	2003/04
Total Visits	6,732	7,300
Total Worked Hours	9,850	9,113
FTE	5.98	5.52

**6.2.13.1 Productivity and staffing**

Productivity is measured as the total worked hours (unit producing and management and operational support) per patient visit (Wkd Hr/Visit).

**Exhibit 6.42  
External Clinics Productivity**

	2002/03	2003/04
Wkd Hr/Visit	1.46	1.25
var NL non-drug \$/Visit	\$ 48.99	\$ 41.79

Comparisons among hospitals of activity and productivity of outpatient clinics are quite difficult because of differences in approaches to reporting workload and staffing. Much of the



workload data for outpatient clinics is incomplete. WMRH External Clinics data includes hours for off-site clinics that do not provide visit statistics. As a result we have not provided a comparison with the peer hospitals performance.

It appears the department has reduced FTEs while accommodating additional visits. Given that there is no valid comparative information, and based on observations it appears that quality of care is not suffering because the current level of performance. Thus, it is recommended that the departments maintain the current level of performance of 1.25 worked hours per visit.

#### **Recommendation:**

It is recommended that:

**(125) The Director of Nursing should maintain the current productivity performance of 1.25 worked hours per visit of the Ambulatory Care Clinics at WMRH.**

### **6.3 Sir Thomas Roddick Hospital**

#### **6.3.1 Overview**

*Sir Thomas Roddick Hospital is a brand new 44 bed acute care facility.*

Sir Thomas Roddick Hospital is a brand new 44 bed acute care facility with a range of inpatient and outpatient services. There is a capacity to grow to 46 beds.

The Hospital moved into its new building in November of 2003. There have been issues associated with changes in practice that go along with delivering services in new space.

*Services are provided, primarily, for the population of the Bay St. George area.*

The services are provided, primarily, for the population of the Bay St. George area. The catchment area serviced by Sir Thomas Roddick Hospital is between Lourdes east to Gallants and south to the Jeffrey's/St. Fintan's area.

The hospital has five nursing units:

- Medical nursing unit which includes medicine, pediatrics and palliative care;
- OBS/Gyn/Mental Health Unit includes new born nursery, birthing rooms, post partum, ophthalmology, gynecology and mental health;
- Medical/Surgical unit which includes, general surgery, acute medicine and intensive care;
- Outpatient/Emergency Department that is staffed with nursing and medical services twenty-four hours per day;

- Outpatient services offered include chemotherapy program (adult only), visiting consultants (pediatrics and orthopaedics), endoscopy/ colonoscopy, and clinics which include internal medicine, surgery (general and gynecology) and obstetrics.

There are 2 general surgeons, 2 obstetricians/gynaecologists and 2 anaesthetists; all salaried.

There are 2 ORs with a pre-op assessment area and a post-op recovery room with 4 bays, 2 of them monitored and there is the availability of an additional portable monitor. The nursing staff are all cross-trained and multi-task. Patient registration is done at central registration because, until recently there was no ward clerk to act as the organizing clerk and flow engineer. This has improved the efficiency of the nursing staff who now can concentrate on the patient and not on logistical and support services.

Unfortunately the main source of sterile supplies for the ORs is on the other side of the building.

It was reported that respiratory care services are a problem because there is no full time Respiratory Therapist and the anaesthetist must do all the adjustments of any respiratory cases himself. However, this does not occur very often.

Although the entire facility is wheelchair accessible, the clinic area where physicians see patients in the ambulatory program is not easily accessible by patients that are on stretchers. This means that patients that are in this situation must be seen in another area of the building. The doors and turning angle are too narrow. Likewise the Electrophysiology area does not allow access by a stretcher because of narrow doorways. This is not acceptable when dealing with cardiac patients under going stress evaluations.

The radiology department is very modern and digitized. Interpretation of the films is off-site.. Since there is no on-site radiologist there is no facility to do x-ray controlled breast biopsies. However, it should be noted that once reports are dictated all physicians are able to access the results of ordered films by phone.

There is a room designated for endoscopy that was not designed for that purpose. It has 2 bed heads for oxygen suction etc. but is too small and not contiguous to a cleaning area and patient flow is not smooth. Close by is a similar room for minor procedures that has the same 2 bed heads and is

used for minor excisions etc. under local anaesthetic. Neither of these areas is conducive to patient privacy.

The number of deliveries at STRH over the past three years was: 172 in 1999/00, 113 in 2002/03, and 136 in 2003/04. At this low volume it will be difficult to support an Obstetrician. High-risk mothers currently are sent to WMRH. This is reasonable since the support for these patients requires a team approach not only for the surgical intervention but also the resuscitation of the babies. This requires not only expertise but also a volume of work for all concerned to maintain an acceptable skill level.

Other surgical specialties are represented by a visiting Orthopaedic surgeon from Corner Brook and a resident Ophthalmologist. There is no urology.

#### **6.3.1.1 Nursing Issues**

There are a number of issues that impact the nursing services at this site.

- Information system support is a significant concern.
  - The nursing leaders report they are not yet able to communicate internally by email since moving into the new building. They are not able to communicate with staff by email.
  - Implementation of order entry has been delayed.
- There is no bio-medical support on-site and the current process/mechanisms are reported to be inadequate to the level of service required.
- The organizational structure/design issues noted earlier in this report are a significant issue for this site.
- Professional development for staff is reported to be essentially non-existent. There is a perception of little/no education locally. A lack of communication and implementation of policies contributes to issues in this area. For example, there was no support/education for fire policies changes when a change of 6 pages was made to the policy. It should be noted that since January of 2004 10 educational sessions have been provided at the STRH including monthly CPR classes, ICU course, ACLS, diabetes education in services, etc.
- There is a need to develop and implement guidelines and standards for constant observation. This was also noted earlier in this report. However the need for practice

standards and guidelines for the use of constant observation is important for this site.

### **6.3.1.2 Float Pool**

The Hospital has an RN Float Pool. They schedule 1-2 staff per 12 hour shift for replacement purposes for sick call and vacation relief. Most of the time these shifts are doing replacement and there are few if any occasions when these scheduled staff are extra. Often there is no staff available in the float pool. This is also an important recruitment and retention mechanism to be able to offer new staff/graduates a full-time position (as Float Staff initially).

### **6.3.1.3 Measuring Productivity**

As noted earlier in the report, the productivity of nursing is measured as nursing worked hours per patient day or visit in the appropriate departments. The productivity of nursing within each area was compared to nursing productivity at selected peer hospitals.

Comparisons are based on 2003/04 data for WHCC and 2002/03 data for the peer comparators.

## **6.3.2 Medical Inpatient Services**

### **6.3.2.1 Department Description and Operations**

This is a general medical unit of 19 beds that are allocated as follows:

- 11 acute medicine
- 4 palliative care
- 4 ALC beds

Typical cases seen in this unit include acute respiratory problems, pneumonia, CVA, diabetes, chronic heart/vascular disease, cellulitis, wound/skin care and management. The palliative patients are co-located at one end of the unit. Although there was concern that perhaps the palliative unit should be staffed separately this is not recommended. All 19 beds should be treated as one unit. A 19 bed unit is already a small unit and a difficult size to staff efficiently. In our experience units of 32-36 beds present the greatest opportunities for efficiency.

Typically both the medicine and surgical units run at approximately 85% occupancy. On medicine this means an

average occupancy of 16 patients. Staff work 12 hour shifts. There is 1 Patient Care Coordinator (PCC) shared with the Med/Surg unit. Typical staffing is 2 RN and 2 LPN on days and 2 RN and 1 LPN on nights. Given the number of patients, this ratio of nurses to patients is generally greater than is seen in other facilities.

The size of this unit (19 beds) makes it difficult to achieve optimal nursing productivity when minimum staffing (station-fill staffing) is required regardless of the number of patients to be cared for.

The workload and staffing for this program provided by WHCC is presented the following exhibit. It suggests that average occupancy for 03/04 has been about 16 patients.

**Exhibit 6.43**  
**Medical Inpatient Services Days and FTEs**

	2002/03	2003/04
Total Patient Days	8,323	5,837
Total Worked Hours	31,135	38,476
FTE	25.37	26.75

### 6.3.2.2 *Productivity and Staffing*

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The exhibit below presents the productivity for the unit for 2002/03 and for 2003/04. The peer hospital productivity range is also presented for comparison purposes.

**Exhibit 6.44**  
**Medical Inpatient Services Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	3.74	6.59
var NL non-drug \$/Pt Day	\$ 6.73	\$ 11.50

**Exhibit 6.45**  
**Medical Inpatient Services Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	8	5.23	5.55	5.95	5.48
var NL non-drug \$/Pt Day	9	\$ 9.85	\$ 10.20	\$ 11.99	\$ 10.61

Because of the current nurse/patient ratios and the size of the nursing unit, nursing staff on this unit are not as productive as the peer hospitals; nursing hours per patient day are significantly higher. However, we feel that there are

opportunities to improve nursing productivity and that this unit should be able to be as efficient as similar units in peer hospitals. This unit should be able to achieve productivity of 5.23 worked hours per patient day.

**Recommendation:**

It is recommended that:

**(126) The Director of Nursing should reduce staffing for the medical unit at STRH to achieve productivity of 5.23 worked hours per patient day.**

**6.3.3 Combined Surgical Services**

**6.3.3.1 Department Description and Operations**

This unit is reported as a 22 bed combined medical/surgical unit that includes obstetrics and mental health inpatient services. It includes the following:

- 2 LDRP rooms and 1 Emergency Delivery Room
- 3 Mental Health beds
- 17 flexible medical/surgical beds

Typical surgical cases on this unit include cholecystectomy, appendectomy, bowel resections, amputation, mastectomy hernia repairs, hemorrhoidectomy, pilonoidal sinus repair, cardiac step-down, unstable angina, etc.

The scope of mental health services has changed since the hospital has designated beds. Activity in this area of service is increasing and the physical environment is not conducive to managing these patients in the general medical surgical milieu. However, adequate care can be provided to these patients in the short term. There may be a need for a day program. There is an ambulatory program for short term intervention managed by social work.

Service for the birthing activity at the hospital is provided within this general medical/surgical unit. Separate staff with obstetrical skills are scheduled to be available for care delivery when a laboring patient arrives. The hospital schedules 2 RNs 24/7 for this service. As noted elsewhere in this report, there are not a significant number of births annually. The low number of births and hence patient days makes it very difficult to use staffing productively.

Staff work 12 hours shifts. Typical staffing includes 4 RN and 1.4 LPN on days and 4 RN and 1 LPN on nights. Two of these RNs on days and nights are obstetrical staff. Presently on days 1 of these obstetrical RNs assist in the OR for endoscopy and to support conscious sedation. As well, they assist in the OR for 1<sup>st</sup> case set-up.

There are opportunities for improved productivity if obstetrical staff are not scheduled separately. Other small organizations ensure at least, but only 1 obstetrically trained staff is scheduled on each shift. But this staff person is available for other duties and patient assignment until a mother in labour arrives.

The workload and staffing for this program is presented the following 3 exhibits. The days and FTEs are shown for medicine/surgery, birthing, and combined surgical services which includes all days and FTEs reported.

**Exhibit 6.46  
Med/Surg Patient Days & FTES**

	2002/03	2003/04
Total Patient Days	3,340	6,268
Total Worked Hours	31,313	33,786
FTE	23.26	23.20

**Exhibit 6.47  
Birthing Patient Days & FTES**

	2002/03	2003/04
Total Patient Days	743	1,156
Total Worked Hours	15,266	15,850
FTE	14.35	12.27

**Exhibit 6.48  
Combined Surgical Services Patient Days & FTES**

	2002/03	2003/04
Total Patient Days	4,083	7,424
Total Worked Hours	46,579	49,636
FTE	37.61	35.47

Patient days for this unit for 2003/04 were 6,268 for med/surg, 652 for mental health and 1,156 for obstetrics for a total of 7,424 and the total FTEs reported were 35.47

### **6.3.3.2 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day).

The productivity for this unit is presented in 3 exhibits. The first includes workload and hours reported for medical surgical and mental health days. Productivity for birthing is provided separately followed by productivity for the combined service.

**Exhibit 6.49  
Med/Surg Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	9.38	6.02
var NL non-drug \$/Pt Day	\$ 27.20	\$ 15.12

**Exhibit 6.50  
Birthing Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	20.55	13.71
var NL non-drug \$/Pt Day	\$ 31.49	\$ 22.14

**Exhibit 6.51  
Combined Surgical Service Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	11.41	6.69
var NL non-drug \$/Pt Day	\$ 27.98	\$ 14.88

The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.52  
Med/Surg Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	3	5.21	5.29	6.54	6.07
var NL non-drug \$/Pt Day	3	\$ 10.46	\$ 11.16	\$ 14.43	\$ 12.87

**Exhibit 6.53  
Birthing Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	6	7.49	8.19	9.35	8.33
var NL non-drug \$/Pt Day	7	\$ 13.72	\$ 21.59	\$ 28.06	\$ 23.64

**Exhibit 6.54  
Combined Surgical Service Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	9	5.43	5.57	6.81	6.29
var NL non-drug \$/Pt Day	10	\$ 10.78	\$ 12.18	\$ 15.76	\$ 13.92

This unit should be able to achieve (an integrated) productivity of 5.43 hours per patient day. However, it is noted that this unit is relatively small. Variability in census



may cause it to have insufficient patients to maintain a reasonable level of productivity on every shift of every day; however over the course of a year, the targeted average level of productivity should be achievable. The minimum staffing level for this unit should be 3 RNs and 1 LPN on days and 2 RNs and 1 LPN on nights. Of the complement of RNs on any shift, at least one should have obstetrical experience. If a laboring patient is admitted, med/surg part-time/casual staff or float pool staff should be used to back-fill the obstetrical nurse who should be providing care to the obstetrical patient and not to the med/surg patients.

**Recommendation:**

It is recommended that:

**(127) The Director of Nursing should reduce staffing for the surgical services nursing unit at STRH to achieve productivity of 5.43 worked hours per patient day.**

**6.3.4 Intensive Care Unit**

**6.3.4.1 Department Description and Operations**

This is a 3 bed unit adjacent to the medicine unit that primarily provides care for medical patients including cardiac patients with MI, dysrhythmia, cardio-version, diabetic ketoacidosis, etc. They also provide support for complex post-operative patients who may have invasive monitoring such as arterial lines, CVP lines, etc. They have provided care for patients with ventilators. There is 1 respiratory therapist on staff.

There is no telemetry currently available. It was supposed to be installed shortly after moving into the building but has not been put in place yet. As a result, monitoring can only happen in the ICU room. There is no ability to monitor the ICU patients out at the inpatient desk. This means that dedicated staff have been assigned to this room even when there is only 1 patient.

The size of this unit makes it very difficult to use staff productively.

The workload and staffing for this program is presented the following exhibit.

**Exhibit 6.55**  
**ICU Patient Days and FTEs**

	2002/03	2003/04
Total Patient Days	395	417
Total Worked Hours	8,474	9,556
FTE	5.56	6.26

#### 6.3.4.2 Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per patient day (Wkd Hr/Pt Day). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.56**  
**ICU Productivity**

	2002/03	2003/04
Wkd Hr/Pt Day	21.45	22.92
var NL non-drug \$/Pt Day	\$ 12.74	\$ 13.47

**Exhibit 6.57**  
**ICU Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Pt Day	8	15.56	18.15	21.75	18.97
var NL non-drug \$/Pt Day	8	\$ 29.83	\$ 40.32	\$ 84.96	\$ 77.10

Based on the worked hours and workload information provided to us by the region, in 2003/04, this functional centre's productivity is significantly worse than the worst quartile level of performance of its peer group. However, because of its low census and small size will be difficult for the ICU to improve its productivity.

Because of the small size and relatively low census of this unit no more than a minimum staffing of 1 RN on days and nights is required to address patient care requirements. Because of its location there is back-up and support available from the adjacent inpatient unit so that this level of staffing is viable.

There may be peaks in census and acuity that generate workload that exceeds the capacity of this minimum level of staffing and the hospital will need to be able to adjust staffing accordingly.

Telemetry capability should be installed as soon as possible to allow monitoring of ICU patients outside the ICU on the inpatient unit. This will help with efficiencies for the ICU and the inpatient area. The nurse assigned to ICU could assist

with care on the inpatient unit when monitoring capability is in place and depending on the status of the patient.

It is recommended that minimum staffing for station-fill purposes for this unit should be 1 RN 24/7.

**Recommendation:**

It is recommended that:

**(128) The Director of Nursing should reduce staffing to the recommended minimum staffing levels for ICU at STRH.**

**6.3.5 Combined OR/PARR**

**6.3.5.1 Operations**

This area includes the following:

- 2 fully equipped OR rooms
- 4 PARR stretchers
- 6 bed pre-admission area
- 1 endoscopy room
- 1 minor procedure room

Staff work across all areas in the department. Recently they reassigned staff to put a PCC in place. Since this change was implemented, staff report they have been able to improve turnaround time and staff satisfaction has improved.

There is a relatively small case volume compared with peers. Efficient use of staff is difficult to achieve with this low volume of activity. It would appear from the workload reported and assuming closure on weekends and holidays, that the unit is averaging only about 3 cases per day. This would not include endoscopy volume.

The workload and staffing for this program are presented in the following exhibit.

**Exhibit 6.58  
Combined OR/PARR Cases & FTEs**

	2002/03	2003/04
Total Cases	697	720
Pre-Admission Visits	1,655	1,996
Total Worked Hours	12,122	13,608
FTE	9.20	9.51

### 6.3.5.2 Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per case (Wkd Hr/Case). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.59  
OR/PARR Productivity**

	2002/03	2003/04
Wkd Hr/Case	17.39	18.90
var NL non-drug \$/Case	\$ 350.46	\$ 362.28

**Exhibit 6.60  
R/PARR Peer Hospital Productivity Range**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Case	2	6.35	6.46	6.57	6.46
var NL non-drug \$/Case	2	\$ 134.16	\$ 146.87	\$ 159.59	\$ 146.87

It should be noted that there are only 2 peers for comparison purposes because relatively few hospitals have so few cases that they have staffed the OR and PARR as a single functional centre.

To provide for additional comparators, we have summed the staffing in the OR and PARR of the other comparators to provide a surrogate measure of their OR/PARR staffing per OR case.

**Exhibit 6.61  
OR & PARR Peer Hospital Productivity**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Case	11	6.54	6.89	7.78	7.03
var NL non-drug \$/Case	11	\$ 252.11	\$ 288.15	\$ 322.65	\$ 283.46

The OR/PARR at STRH looks to be much less productive than similar services at peer hospitals. However, the pre-admission visit activity provides additional workload for the staff of the unit. The minimum level of staffing required for functionality and patient safety should still provide adequate staffing to handle the pre-admission workload. Minimum

staffing for the area should provide 2 staff required for the OR, 2 staff required for the PARR/Pre-admission area and 2 staff required for the endo/minor procedure room. Taken together, this level of coverage will require approximately 8 FTE staff positions. Even though a PCC was recently added in this area, consideration should be given to converting this role to that of a 'working supervisor' and include the position as part of the minimum staffing.

**Recommendation:**

It is recommended that:

**(129) The Director of Nursing should reduce staffing to the recommended minimum staffing levels for the OR/PARR at STRH.**

**6.3.6 Combined Emergency/Outpatient**

**6.3.6.1 Department Description and Operations**

This area provides 24/7 service and is staffed with 2 RNs and 1 physician. There is an additional nurse providing triage from 1000-1800 hours Monday to Friday. It includes 1 trauma room, a suture/minor procedure room and plaster room.

During the site visit workload was reported as approximately 65-75 visits/day for the ER. It appears outpatient workload is reported separately and this is shown in separate table.

Renal workload activity is not included here but 5.56 FTEs are reported for this program. This is a 4-station satellite for WMRH. It operates for 12 hours Monday, Wednesday, and Friday and 8 hours Tuesday, Thursday, and Saturday. There are currently 12 patients. The unit could accommodate 16 patients but are not funded for this level of activity.

Workload information provided by the corporation is shown in the following exhibit. External Clinics have been omitted from the discussion of OPD because of incomplete and inadequate workload data from the peer organizations.

**Exhibit 6.62  
Combined ED/OPD Visits and FTEs**

	2002/03	2003/04
Total Visits	34,309	35,885
Patient Days	60	49
Total Worked Hours	34,161	37,163
FTE	25.53	26.59

### 6.3.6.2 Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (Wkd Hr/Visit). The peer hospital productivity range for comparison purposes is also presented.

**Exhibit 6.63  
Combined ED/OP Productivity**

	2002/03	2003/04
Wkd Hr/Visit	1.00	1.04
var NL non-drug \$/Visit	\$ 4.55	\$ 5.22

**Exhibit 6.64  
Combined ED/OP Peer Hospital Productivity**

Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	10	0.92	1.09	1.21	1.13
var NL non-drug \$/Visit	11	\$ 5.04	\$ 5.59	\$ 6.88	\$ 5.84

STRH productivity is comparable to its peers in ED/OP. However, it appears that the hospital has already reduced its staffing to the minimum feasible levels in ED. Current staffing in the outpatient clinics appears to be appropriate. The current level of staffing is satisfactory until such time as workload increases beyond this capacity. There may be a need to consider increasing the staffing levels if volumes increase, particularly related to chemotherapy.

## 6.4 Health Centres

There are 4 health centres throughout the region that provide a combination of acute and long-term care. These Health Centres include:

- Bonne Bay Health Centre, Norris Point
- Calder Health Centre, Burgeo
- Dr. Charles L LeGrow Health Centre, Port aux Basque
- Rufus Guinchard Health Centre, Port Saunders

The Health Centres serve as the focus of health care activity in their own and surrounding communities. All the Health Centres are relatively new facilities with sufficient up-to-date equipment and furnishings. The buildings are fully wheelchair accessible including bathrooms in patient/resident rooms.

#### **6.4.1 Issues in Management & Operations Across Health Centres**

##### **6.4.1.1 Organizational Structure**

The issues associated with the current regional administrative structure noted earlier in this report appear to impact decision-making and operational efficiency in all the health centers. Communication in the regional model appears to be difficult for all health centers. Regional staff satisfaction surveys confirm that communication is an area of concern.

##### **6.4.1.2 Programming for LTC Residents**

It was reported during the site visits and by observation of the consultants that there is limited programming available for LTC residents. Centres have portions of FTEs for recreation therapy aides and oversight by a specialist who must cover a number of sites. The ratios reported are 1 FTE for 30 residents and 0.5 FTE for 22 residents. There are no standards commonly reported across the country for recreational therapy resources.

The staff that are on-site are doing their best with limited resources and the use of volunteers. Although recent resident and family satisfaction surveys have indicated satisfaction with current recreation activity, the consultants that visited these Centres had a general sense that there is quite limited psycho-social stimulation or activation provided for residents. It is difficult to provide quality of life and appropriate socialization/participation with limited recreation resources. A review of the recreational therapy service and the activities being provided for residents is recommended to determine if there are alternative, more effective approaches to providing for appropriate resident activation.

#### **Recommendation:**

It is recommended that:

- (130) The CNO and VP Rural along with the recreation staff should review recreation services to determine how they might be augmented to provide more stimulation for LTC residents.**

### 6.4.1.3 *Workload and Productivity Measurement for the Health Centres*

For purposes of comparison, we combined patient days reported for inpatient acute and long-term care to create a total health centre patient days measure. Using methodologies developed in other like studies conducted elsewhere we have created a surrogate measure for equating a patient day with an emergency/outpatient visit. We used a factor of 4 for acute days and a factor of 3 for long term care days. That is, 1 acute inpatient day would be the equivalent to 4 ED/OP visits and 1 LTC patient day would be equivalent to 3 ED/OP visits. Workload for the health centers is presented as equivalent visits.

***Health Centre productivity in WHCC ranged from a low of 0.89 to a high of 1.66 worked hours/equivalent visit.***

Health Centre productivity in WHCC ranged from a low of 0.89 worked hours per equivalent visit to a high of 1.66 worked hours per equivalent visit. This is a wide range for entities within one corporation doing essentially the same work. The Corporation should examine its staffing of the health centres to ensure equitable distribution of resources to care for the patients of each Centre.

The productivity for similar health centers in other jurisdictions is:

- Best quartile: 1.011 worked hours per equivalent visit
- Median: 1.154 worked hours per equivalent visit

In considering the reallocation of staff, WHCC should be guided by these performance levels achieved by peer organizations across Canada.

#### **Recommendation:**

It is recommend that:

**(131) The VP Rural should review the allocation of staff resources among the Health Centres in the region and rebalance staffing to ensure equity among the Centres.**

## 6.4.2 *Bonne Bay Health Centre, Norris Point*

### 6.4.2.1 *Description and Operations*

The Bonne Bay Health Centre was opened in late 2001. During the site visit, it was reported that there were 8 acute care beds, 14 long term care beds, an emergency department and outpatient clinic, laboratory and x-ray services.



Community programs including public health, and child, youth and family services are also provided on site. The facility also provides space for visiting professionals such as medical specialists, audiologists, speech language pathologists, psychologists, etc.

#### **6.4.2.2 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per equivalent visit (hrs/visit).

**Exhibit 6.65  
Bonne Bay HC Productivity**

<b>Bonne Bay Health Centre</b>	<b>2002/03</b>	<b>2003/04</b>
Total Patient & Resident Days	7,255	6,650
Total ER/OP Visits	8,033	7,835
Workload	31,976	29,429
Worked Hours	42,505	38,648
Worked hrs/workload	1.33	1.31

The productivity performance of this centre is worse than the median quartile and second worst of the health centers in the region.

### **6.4.3 Calder Health Centre, Burgeo**

#### **6.4.3.1 Description and Operations**

Calder Health Care Centre is relatively new facility that provides primary health care services and long term care services to the communities of Burgeo, Grand Bruit, Grey River, Francois and Ramea. During the site visit, the Centre reported 18 Long Term Care beds, 4 Acute Care beds and 2 observation/holding Beds, an emergency department and outpatient clinics, laboratory and x-ray services. Community programs including public health, and child, youth and family services are also provided on site.

Coastal Clinics are operated in the Communities of Ramea, Grey River, Grand Bruit and Francois. Each of these Communities has a designated Health Care Facility Clinic that is operated through the Calder Health Care Centre. Ramea Clinic operates a scheduled clinic Monday through to Friday with Emergency on-call services in the off-hours. The clinics in Grand Bruit, Grey River and Francois are scheduled to be held by the Nurse Practitioner from Ramea every Tuesday via Air Services (weather permitting).

### 6.4.3.2 Productivity and Staffing

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per equivalent visit (Worked hrs/workload).

**Exhibit 6.66  
Calder HC Productivity**

<b>Calder Health Centre</b>	<b>2002/03</b>	<b>2003/04</b>
Total Patient & Resident Days	7,419	7,012
Total ER/OP Visits	7,622	7,690
Workload	30,620	35,738
Worked Hours	39,614	34,429
Worked hrs/workload	1.29	0.96

The productivity performance of this centre is better than the median of the peer health centres and second best of the health centres in the region.

## 6.4.4 Dr. Charles L. LeGrow Health Centre, Port aux Basques

### 6.4.4.1 Description and Operations

The Dr. Charles L. LeGrow Health Centre is a 50 bed facility which provides acute, long term care and outreach services to the entire south west coast of Newfoundland. The Health Centre is designed as a district hospital with limited surgical services and it continues to develop programs and services within the mandate of the institution and the Western Health Care Corporation.

There are 20 acute care beds, which include two 2 intensive care / monitoring beds, 2 pediatrics, 2 obstetrics, and 14 medical and surgical care. At the present time the region reports there are only 14 of these 20 beds staffed and in operation. There are 30 long term care beds including 4 beds which are used for short term respite care, and slow paced rehabilitation.

The Centre also provides emergency services and outpatient clinics, operating room, chemotherapy, low risk obstetrics, pharmacy, diagnostic services in lab and radiology, and an adult day care program. Community programs including public health, and child, youth and family services are also provided on site.

Unfortunately, there have been no anaesthesia services available since August 2003. This has had a direct impact on the provision of surgical and obstetrical services. Primiparas and any higher risk obstetrics have been referred out and only

those procedures that can be done without general or regional anaesthetic have been performed locally.

Endoscopy services have been maintained though equipment is fibre optic and is not current. The VP Clinical Operations should ensure that the endoscopy equipment is upgraded at the Centre and/or that endoscopy services are provided by an outreach/mobile facility from the WMRH.

#### **6.4.4.2 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per equivalent visit (hrs/visit).

**Exhibit 6.67  
LeGrow HC Productivity**

<b>LeGrow Health Centre</b>	<b>2002/03</b>	<b>2003/04</b>
Total Patient & Resident Days	13,361	14,070
Total ER/OP Visits	17,243	19,288
Workload	48,042	50,786
Worked Hours	80,604	74,972
Worked hrs/workload	1.68	1.48

The productivity performance of this centre is worse than the median quartile and the worst of the health centers in the region.

#### **6.4.5 Rufus Guinchard Health Centre, Port Saunders**

##### **6.4.5.1 Current Characteristics**

This Health Centre opened in 1994 and has 22 Long Term Care beds and 8 inpatient acute care beds of which 1 is designated as palliative and 2 observational beds. It provides emergency services and outpatient clinics, laboratory and x-ray services. Community programs including public health, and child, youth and family services are also provided on site.

##### **6.4.5.2 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per equivalent visit (hrs/visit).

**Exhibit 6.68  
Rufus Guinchard HC Productivity**

<b>Rufus Guinchard Health Centre</b>	<b>2002/03</b>	<b>2003/04</b>
Total Patient & Resident Days	8,032	8,360
Total ER/OP Visits	16,174	17,201
Workload	42,419	44,018
Worked Hours	41,831	39,319
Worked hrs/workload	0.99	0.89

The productivity performance of this centre is better than the best quartile and is the best of the health centers in the region.

### **6.5 Long Term Care Services**

In addition to the long term care services offered at the Health Centres, there are 4 sites in two communities that provide institutional-based long term care services:

- The Bay St. George Long Term Care Centre
- LTC in Corner Brook
  - Corner Brook Inter-faith Home for Senior Citizens
  - The Dr. J.I. O’Connell Centre
  - The 5<sup>th</sup> & 6<sup>th</sup> Floors of the Western Memorial Hospital (WMH)

Together these facilities provide long and short term continuing care services, protective care, and slow stream rehabilitation.

All the facilities use an interdisciplinary model in their approach to care and are to be commended for maintaining this approach.

#### **6.5.1 Nursing Staff Skill Mix in LTC**

As part of the Best Practice Review, a review of empirical research on the relationship between skill mix and outcomes of different client groups in specific areas such as acute care, sub-acute care, long term care was undertaken.

Staff mix here refers to the combination or grouping of different categories of workers employed for the provision of care to a designated population of clients. For the purposes of this study it includes Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and unlicensed care providers here referred to as Personal care attendants (PCAs).

***Residents' care requirements should determine both the amount and type of nursing care.***

Longer life expectancies, advances in medical science, and changes to the health care delivery system are among those factors that are leading to increased care needs in the long term care population. The type of care required by residents should drive both the amount of care provided by nursing staff as well as the mix of staff used to deliver that care.

#### ***6.5.1.1 Literature Review***

There appears to be a continuing shortage of credible studies that address skill mix of nursing staff in relation to outcomes.<sup>58</sup> Some of the more rigorous studies were summarized by Hailey and Hartsall and are presented in a table in an Appendix to this report.

***A recent landmark study does not offer an optimal skill mix.***

A recent landmark study of 19 hospitals in Ontario showed that nursing staff skill mix had a statistically significant, negative influence on nursing hours, because as staff skill mix decreased the number of nursing hours required per patient increased.<sup>59</sup> At P=0.05, for instance, staff mix models that included a lower proportion of RNs were related to the use of more nursing hours. Moreover, the data show that costs rise as nursing care hours increase, even though salaries for non-RN staff are lower. Mc Gillis Hall and colleagues do not, however, offer an optimal skill mix.

The authors also found that skill mix has a significant effect on medication errors and wound infections, as skill mix increases the incidence of these adverse events decreases. The authors did not find any significant correlation between nurse experience level and patient outcomes. The authors suggests that efforts must be made by unit managers to balance both the experience level and the mix of nursing staff to ensure quality patient outcomes are not compromised in an effort to reduce costs. This study was focused on acute care and McGillis Hall is in the process of undertaking a similar study for long term care.

<sup>58</sup> Hailey, D., Hartsall, C. "Nursing Skill Mix and Health Care Outcomes" Alberta Heritage Foundation for Medical Research, IP-\* Information Paper, December 2001.

<sup>59</sup> Hall, LM, Doran, DI et al. "A study of the impact of nursing staff mix models and organizational changes strategies on patient, system and nurse outcomes, a summary report of the Nursing Staff Mix Outcomes Study. Toronto: University of Toronto, 2001. Available: <http://www.fhs.mcmaster.ca/nru/web/McGillis%20Hall.pdf>.

***There is no difference in outcomes for LTC residents for care from different nursing skill levels.***

Anderson et al<sup>60</sup> considered patterns of resource allocation that related resident outcomes for all nursing homes in Texas. Secondary data were obtained from the state Department of Health Services and 11 items selected that reflected outcomes of care. Comparing pattern scores by resident outcome groups, for those with the best and worst average outcomes, differences for RNs, LPN type category and aides were statistically non-significant.

Hailey et al in their review for the Calgary Health Region noted earlier suggest that at present there is little in the literature to assist with decisions about the nursing workforce. Those studies that are available, particularly for LTC, tend to have only marginal relevance to practical issues that will be faced by regions. The studies also have some significant methodological limitations. They suggest there is a need to recognize the importance of context and practice settings and also the influence of non-nursing staff outcomes.

The way forward for regions may be to introduce enhanced LPN roles and/or PCA roles in specific areas with appropriate evaluation.

#### ***6.5.1.2 Skill Mix in Other Canadian Jurisdictions***

In Ontario, the Nursing and Health Outcomes Project (NHOP) was created in response to recommendations 5 and 6 of the *Good Nursing Good Health: An Investment for the 21st Century* report. The purpose of The Nursing and Health Outcomes Project is to identify nursing-sensitive patient outcomes and their attendant nursing inputs and processes that could be abstracted from patients' charts or provided in other formats. This would allow administrators and researchers in the future to describe how different nursing interventions and different numbers and types of nurses (RNs, RPNs) affect patient outcomes. In the longer term, it may be possible to develop a funding formula that is nursing-specific. The project focuses on acute care, long-term care, complex continuing care and community care (home care). Many of the identified inputs are collected in the Ontario hospitals' MIS. Some information on nursing inputs is also collected within Ontario's long term care and home sectors but it is not centrally reported. As noted above there are emerging studies

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<sup>60</sup> Anderson, RA, Hsieh P, Su H. "Resource allocation and resident outcomes in nursing homes: comparisons between the best and worst. *Res Nurs Health* 1998; 21:297-313.

examining staff mix and outcomes and the evidence is increasing that staff mix matters. Information on RN hours, RPN (LPN) hours and unlicensed assistive personal (UAP or PCA) hours for long term care is now becoming available.

In a study<sup>61</sup> examining the current utilization of LPNs in British Columbia, most of the Health Authorities are involved in looking at staff mix. The Vancouver Island Health Authority and Vancouver Coastal Health Authority are both examining the best staff mix of RN, LPN and PCA role across the acute, sub-acute and residential care areas. Fraser East is involved in a three-year project to introduce a new collaborative practice model for the RN/LPN/PCA role working in residential care.

In Nova Scotia, the Department of Health published a Task Force Report on Resident/Staff Ratios in Nursing Homes in February 2002. In their review of nursing home staffing standards used in other provinces, they identified that drawing comparisons in staffing standards across the country is impaired by several factors including:

- The quality to which other provinces completed the survey of the task force.
- Regionalization and the level to which provinces are involved in funding.
- Different funding methods e.g. Global budgeting, case mix payments systems, and population needs based funding methods.

Due to these differences the study was not able to draw useful comparisons with Ontario, British Columbia, Alberta, Saskatchewan, and PEI. The study was able to compare existing information in the other provinces. Each of these provinces has a different method of classifying residents into levels of care. Staffing levels vary by level of care. For the purposes of the study, provinces were given a set of standard level of care definitions and were asked to fit their information to those categories. The summary of their findings is presented in the table below.

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<sup>61</sup> Greenlaw, B “Licensed Practical Nurses: Current Utilization: Hospital Employees Union, Burnaby, BC: February 2003. Available: [www.heu.org](http://www.heu.org) under special reports.

**Exhibit 6.69**  
**Staffing Standards for Skill Mix and Direct Hours of**  
**Care from the Nova Scotia Task Force**

Province	Direct Care Hours* by RN/LPN/PCW			
	Level 1	Level 2	Level 3	Level 4
NS	n/a n/a	NS level I = 1.5 hrs budget target for PCW - others unspecified	NS level II = 3.25 hrs budget target 15/15/70	n/a n/a
MB	0.5 hrs 10/0/90	2.0 hrs 10/20/70	3.5 hrs 20/15/65	3.5 hrs 20/15/65
NB	n/a n/a	2.5 hrs 20/40/40	2.5 hrs 20/40/40	n/a n/a
NF	0-1 hrs  100% PCW	2.0 hrs  100% PCW	3.0 hrs 20/80 (LPN & PCW)	3.2 hrs. 20/80 (LPN & PCW)

\*excludes M&O hours

### 6.5.1.3 Findings for LTC in the Region

As noted above there is a growing body of research regarding the link between staff mix and nursing-sensitive client outcomes. It points to the need for decision-makers to consider the appropriate utilization of professional nurses (RNs and LPNs) and unregulated providers (PCAs).

***The needs of LTC clients are increasingly complex in both community and institutional settings.***

The changing characteristics of residents in long term care facilities in the region will impact the model of nursing care delivery. The goals of nursing are to improve health outcomes, quality of care, quality of life, and to ensure the provision of safe, ethical nursing care. The prevalence of disease in the senior's population is showing a steady increase.<sup>62</sup> The needs of LTC clients are increasingly complex in both community and institutional settings. Nurses are caring for clients with complex care and treatment plans some of whom are technologically dependent.<sup>63</sup>

These changing needs will impact the models of nursing care delivery in the future. LTC requires a variety of care providers with varying levels of knowledge and expertise who are responsible for meeting the basic and complex needs of residents. There has been discussion regarding the role of the

<sup>62</sup> Government of Canada, national Advisory Council on Aging (2001). Report card seniors in Canada. Ottawa, Public Works and Government Services Canada.

<sup>63</sup> Association of Registered Nurses of Newfoundland and Labrador, **The Role of the Registered Nurse in Long Term Care Position Statement and Guidelines**, February, 2004.



RN, LPN and the use of non-regulated health care providers in LTC in the region.

***The Region should utilize the RN in a coordinating and consulting role.***

Given the patient population and the changing needs, the Region should ensure a nursing care delivery model that utilizes the RN in a coordinating and consulting role. This means that the RN will follow the guidelines established by the provincial association. This means the RN will utilize the nursing process to:

- Conduct a holistic needs assessment of each resident on a regular basis.
- Oversee and ensure the implementation of the plan of care
- Provide direct nursing care.
- Evaluate the outcomes of the plan of care for each resident.

Essentially the RN will use their knowledge and skills to oversee and provide care for such things as bowel/bladder management, medication use, restraint use, behavioral management, wound and skin care, adjustment strategies, fall prevention and restorative care.

RNs need to be more actively involved in planning and evaluating care and communicating with families in giving clinical leadership at the unit level and not relying on managers.

***LPNs can autonomously care for residents who have less acuity and less complex care needs with predictable responses and outcomes.***

LPNs can autonomously care for residents who have less acuity and less complex care needs with predictable responses and outcomes. As care requirements become more unpredictable, the greater the need for LPNs to collaborate with RNs.

WHCC has identified opportunities to enhance the role and utilization of the LPN so that they are working to the full scope of their practice. There are initiatives already underway to enhance the skills of LPNs.

***Currently, much of the care being provided by LPNs in the region is provided by PCAs in other jurisdictions.***

Currently, much of the care being provided by LPNs is care that is being provided by PCAs in other jurisdictions. When introducing the role of a PCA, clear standards of care, expectations for performance and monitoring of performance should be in place.

#### ***6.5.1.4 Moving to Change the Skill Mix in the Region***

In the WHCC Region the current skill mix in LTC is

- RN: 24%
- LPN: 75%
- PCA: 1%

***No common standards across the country with respect to the appropriate skill mix in LTC.***

There are no common standards across the country with respect to the appropriate skill mix in LTC. From the data noted above, generally, the professional nurse mix (RN plus LPN) is in a wide range from 25-60% of total nursing staff hours.

It is clear that there is an opportunity for the region to change the current skill mix to be more in line with other provinces with respect to the use of PCAs. It appears that there is an opportunity for the region to achieve some savings while still ensuring an appropriate standard of care for residents.

***The Region should change its skill mix; initially moving toward a mix of 60% professional nursing to 40% unregulated provider.***

As noted above, the current skill mix in LTC in the region is reported as 99% professional and 1% unregulated staff. Based on the literature and the diversity of current practice across the country, we are not in a position to make a firm recommendation regarding mix. However, it may be reasonable for the Region to consider initially moving toward a mix of 60% professional nursing to 40% unregulated provider.

We would suggest the Department and the Region work together to establish an acceptable target for professional mix and then develop a plan to significantly extend the role of the PCA in the LTC treatment setting. Appropriate training will need to be ensured for the role of the PCA and for the other team roles that will work with this new role. It is suggested that by care area, the centers with long term care identify opportunities to incorporate the role of a PCA with both the RNs and LPNs working to their scope of practice. The Region should then develop a plan for implementation of the new role in the appropriate care areas.

The savings resulting from this change will be a function of the different in wage rates among the different skill levels of nursing staff. This will not provide any reduction in nursing hours. Wage rates for PCAs likely will be the result of bargaining. We have not estimated the savings from this substitution of skill levels. Also, since there are currently a very limited number of PCAs in the region, they will need to be trained and the time frame for realizing any savings will be a function of the time required to train this new staffing level.

**Recommendation:**

It is recommended that:

- (132) The Chief Nursing Officer and the Directors of Nursing should develop and implement a new model of nursing care delivery for LTC that includes RN and LPN providers working to their full scope of practice and that introduces the role of PCA.**

**6.5.1.5 Professional Support Issues for Nursing in LTC**

There is no specialized professional support for nursing in LTC in WHCC. There was a Clinical Nurse Specialist for gerontology but it was reported that this role was not utilized to its full capacity and/or accepted by all the facilities. As a result this individual left the position. However, given the number of residents/patients who are elderly the region should be providing a professional resource to the nursing staff to ensure they are educated in and supported in implementing best practice in the delivery of long term care.

This role could also be very helpful in assisting with the implementation of changing the roles and responsibilities RNs and LPNs up to ensure they are functioning at the full scope of their practice.

There is no ability to support implementation of regional initiatives designed to improve quality of care which include such things as:

- interdisciplinary model of care
- resuscitation policy
- fall prevention / least restraint program
- foot care program
- wound care program
- clinical competency self assessment

A professional resource for LTC in the region is of primary importance.

**Recommendation:**

It is recommended that:

- (133) The Chief Nursing Officer should establish a professional resource role for nursing staff in LTC.**

### 6.5.1.6 Staffing Levels

The staffing standard from the DOHCS for nursing in LTC is 3.0-3.5 unity producing staff hours per patient day. It should be noted that significant differences in the organization of long-term care services among provinces makes inter-provincial comparisons of productivity in long-term care facilities quite difficult. This variation in resident care requirements and related staffing levels can be seen in the following comparison of LTC staffing standards from across Canada.

**Exhibit 6.70**  
**Nursing Home Standards Canadian Comparisons<sup>64</sup>**

Province	Hours of Care	Skill Mix (RN/LPN/PCW)
Newfoundland standard	3.0-3.2	20/80/00
actual	3.0-3.5	25/69/06
Nova Scotia	3.25	15/15/70
New Brunswick	2.5-3.0	20/40/40
PEI	3.0-3.5	10/5/85
Ontario	2.6	12/16/1972
Manitoba	2.0-3.0	20/15/65
Saskatchewan	3	20/30/50
Alberta	2.0-4.0	22/02/76
British Columbia	2.0-3.0	n/a

Nursing home care in WHCC includes care that in other provinces might be considered chronic hospital care, nursing home care and personal care. We have drawn on our experience in working in LTC in other provinces to assess the staff:workload relationship in WHCC. The Bay St. George Long Term Care Centre

### 6.5.1.7 Description and Operations

The Bay St. George Long Term Care Centre is a 114-bed facility located in Stephenville Crossing that provides comprehensive and holistic care. The majority of patients are level II and III. Eligibility and level of care is determined by the Regional Assessment Team.

The Home is designed with four separate resident care units. Three of the four units are designed for the functionally impaired, with the remaining unit (Protective Care) designed

<sup>64</sup> The Department of Health in Newfoundland provided the Best Practices Review team with findings from comparisons made in 2003.

for those individuals experiencing severe mental impairment and/or organic brain disorders, who require a secure environment. The three open units also have alarm systems on doors and use a patient wander guard system.

There is a Director of Nursing/Site Coordinator for the Centre. The four units are divided into two areas each with a manager:

#### *South chronic*

There is one unit of 33 beds that has 3 short stay beds. The other unit is a 26 bed unit with one bed designated for respite. In these units there is the capacity to for complex continuing care including care residents with chronic ventilation. These units also manage residents with dementia, personality problems, etc. in private rooms as required.

#### *North protective*

There is one unit of 33 beds with mostly level III residents. The other unit is a 22 bed secure unit providing protective care. This unit has an average occupancy of about 77%.

#### **6.5.1.8 Facilities/Equipment and Allied Health Support**

There is generally sufficient and appropriate space for providing services to this population. In the past 2 years the organization has improved its access to new patients lifts and they will be receiving more. This will assist in keeping work related injuries down.

There is good support from the community pharmacist and the facility uses unit dose. There is the full range of allied support services with recreation therapy workers for each unit.

#### **6.5.1.9 Model of care delivery**

There are gaps in clinical leadership at the unit level. RNs do not appear to be coordinating care in the LTC setting. They seem to be occupied with medication and treatments. LPNs are not working to their full scope of practice in all areas and could be doing some of the activities currently performed by RNs. Staff work in teams but there does not appear to be an approach to total patient/resident care.

#### **6.5.1.10 Support for Education, Staff Health and Infection Control**

During regionalization, the Centre lost a “director of program” position that did all of the functions associated with WHMIS,

occupational health and safety, infection control, policy/procedure development and implementation, and education. Currently there is supposed to be 0.5 of educator allocated to the facility. This role is currently involved in all the regional educational activities. There appear to be limited education activities that are directly applicable to the centre.

The Region should be ensuring that resources are available to support the staff in the facility with respect to education, infection control and occupational health and safety.

**Recommendation:**

It is recommended that:

**(134) The VP Clinical Operations (BSG) and the VP Human Resources should reallocate education resources to support site-specific needs.**

**6.5.1.11 Productivity and Staffing**

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per workload, in this case resident days (Wkd Hr/Resident Day).

**Exhibit 6.71  
Bay St. George Productivity**

<b>Bay St. George</b>	<b>2002/03</b>	<b>2003/04</b>
Total Resident Days	39,135	39,316
Worked Hours	146,996	146,452
Worked Hr/Resident Day	3.76	3.72

This productivity reflects our experience in high performing long-term care facilities in other provinces<sup>65</sup>. As has been discussed, the effectiveness of patient care can be improved by modifying the model of care; additional nursing hours are not required.

**6.5.2 LTC in Corner Brook**

There are a number of overarching issues that impact the quality and efficiency of long term care in Corner Brook.

<sup>65</sup> Significant differences in the organization of long-term care services among provinces makes inter-provincial comparisons of productivity in long-term care facilities quite difficult. Nursing home care in WHCC includes care that in other provinces might be considered chronic hospital care, nursing home care and personal care. We have drawn on our experience in working in LTC in other provinces to assess the staff: workload relationship in WHCC.

### **6.5.2.1 Physical Environment**

The physical facilities of all the sites in Corner Brook are sub-optimal and do not provide the same level of LTC environment available to citizens in other communities in the region. Each facility has some especially difficult physical situations and these will be highlighted in the discussion of each of the facilities. The overall characteristics of the physical facilities include:

- inappropriate space for current use
- lack of space for long term living
- equipment requires more space than is available in room or is available designated storage areas
- electrical service inadequate for equipment needs
- no dining rooms
- lack of privacy, family space
- bathrooms too few and inaccessible
- noisy, congested lounge areas
- medication and treatment rooms inadequate size
- risk for staff providing service moving patients in and around care areas
- deteriorating physical condition of facilities

All of these factors contribute to frequent family issues regarding inappropriate living environment and/or incompatible roommate situations with little or no ability to make changes to address the issues.

The physical environment also places pressure on the LTC program when the acute care environment is also facing pressures of more rapid turnover and decreasing lengths of stay. There is often frustration in the acute care environment when there are “empty” beds in LTC. These beds are usually not able to be used for clients because of the needs of the client for equipment, care/technology supports etc. Often the bed/room space is not adequate to meet the needs of the referred client.

### **6.5.2.2 Complexity of Care**

It was reported that the LTC units in Corner Brook are often seen as the place of last resort and the need to deal with increasingly complex patients is high, particularly related to

behavioral management. There is a perception that they cannot refuse to take patients even though they may not have the appropriate resources. Although they may be treated like a regional centre, they do not receive any additional funding to manage the complexity of care. Some additional challenges include:

- increasing psycho-geriatric need clients with a lack of programming and psycho-geriatrician support
- inadequate services for integrating young disabled adults
- increasing concentration on end-of-life care with a lack of appropriate resources/support or programming
- increasing levels of dementia (70 - 80% of resident population) with fluctuating needs for protective care
- inconsistent, timely medical support

#### **6.5.2.3 Management Structure**

This is a large service spread over 3 sites and this impacts timely communication and clinical coverage. Other LTC in the region is in one location. The adjacency to acute care also limits the adoption of a long term care philosophy, and often impacts the ability of the managers to focus on long term care priorities.

As noted earlier in this report, the organizational structure limits the effectiveness of management. The Site Coordinator reports to the VP, Clinical Operations and other services (environmental, dietary, facilities) report to other VP's. Therefore, the ability of the Site Coordinator to effectively provide a quality service is seriously impacted by the inability to control limited human resources, scheduling, maintenance, etc. Concern was also expressed during the site visit that in Corner Brook this reporting structure does not ensure a voice for nursing concerns at the senior management table.

#### **6.5.2.4 Summary of Operations by Site**

The following table presents a summary of each of the LTC in each of the facilities in Corner Brook:



**Exhibit 6.72<sup>66</sup>**  
**Corner Brook Long Term Care by Site**

Unit	Beds	Budgeted HPPD	Level of Care
O'Connell			
2 VAC	18	4.38	3 Level II's remainder Level III
3 O'CC	22	3.25	1 Level II remainder Level III
4 O'CC	26	3.31	All Level III
<b>Sub-Total</b>	<b>66</b>		
WMRH			
5 WMRH	31	3.39	All Level III
6 WMRH	31	3.87	9 Level IV's Remainder Level III
<b>Sub-Total</b>	<b>62</b>		
Interfaith			
St. Luke's	34*	3.21	All Level III. *includes 2 respite beds
Good Sam	24	2.96	2 Level II's remainder Level III
NF / ML	45	2.89	4 Level II's remainder Level III
<b>Sub-Total</b>	<b>103</b>		
<b>TOTAL</b>	<b>231</b>		

#### 6.5.2.5 Corner Brook Inter-faith Home for Senior Citizens

The four units are comprised of

- St. Luke's Unit, a 34 bed unit with 10 semi private rooms, 4 four-bed wards. This unit has 34 long term care beds for level III frail elderly and some residents with dementia. There are 2 respite beds within these 34 beds in which priority is given to persons with dementia who don't require protective care.
- Good Samaritan Unit a 24 bed unit with 8 semi-private and 8 private rooms. The unit provides care for residents requiring level II and III care.
- Newfoundland Unit a 24 bed unit with 8 semi-private and 8 private rooms. This unit provides care for residents requiring level II and III care.

<sup>66</sup> Table provided by WHCC Director of Nursing, LTC.

- Memory Lane Unit, a 21 bed unit with 10 semi-private and 1 private room. This unit also provides care for residents requiring level II and III care.

### **Issues in Operations/Management**

This was a personal care home that has evolved into LTC. There are significant issues of space in this facility in the resident rooms. This often leads to significant issues for simple things such as access to closet space, placement of chairs in a room, access to bathrooms. There are not closets for residents in many of the rooms. Bathrooms often serve as an area for storage of personal clothing and items. There is significant difficulty in moving wheelchairs and/or beds particularly in Memory Lane.

All of the physical problems result in staff having to move equipment and residents frequently. There are frequent issues associated with room changes.

#### **6.5.2.6 J. I. O'Connell Centre**

### **Operations**

The J.I. O'Connell Centre is a 66 bed facility. Eighteen of these beds are the Western Newfoundland Veterans Unit, and 8 beds are an adult rehabilitation unit. The 8 rehabilitation beds are counted in the acute care bed counts for the WMRH site.

The 5th and 6th Floors of Western Memorial Regional Hospital are long term care units and are associated with the J.I. O'Connell Centre. The 5th Floor is a 31 bed secure care unit for persons suffering from dementia. The 6th Floor has residents who require complex care, long term care and transitional care.

### **Issues of Operations/Management**

The 2nd level VA unit has had recent renovations under the auspices of the Department of Veteran's Affairs to improve the physical environment. This has created a much more environmentally friendly living and working space.

The remaining units in the O'Connell Centre have rooms that do not accommodate needs of many current/potential residents for the type of equipment and supportive care etc. they require.

### 6.5.2.7 Productivity and Staffing for LTC in Corner Brook

Productivity is measured as the total worked hours (unit producing and management and operational support) per workload, in this case patient days (Worked Hr/Pt Day) and is shown in Exhibit 6.73.

**Exhibit 6.73  
Corner Brook LTC Workload & Productivity**

Corner Brook LTC	2002/03	2003/04
O'Connell Patient Days	44,673	44,365
Interfaith Home Patient Days	36,955	35,890
Total LTC Patient Days	81,628	80,255
Worked Hours	310,649	304,618
Worked Hr/Pt Day	3.81	3.80
Rehab Patient Days	2,554	2,265
Worked Hours	17,460	17,338
Worked Hr/Pt Day	6.84	7.65

Hours/patient day are slightly higher in LTC in Corner Brook and may be related to the following:

- Additional and separate funding for a higher level of staff for the Veteran's Unit.
- Poor physical facilities requiring additional staff levels especially in Interfaith and O'Connell.
- Higher complexity of patients.
- Low occupancy on the protective unit.

However, the productivity of this service reflects our experience in high performing long-term care facilities in other jurisdictions<sup>67</sup>. As has been discussed, the effectiveness of patient care can be improved by modifying the model of care; additional nursing hours are not required. The current level of nursing productivity should be maintained.

There is a concern regarding the productivity for the rehab unit. This is a very small unit and small units are very inefficient. WHCC should explore ways of utilizing the staff

<sup>67</sup> Significant differences in the organization of long-term care services among provinces makes inter-provincial comparisons of productivity in long-term care facilities quite difficult. Nursing home care in WHCC includes care that in other provinces might be considered chronic hospital care, nursing home care and personal care. We have drawn on our experience in working in LTC in other provinces to assess the staff: workload relationship in WHCC.

of the rehabilitation unit more productively perhaps by using them to provide support for LTC patients.

The following table shows that in jurisdictions in Ontario nursing productivity in inpatient rehabilitation ranges from 3.8-6.1 worked hours per patient day.

It is suggested that the organization use the maximum performance level of 6.14 worked hours per patient day as a target for rehabilitation. The unit is using minimum staffing levels of 2 per shift. Because of the location of this unit (within a LTC unit) it may not be necessary to provide this type of coverage on evenings or nights. Staffing could be reduced to 1 person with back up support and relief being provided from the co-located LTC unit.

**Exhibit 6.74**  
**Rehabilitation Comparisons**

2002/03 Data - Ontario Peers	Valid N	25th Percentile	50th percentile	75th Percentile	Minimum	Maximum	Mean
712813000 Combined Rehabilitation	18	4.3070	4.7070	5.0137	3.7624	6.1368	4.7283

**Recommendation:**

It is recommended that:

**(135) The Director of Nursing should reduce staffing for the rehabilitation service to achieve productivity of 6.14 worked hours per patient day.**

**6.5.2.8 Potential Service Consolidation**

**Protective Units in LTC**

As noted above, there has been a challenge in keeping sufficient occupancy to ensure efficient use of staff assigned in the protective units in Bay St. George and in Corner Brook. The Region is encouraged to consolidate this service in one location to use the specialized resources required for care of this population most effectively.

**Recommendation:**

It is recommended that:

**(136) The Vice Presidents for Clinical Operations should consolidate protective services for LTC residents in the region onto one site.**

## **6.6 Therapeutic Services**

### **6.6.1 Pharmacy**

#### **6.6.1.1 Current Characteristics**

The Pharmacy department is led by a Regional Director of Pharmacy. This individual also has responsibility for Respiratory Therapy for the organization. The Regional Director reports to the Vice President of Clinical Operations. In the matrix structure adopted by WHCC, this means that the Regional Director reports to all three Vice Presidents of Clinical Operations in the Corporation.

Western Health Care Corporation has three hospital pharmacy departments. They are located at Dr. Charles L. LeGrow Health Centre, Sir Thomas Roddick Hospital and the Western Memorial Regional Hospital. These sites provide pharmacy services to the various hospitals, LTC facilities and medical clinics in the region as follows:

- The Western Memorial Pharmacy provides Pharmacy Services to Rufus Guinchard, Bonne Bay and Calder Health Centres as well as the Corner Brook Interfaith Home, O'Connell Centre and Western Memorial sites.
- The Charles LeGrow Pharmacy provides services to the acute care and long term care residents at the site. In addition, it provides Pharmacy services to the medical clinics at Lapoile and the Codroy Valley.
- Sir Thomas Roddick provides pharmacy services to the acute care patients at the site and to the medical clinics at Lourdes, Cape St. George Medical Clinic, Jeffrey's, Stephenville Crossing, and St. George's.

Chemotherapy services are provided at all three pharmacy sites. Total parenteral nutrition services (TPN) are provided at the Western Memorial site. Outpatient services at the WMRH site include provision of anti-rejection medications for transplant patients plus work-up for transfer to Halifax or Ontario, medication for renal dialysis patients and clinical trials involving Remacade.

The Respiratory Therapy function at the WHCC was previously lead by a separate Director. Currently the service comes under the portfolio of the Regional Director of Pharmacy. A Clinical Leader, who is also a working Respiratory Therapist (RT) with a caseload, provides practice leadership for the program. There are 3 other RTs that provide

24/7 coverage for the Western Memorial Regional Hospital. Sir Thomas Roddick Hospital in Stephenville also has 1 RT.

### **6.6.1.2 Issues in Management and/or Operations**

The following issues related to pharmacy management and operations were identified through site visits and interviews:

- The pharmacy department operates three different drug distribution systems:
  - Unit Dose Drug Distribution for acute care patients at the Western Memorial Site (Corner Brook).
  - Traditional drug distribution for acute care at the Sir Thomas Roddick Hospital (Stephenville).
  - Ward Stock system for acute care at the LeGrow site.
  - LTC drug distribution for the region is a mixture of the 34 –day carded system and a traditional system.
- Operating three different drug distribution systems can be costly and inefficient for the organization. Numerous studies concerning unit dose drug distribution systems have been published indicating that they are superior over other drug distribution methods because they are:
  - safer for the patient
  - more efficient and economical for the organization, and
  - a more effective method of utilizing professional resources<sup>68</sup>.
- Space needs and staffing has been described as the major impediments to improving drug distribution systems. Our review of the facilities indicate that at the Western Site (Unit Dose), space is limited but well organized and used. The Sir Thomas Roddick Hospital, is a brand new, well designed space that is ready to accommodate a unit dose system. An external, third-party space review was completed for Pharmacy services at the LeGrow site which has indicated a need for additional space for the service. It has been recognized that if Sir Thomas Roddick and LeGrow sites are to move towards a unit dose drug distribution system then capital investment will be required and pharmacy labour costs may increase.

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<sup>68</sup> American Society of Hospital Pharmacists. ASHP statement on unit dose drug distribution. Am J Hosp Pharm. 1989; 46:2346.

- There is no standardized workload measurement system in place for pharmacy in the province. This is problematic because it makes managing resources in the department difficult. There is a provincial group trying to implement MIS guidelines and a pilot project was planned but it was reported that there was no funding available.
- Although presently the department is fully staffed for all approved positions, there have been pockets of recruitment problems. There are limited continuing education opportunities which complicate retention efforts. It has been reported that recruitment is difficult as community retail pharmacy salaries are significantly higher than those available in WHCC.
- The Pharmacy Department and the P&T committee are responsible for the ongoing maintenance of the formulary. The P&T committee is a subcommittee of the MAC and meets after Regional MAC meetings. The director has described difficulty in receiving compliance with the drug formulary from some physicians, indicating instances where non-formulary drugs are used and guidelines not being followed. The P & T Committee has experienced difficulty in organizing education sessions with physicians. It has been reported that physicians are unengaged and uninterested in committee work. To be effective, the formulary system must have the approval of the organized medical staff, the concurrence of individual staff members, and the functioning of a properly organized P&T committee of the medical staff. The basic policies and procedures governing the formulary system should be incorporated in the medical staff bylaws or in the medical staff rules and regulations<sup>69</sup>. And the policies must be enforced aggressively by the RMAC.
- Pharmacy involvement on the clinical floors is limited. There is currently 1 FTE dedicated position to manage antibiotic utilization as well as 0.6 FTE positions for an ICU pharmacist.
- The Meditech Pharmacy information system module is in use at WHCC, however there is a different information system used for LTC (Bonne Bay, Burgeo, Port Saunders). LTC is being billed to the province using this system. This other system is not interfaced with the Meditech system

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<sup>69</sup> American Society of Hospital Pharmacists. ASHP statement on the formulary system. *Am J Hosp Pharm.* 1983; 40:1384–5.

and creates manual work to integrate and update patients records. In addition, it poses risks as a separate repository for patient information may result in inability to manage potential adverse drug-drug interactions.

- It has been reported that medication is routinely administered to outpatients. Also, some patients are coming to the hospital for no reason other than to receive an injection.

### 6.6.1.3 Opportunities to Reduce Operating Costs

Pharmacy workload is currently not being reported in the hospital's MIS statistical data. As mentioned above, there is no formal workload measurement system in place for the region. There is a provincial group responsible for developing a workload system, however none has been put in place and the future progress has been impeded for lack of funding for a pilot project.

In lieu of workload data, drug costs were examined as a measure of the performance of the pharmacy department. The drug costs presented below, exclude extra votes and drug costs related to oncology and dialysis so as not to skew the analysis. 2003/04 data for WHCC is projected based on nine months of data.

**Exhibit 6.75**  
**Comparison of Drug Costs as a**  
**Percent of Net Operating Costs**

WHCC	2003/04	2.56%
	2002/03	2.47%
	2001/02	2.66%
2002/03 Peer Data	25th %ile	2.11%
	Median	2.54%
	75th %ile	2.91%
	Min	0.70%
	Max	3.73%
	# Peers	8

As can be seen from this exhibit, WHCC drug costs as a percentage of net operating costs in 2002/03 lie between the median and the 75<sup>th</sup> percentile of the peer group. If WHCC achieved the performance level midway between the 25<sup>th</sup> percentile and median peer group performance, then this would result in \$190,000 in savings for the organization.



There are number of factors that may be contributing the high drug costs at WHCC compared to the peer hospitals. They are as follows:

- The use of ward stock and traditional drug distribution at two of the WHCC sites. Unit dose systems have been proven to be more effective and economical than alternative distribution systems. Unit dose systems allow for a reduction in the size of inventories located in the patient care areas.
- Lack of adherence to the formulary, the interview process revealed that there are often cases where non-formulary drugs are used and this may result in an expensive non-formulary drug being used when a less expensive substitute is available.
- The transportation costs associated with moving drugs across WHCC sites and medical clinics could also be a contributing factor to the high drug costs.
- Pharmacy purchasing is not centralized; technicians on site also function as buyers. De-centralization of this function may result in, missed opportunities for volume discounts, lack of control on inventory and missed credits for expired medications.

Converting to unit dose drug distribution system will reduce overall drug expenditures and promote drug safety. However, based on our experience in other hospitals, there are additional labour costs associated with a unit-dose systems. Site interviews with the director indicated that the plans are in place for fully converting WHCC to unit dose system utilizing the existing resources.

Increased pharmacy participation in multidisciplinary teams can assist in reducing costs and ensuring adherence to the formulary. Pharmacists can suggest more appropriate (often lower cost) drugs and changes in dosage and scheduling of drugs.

In addition, the pharmacy Director can identify the top ten highly utilized drugs by clinical program and evaluate their appropriateness and if possible suggest lower cost substitutes. According to a document provided to us by the Director, the

following three agents are examples of expensive drugs that account for significant cost<sup>70</sup>:

- Tenecteplase 50mg vial \$213,300
- Sevoflurane anesthetic agent \$100,200
- Botox \$82,280

Also, appropriate shifts from intravenous to oral drug administration, especially for antibiotics, can result in significant savings in drug costs and also reductions in lengths of stay.

Based on our site observations and interviews we believe there are opportunities for the Pharmacy Department to improve its drug cost performance. The pharmacy department should utilize existing resources to implement a single unit-dose system for the region and strengthen formulary management. With these improvements, the department should be able to realize a reduction in overall drug costs. The Director of Pharmacy should establish a target for WHCC drug costs at the best quartile performance of peer hospitals; 2.11% of Net Operating Costs.

**Recommendations:**

It is recommended that:

- (137) The Director of Pharmacy should work with the P&T Committee to develop additional policies to strengthen physician compliance to the region's formulary.**
- (138) The Director of Pharmacy should work with the P&T Committee to improve drug utilization and monitoring.**
- (139) The Director of Pharmacy should implement a single unit-dose distribution system across the organization.**
- (140) The Director of Pharmacy should work with the P&T Committee to reduce the amount of medication being provided to hospital outpatients.**

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<sup>70</sup> "Can we review the use of high priced drugs with a view of substituting more cost effective agents" Budget Consultations 2004/2005

**(141) The Director of Pharmacy should establish a target for WHCC drug costs at 2.33% of Net Operating Costs.**

## **6.6.2 Rehabilitation Services**

### **6.6.2.1 Current Characteristics**

Rehabilitation Services at WHCC include Physiotherapy, Occupational Therapy, Social Work, Psychology and Employee Assistance Services. The Rehabilitation Services portfolio is lead by a Regional Director who reports to the Vice President of Clinical Operations. Given the matrix structure of the organization, this Regional Director actually reports to three VP of Clinical Operations. The Regional Director is supported by an Assistant Director located primarily at the Stephenville site and who has responsibility for the rural sites of Port aux Basque, Calder, Bay St. George, Adult Rehab in Corner Brook and the O'Connell Centre. The Regional Director is located at Corner Brook site and also covers the rural sites of Bonne Bay and Port Saunders.

The majority of physiotherapy services are inpatient based. The most serviced clinical areas are Orthopaedics, Cardio Respiratory and Adult Rehabilitation. Outpatient physiotherapy services are mostly related to motor vehicle accidents and joint-related cases.

Occupational therapy services are mostly inpatient-based, with general medicine being the most highly serviced clinical program.

An Adult Rehabilitation program that treats patients with amputation, strokes and MVAs is established at the Corner Brook site. There are RNs, LPNs and a psychiatrist attached to this program in addition to occupational therapy, physiotherapy, social work and dietician resources.

Social Work services consist of educating the clinical teams on emphasis of short-term interventions. There is a focus on discharge planning.

The Employee Assistance program is provided to all WHCC sites. The resources for this program are social workers and they focus on workplace wellness and education. They are physically located on the WMRH and STRH sites.

There is 1 FTE psychologist for the region to provide psychology services. This individual is primarily responsible

for acute and LTC services at Corner Brook and supports psychiatry, but also takes referrals from other areas.

#### ***6.6.2.2 Issues in Management and/or Operations***

The following issues related to rehabilitation services management and operations were observed through site visit interviews:

- The matrix management organization structure for this portfolio has created some challenges in delivering services. Directors have reported that some therapists are not performing enough of the required clinical duties.
- The Regional Director is responsible for a wide range of disciplines in this portfolio and it is not possible to take on professional practice leadership duties for all of these disciplines.
- Physiotherapy services at the Corner Brook site are located in a facility that lacks assessment beds; staff often need to move patients to a different part of the hospital. There is a general lack of space in the department that can impact patient confidentiality and service effectiveness.
- It has been reported that the geography and weather can be a challenge in providing rehabilitation services across the region. The lack of staff to service rural areas impacts operations and the ability to meet rehabilitation needs in the region. A model that is being developed involves a “traveling clinic”, wherein a team of rehabilitation professionals will travel to sites and provide services. However, the availability of resources to provide this kind of service is the barrier to implementation.
- Gaps in physiotherapy and occupational therapy services were described to the consultants. It was reported that there is an inadequate service response to the needs of patients in adult rehabilitation, long term care, palliative care, chronic disease management and outpatient physiotherapy. Inadequate human resources was reported to be the major barrier in meeting these client needs.

- A recent review of human resources provided to the Health and Community Services Health Human Resource Planning Committee<sup>71</sup> indicate that for the western region, there are 6.5 more occupational therapist positions required to meet the recommended inpatient, ambulatory, community and long term care staffing ratios. HayGroup has not been able to obtain a final copy of this report and therefore we have not reviewed the analysis. We provide the reference to this study for information purposes. Detailed productivity analysis using hospital and peer workload data is provided in the following section.

### 6.6.2.3 Opportunities to Reduce Operating Costs in Physiotherapy

Physiotherapy and Occupational Therapy follow the MIS guidelines workload measurement system. There is currently no workload measurement system for social work implemented at WHCC. The following exhibits describe the productivity of the physiotherapy functional centres for the WHCC sites. Total worked hours is the sum of UPP and M&O hours for the functional centre and workload is measured in terms of visits<sup>72</sup> and telephone contacts.

Exhibit 6.76 shows physiotherapy workload and FTEs for Western Memorial Regional Hospital and Rufus Guinchard Health Centre. Physiotherapy at WMRH provides support to RGHC. These exhibits exclude the O'Connell & Interfaith Homes.

**Exhibit 6.76**  
**WMRH/RGHC Physiotherapy Visits & FTEs**

<b>WMRH &amp; RGHC</b>	<b>2002/03</b>	<b>2003/04</b>
Total Visits	15,238	14,126
Total Worked Hours	12,347	13,209
FTE	7.38	8.11

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (worked hrs/visit). As indicated in Exhibit

<sup>71</sup> Current Supply and Gaps in Service Issues for Physiotherapy, Occupational Therapy and Speech Language Pathology in Newfoundland and Labrador: A Consultation Document. This was prepared by the Allied Health Human Resources Planning Committee for the Health and Community Services Human Resources Sector Study. The final document/report of the Health and Community Services Human Resources Sector Study can be found on [www.nlhba.nf.ca](http://www.nlhba.nf.ca).

<sup>72</sup> In this characterization, a visit is used to represent a physiotherapy attendance

6.77, productivity of WMRH & RGHC has decreased from 2002/03 to 2003/04. 2003/04 productivity is above the worst quartile peer performance level.

**Exhibit 6.77**  
**WMRH/RGHC Comparison of Physiotherapy Productivity**  
**(Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	0.81	0.94			
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	14	0.70	0.80	0.87	0.82

Meeting the physiotherapy needs of RGHC may be contributing to the poor productivity for this functional centre, due to the travel time required to reach Port Saunders. However, even after taking into account the need to support RGHC, the median level of productivity performance of the peer organizations should be attainable by this functional centre. If it achieved the median level performance of its peers, then it would have required 5.79 FTEs to provide for 14,126 attendances.

**Recommendation:**

It is recommended that:

**(142) The Regional Director should adjust staffing to achieve productivity of 0.80 hours per visit for physiotherapy services at the WMRH & RGHC.**

The following exhibit shows physiotherapy workload and FTEs for Sir Thomas Roddick Hospital, Calder Health Centre and Bay St. George LTC. Physiotherapy at STRH provides support to Calder and Bay St. George.

**Exhibit 6.78**  
**STRH Physiotherapy Visits & FTEs**

	2002/03	2003/04
Total Visits	4,080	6,101
Total Worked Hours	6,643	7,540
FTE	3.40	3.94

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (worked hrs/visit). As indicated in the following exhibit, productivity of STRH has decreased from 2002/03 to 2003/04. Productivity in 2003/04 worse than the worst quartile peer performance level.

**Exhibit 6.79**  
**STRH Physiotherapy Productivity Comparison**  
**(Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	1.63	1.24			
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	11	0.76	0.80	1.05	0.91

Understanding the possibility of a different model of care that may not be comparable to the peers, we removed BSG LTC data and then re-calculated productivity for STRH. There was no appreciable difference as the resulting productivity was consistent with the levels presented above. Additional workload associated with travel time to service Calder and BSG could be contributing to poor performance. Taking into account the need to support these remote sites, it is recommended that this functional centre aim to achieve the worst quartile performance level. This would result in 2.91 FTE based on 5,413 attendances.

**Recommendation:**

It is recommended that:

**(143) The Regional Director should adjust staffing to achieve productivity of 1.05 worked hours per visit for physiotherapy services at the STRH & supported sites.**

Exhibit 6.80 shows physiotherapy workload and FTEs for Bonne Bay Health centre.

**Exhibit 6.80**  
**BBHC Physiotherapy Visits & FTEs**

	2002/03	2003/04
Total Visits	2,398	2,250
Total Worked Hours	1,912	1,931
FTE	1.57	1.50

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (worked hrs/visit). As indicated in Exhibit 6.81, productivity of Bonne Bay has decreased from 2002/03 to 2003/04. 2003/04 productivity is between the median and worst quartile peer performance level.

**Exhibit 6.81**  
**Comparison of BBHC Physiotherapy Productivity**  
**(Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	0.80	0.86			
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	11	0.76	0.80	1.05	0.91

Based on the information provided to us by WHCC, if this functional centre had achieved the best quartile level of performance then it would have required 0.88 FTEs for 2,250 attendances.

Exhibit 6.82 shows physiotherapy workload and FTEs for Charles L. LeGrow Health Centre.

**Exhibit 6.82**  
**LeGrow HC Physiotherapy Visits & FTEs**

	2002/03	2003/04
Total Visits	1,605	633
Total Worked Hours	1,580	2,283
FTE	0.93	1.25

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (worked hrs/visit). As indicated in Exhibit 6.83, productivity of LeGrow in 2002/03 was in between the median and worst quartile peer performance level<sup>73</sup>.

**Exhibit 6.83**  
**Comparison LeGrow HC Physiotherapy Productivity**  
**(Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	0.98	3.61			
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	11	0.76	0.80	1.05	0.91

Based on the information provided to us by WHCC, if this functional centre had achieved the best quartile level of performance then it would have required only 0.62 FTEs for 1,605 attendances.

Based on the findings of this review, we feel that Bonne Bay and LeGrow Health Centres should be able to achieve the best

<sup>73</sup> 2003/04 data for LeGrow were not used for the analysis.



quartile level performance in their delivery of physiotherapy services.

**Recommendation:**

It is recommended that:

**(144) The Regional Director should adjust staffing to achieve productivity of 0.76 worked hours per visit for physiotherapy services at Bonne Bay and LeGrow Health Centres.**

**6.6.2.4 Opportunities to Reduce Operating Costs in Occupational Therapy**

Exhibit 6.84 shows Occupational Therapy workload and FTEs for Western Memorial Regional Hospital. The FTE and hours shown do not include the OT support to LTC in Corner Brook. In 2002/03, this constituted 2.72 FTE and 4,317 worked hours.

**Exhibit 6.84**  
**WMRH Occupational Therapy Visits & FTEs**

	2002/03	2003/04
Total Visits	4,639	2,731
Total Worked Hours	7,146	5,205
FTE	4.48	3.22

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (hrs/visit). As indicated in Exhibit 6.85, productivity of WMRH is significantly above the worst quartile performance level.

**Exhibit 6.85**  
**WMRH Occupational Therapy Total Productivity Comparison (Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	1.54	1.91			
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	13	0.87	1.14	1.23	1.06

Based on the information provided to us by WHCC, if this functional centre had achieved the best quartile level of performance then it would have required 1.21FTEs for 2,731 attendances. Exhibit 6.86 shows Occupational Therapy workload and FTEs for the Work Assessment Western Memorial Regional Hospital. In 2003/04, this constituted 3.98 FTE and 1,071 worked hours.

**Exhibit 6.86**  
**WMRH Work Assessment Occupational Therapy Visits & FTEs**

	2002/03	2003/04
Total Visits	1,219	1,071
Total Worked Hours	5,134	6,436
FTE	3.22	3.98

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit (hrs/visit). As indicated in Exhibit 6.87, productivity of WMRH is significantly worse than the worst quartile performance level of the peer organizations.

**Exhibit 6.87**  
**WMRH Work Assessment Occupational Therapy Total Productivity Comparison**  
**(Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	4.21	6.01			
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	13	0.87	1.14	1.23	1.06

Based on the information provided to us by WHCC, if this functional centre had achieved the best quartile level of performance then it would have required 0.48 FTEs for 1,071 visits.

Exhibit 6.88 shows Occupational Therapy workload and FTEs for Charles L. LeGrow Health Centre.

**Exhibit 6.88**  
**LeGrow HC Occupational Therapy Visits & FTEs**

	2002/03	2003/04
Total Visits	638	N/A
Total Worked Hours	2,585	2,465
FTE	1.55	1.48

Productivity is measured and compared as the total worked hours (unit producing and management and operational support) per visit<sup>74</sup> (hrs/visit). As indicated in Exhibit 6.89, productivity of LeGrow is significantly above the worst quartile performance level.

<sup>74</sup> In this characterization, a visit is used to represent an occupational therapy attendance

**Exhibit 6.89**  
**LeGrow HC Occupational Therapy Productivity Comparison**  
**(Worked Hours/Visit)**

	2002/03	2003/04			
Wkd Hr/Visit	4.05				
Productivity Range	Peers	Best Quartile	Median	Worst Quartile	Mean
Wkd Hr/Visit	13	0.87	1.14	1.23	1.06

Based on the information provided to us by WHCC, if this functional centre had achieved the best quartile level of performance then it would have required 0.28 FTEs for 638 attendances.

The Regional Director should consider re-organizing the model of occupational therapy care to better utilize the current staffing to meet patient care requirements and improve productivity. With improved work processes, we feel that occupational therapy should be able to achieve the median productivity performance of the peer organizations.

**Recommendations:**

It is recommended that:

- (145) The Regional Director should adjust staffing for Occupational Therapy at Western Memorial Regional Hospital to achieve productivity of 1.14 worked hours per visit.**
- (146) The Regional Director should adjust staffing for Occupational Therapy at Charles L. LeGrow Health Centre to achieve productivity of 1.14 worked hours per visit.**

## **6.7 Diagnostic Services**

### **6.7.1 Clinical Laboratories**

#### **6.7.1.1 Departmental Description**

The WHCC clinical laboratories encompass a core laboratory at STRH and WMRH as well as Specimen Collection, Microbiology at the WMRH site, Pathology, Cytology, Histology and morgue operations. EEG and EKG at the WMRH also fall under laboratory services.

The Health Centres of WHCC offer basic specimen collection and haematology services while all other laboratory requirements are sent to the WMRH site.

The following table presents the FTE counts for the Clinical Laboratories:

**Exhibit 6.90  
WHCC Clinical Laboratories FTEs**

	<b>2002/03</b>	<b>2003/04</b>
Clinical Laboratory – Bonne Bay	1.70	1.70
Clinical Laboratory - LeGrow	8.46	6.13
Core Laboratories - STR	16.66	15.18
Clinical Laboratory - Calder	4.62	3.22
WMRH – Gen Admin	4.2	5.13
WMRH – Procurement	11.03	11.81
WMRH – Anat. Path.	8.10	9.52
WMRH – Microbiology	10.12	10.67
WMRH – Combined	22.72	20.63
<b>WHCC Laboratory Total</b>	<b>87.61</b>	<b>87.79</b>

#### **6.7.1.2 Organization Design**

The regional Director Laboratory services reports directly to the VP Clinical Operations – Corner Brook and in a matrix model is also responsible to the VP Clinical Operations BSG and Rural. There are two Assistant Directors. Assistant Director A has responsibility for Core Laboratory functions, EEG and EKG services at WMRH and as well as all clinical laboratory operations at STRH and LeGrow Health Centre. Assistant Director B is responsible for patient processing / specimen referral, pathology/cytology/histology/morgue and microbiology at the WMRH site as well as all clinical laboratory operations for Bonne Bay, Rufus and Calder Health Centres.

#### **6.7.1.3 Facilities, Equipment and Supplies**

The following observations and findings are made:

- Equipment platforms are not standardized across the region.
- Management has identified the need to replace Core Laboratory equipment at all sites in the Region with the exception of WMRH. Outdated equipment has contributed to excessive maintenance costs and to quality concerns arising from excessive downtime.
- Management has identified a particularly urgent need to replace a number of hematology analyzers that will no longer be supported by the vendor as of December 31, 2004. To avoid a lapse in service, management has identified September 1, 2004 as the deadline for issuing a purchase order to replace this equipment.

- Based upon the current ordering practices and test volumes, the obsolete hematology analyzers should be replaced. Management has a recommended replacement approach based on responses to a tender issued in early 2004.
- Management has recommended the replacement of equipment and revising test menus and is awaiting approval from the Department to proceed. The approval required from the Department is the ability to use budgeted operating funds towards a capital lease.

#### ***6.7.1.4 Operations Review***

The following observations and findings are made:

- A core laboratory operation was initiated at WMRH to provide service efficiencies; it began operation in February 2003.
- Over the past year, clinical laboratory workload reporting was updated based on the provincial MIS guidelines with the addition of new codes and functions.
- Management reports that test menus at the various sites throughout the region have not been changed for several years. Management has undertaken an extensive and comprehensive review of the test menus and prepared a proposal for a revised test menu for each location. The proposed test menu was developed with extensive consultation and input. Implementation of these recommendations should result in improved operational efficiency.
- Based on the proposed test menus, management has identified the potential for cost avoidance through the downsizing of equipment and adjustment of staff schedules.

#### ***6.7.1.5 Productivity and Staffing***

The Clinical Laboratories productivity is measured as the total worked hours per patient care workload unit. To facilitate appropriate comparisons and minimize reporting differences, staffing and workload for all clinical laboratory operations have been consolidated. The department's consolidated productivity is presented in the following exhibit.

**Exhibit 6.91  
Laboratory Productivity Comparison**

Clinical Laboratory – All combined		Worked Hours / Workload Unit
WHCC	2002/03	0.0185
	2003/04	0.0169
Peer Range 2002/03	Best Quartile	0.0191
	Median	0.0221
	Worst Quartile	0.0252
	Number of Peers	14

Based on the information provided by the corporation, clinical laboratory performance is better than the best quartile performance of the peer organizations. The performance improvement from 2002/03 to 2003/04 is largely attributed to changes in workload data collection and measurement practices at WHCC. However, based on our on-site interviews, observations and analyses, and as already identified by management, there are opportunities to further improve efficiencies and overall service delivery through:

- Revision of site specific test menus
- Downsizing of equipment in relation to revised test menus
- Adjustment of staffing schedules in relation to revised test menus
- The acquisition of laboratory equipment through reagent leases versus capital purchases

**Recommendation:**

It is recommended that:

**(147) The Regional Director, Laboratory services should review and revise as necessary the proposed test menus and equipment requirements, in relation to the clinical service adjustments arising out of this review.**

**6.7.2 Diagnostic Imaging**

**6.7.2.1 Departmental Description**

The WHCC Diagnostic Imaging service encompasses General Radiology, X-ray, Mammography, Computed Tomography, Ultrasound, Nuclear Medicine, BMD, ECG as well as the Provincial Breast Screening Program.

The following table presents the FTE counts for Diagnostic Imaging:

**Exhibit 6.92**  
**WMRH Diagnostic Imaging FTEs**

<b>WMRH</b>	<b>2002/03</b>	<b>2003/04</b>
D. I. – General	3.17	3.79
X-Ray	34.72	32.15
Mammography	4.82	3.65
Ultrasound	3.63	4.00
Diagnostic Cardiology	5.79	4.65
Electrodiagnosis	0.96	0.99
Interventional Angio	0.78	3.85
CT	7.56	5.55
Nuclear Medicine	2.19	1.97
<b>DI Total</b>	<b>63.62</b>	<b>60.60</b>

**Exhibit 6.93**  
**STR Diagnostic Imaging FTEs**

<b>STR</b>	<b>2002/03</b>	<b>2003/04</b>
X-Ray	12.38	10.83
Mammography	0.00	0.94
Ultrasound	1.41	1.24
Diagnostic Cardiology	1.99	1.99
<b>DI Total</b>	<b>15.78</b>	<b>15.00</b>

**Exhibit 6.94**  
**Other sites, Diagnostic Imaging FTEs**

	<b>2002/03</b>	<b>2003/04</b>
D.I. – General – Bonne Bay	5.62	4.43
D.I. – General – Rufus	6.47	4.81
D.I. – General – Calder	2.50	2.50
X-Ray – LeGrow	6.92	5.92
<b>DI Total</b>	<b>21.51</b>	<b>16.86</b>

**Exhibit 6.95**  
**TOTAL WHCC Diagnostic Imaging FTEs**

<b>WHCC</b>	<b>2002/03</b>	<b>2003/04</b>
<b>DI Total</b>	<b>100.91</b>	<b>92.46</b>

### 6.7.2.2 Organization Design

The regional Director Diagnostic Imaging Services reports directly to the VP Clinical Operations – Corner Brook and in a matrix model is also responsible to the VP Clinical Operations BSG and Rural. There are two Assistant Directors. Assistant

Director A has responsibility for CT, Interventional radiology, Mammography, nuclear medicine, the provincial breast screening program as well as all diagnostic imaging operations at STRH, Bonne Bay and Rufus Health Centres. Assistant Director B is responsible for BMD, Ultrasound, ECG at the WMRH site as well as all diagnostic imaging services at the Deer Lake clinic, LeGrow and Calder Health Centres. The two directors share responsibility for both General X-ray and operations at STRH.

### **6.7.2.3 Facilities, Equipment and Supplies**

The following observations and findings are made:

- PACS has not yet been implemented by the WHCC. It has been implemented in all other provincial regions. A portion of the capital required for this implementation has been provided by the Provincial government.
- A number of the general x-ray rooms are greater than 25 years old and require replacement.

### **6.7.2.4 Operations Review**

The following observations and findings are made:

- WHCC, like other regions, have had great difficulty recruiting radiologists. The radiologist position at STRH has been vacant for two years while 2 positions at the WMRH have been vacant for approximately a year.
- The shortage of radiologists has contributed to poor utilization and the inability to manage inappropriate ordering of exams and has also made it difficult to enforce various clinical protocols and guidelines. (Management has noted that there are no established protocols for ECG, carotid Doppler and renal colic.)
- Western Region residents are experiencing extended wait times for diagnostic imaging exams as a result of the shortage of radiologists.
- Management has identified the need to schedule examinations in a manner that allows patients to access the next available appointment and the service closest to their residence.
- The increase in oncology services at WMRH has increased the workload for diagnostic services particularly in CT and nuclear medicine.



### 6.7.2.5 Productivity and Staffing

The Diagnostic Imaging productivity is measured as the total worked hours per patient care workload unit. To facilitate appropriate comparisons and minimize reporting differences, all diagnostic imaging operations have been consolidated. The department's productivity is presented in the following exhibit.

**Exhibit 6.96  
Diagnostic Imaging Productivity Comparison**

Diagnostic Imaging – All combined		Worked Hours / Workload Unit
WHCC	2002/03	0.0616*
	2003/04	0.0380
Peer Range 2002/03	Best Quartile	0.0393
	Median	0.0452
	Worst Quartile	0.0555
	Number of Peers	14

\* Reported workload in 2002/03 appeared to be incomplete. In 2003/04 the department was more efficient than the best quartile performance of the peer organizations from across Canada.

#### **Recommendations:**

It is recommended that:

- (148) The VP Clinical Operations and the Regional Director, Diagnostic Imaging services should expedite acquisition and implementation of a regional PACS in WHCC.**
- (149) The VP Clinical Operations and the Regional Director, Diagnostic Imaging services should develop a comprehensive capital equipment replacement and renewal strategy.**

## **6.8 Support Services**

### **6.8.1 Food services**

#### **6.8.1.1 Departmental Description**

The Food services department operates conventional kitchens throughout the Western Region providing meals for both acute and long-term care. In addition, the department provides Catering and Cafeteria services as well as Clinical Nutrition to all regional sites.

The WMRH kitchen serves both the WMRH and the O’Connell Centre. A stand alone kitchen exists at the Corner Brook Interfaith Home while LeGrow, Bonne Bay, Rufus and Calder Health Centres each provide tray and dining service for their residents. The kitchen at Bay St. George provides meal services for both the residents and the acute care patients at STRH. There is also a cafeteria operating at STRH. The following table presents the FTE counts for Food Services:

**Exhibit 6.97**  
**WHCC Food Services FTEs**

	<b>2002/03</b>	<b>2003/04</b>
Food Services - WMRH	62.95	62.86
Food Services – Bonne Bay	7.38	7.60
Food Services – Calder	7.32	6.63
Food Services – STR	5.10	4.65
Food Services – LeGrow	10.77	10.99
Food Services – Rufus	7.66	7.11
Food Services – BSG	28.06	26.91
Food Services - Interfaith	26.26	26.17
<b>Total</b>	<b>155.50</b>	<b>152.92</b>

### **6.8.1.2 Organization Design**

Food Services report through a Regional Director, Nutritional Services to the VP Corporate Services and CFO. At sites outside of Corner Brook, Nutritional Services staff report to a Support Services Manager (if the site has one) or the Site Coordinator for daily issues.

### **6.8.1.3 Operations Review**

The following observations and findings are made:

- The WMRH kitchen provides meals for both the WMRH and the O’Connell Centre. The O’Connell Centre meals are provided through tray services as well as dining room service.
- The consolidation of meal preparation for WMRH and the O’Connell centre has achieved efficiencies and required implementation of an advanced transportation systems. The same transportation system is in place between BSG and STRH for the acute meals provided to STRH. There are further opportunities to consolidate meal preparation within the region, such as the Corner Brook Interfaith Home, that would further reduce operating costs

- The dietary system at WMRH (DFM – Dietary Food Management) that manages production requirements through the integration of diet orders and menu selections is outdated. The system is not capable of being integrated with Meditech; it cannot be interfaced with the ADT system or purchasing.
- To date each site within the region has a unique menu. Management is in the process of reviewing the feasibility of regional menu standards to facilitate purchasing, production forecasting and to minimize waste. Regional therapeutic and texture modified standards have been completed.
- Management has identified a number of opportunities for improved efficiency and service delivery such as sanitation equipment and layout improvements at WMRH, Meditech purchasing at WMRH, new tender for disposables and chemicals, nutrition screening program and expansion of preventative clinical services, evaluation of floor stock and nourishment standards. These opportunities should be investigated in relation to opportunities to move away from conventional production and further consolidation of meal preparation activities.

#### 6.8.1.4 Productivity & Staffing

The performance indicator for Food Services is “net cost per inpatient and resident day.” Reported “meal day” statistics were used first to separate inpatient costs from outpatient costs. The remaining inpatient costs were divided by the number of inpatient and resident days to calculate the productivity indicator. The department’s performance is presented in the following exhibit for all WHCC sites combined.

**Exhibit 6.98**  
**Comparison of Food Services Costs**

Food Services		Net Cost / inpatient and resident day
WHCC	2002/03	\$29.18
	2003/04	\$29.70
Peer Range 2002/03	Best Quartile	\$27.24
	Median	\$29.91
	Worst Quartile	\$35.24
	Number of Peers	18

The Food services performance indicator shows that WHCC performance is slightly better than the median of the peer comparators. There appeared to be wide variation among the WHCC sites in cost per patient day based on the data

provided. Site results ranged from \$17.98 to \$39.56 per inpatient day in 2003/04. One way to improve overall cost performance for WHCC would be to focus on the higher cost sites. The following exhibit provides cost per patient day by site based on the data provided. It should be noted that the particularly wide variation may be partly due to accounting / data.

**Exhibit 6.99**  
**WHCC Food Service cost per patient day by site**

	<b>2002/03</b>	<b>2003/04</b>
Food Services - WMRH	37.09	36.87
Food Services – Bonne Bay	22.12	38.15
Food Services – Calder	21.60	21.24
Food Services – STR	16.71	17.98
Food Services – LeGrow	16.43	18.02
Food Services – Rufus	42.94	36.63
Food Services – BSG	42.00	39.56
Food Services - Interfaith	24.44	25.97
<b>WHCC Combined</b>	<b>29.18</b>	<b>29.70</b>

Transportation challenges between the Health Centres and the Hospitals within the region may preclude consolidation of all regional food services activities at any single location. Such an option should, however, be investigated. Consolidation of activity for BSG, STRH and the Corner Brook operations at a minimum should be feasible. There are opportunities to further improve efficiencies and overall service delivery as follows:

- Implementation of a new food services system that will integrate with Meditech modules (ADT and purchasing);
- Continued implementation of regional menu standards;
- Further consolidation of meal preparation activities to achieve greater economies of scale;
- Role review of Clinical Dieticians and possible introduction of Dietary technicians for menu entry;
- Review the business case associated with modernizing kitchen facilities to more efficient current standards, such as a cook-chill operations;
- Investigation of retail food services options including outsourcing and regional standards.

**Recommendations:**

It is recommended that:

- (150) The Regional Director, Nutrition services should establish a net operating cost performance target equivalent to \$27.24 net cost per inpatient & resident day<sup>75</sup>.**
- (151) The Regional Director, Nutrition services should investigate the business case and feasibility of migrating away from conventional production either through capital investment or outsourcing arrangements including retail operations.**

**6.8.2 Materials Management****6.8.2.1 Departmental Description**

Materials Management encompasses purchasing, stores, sterile processing, print shop, mailroom and portering, transportation services and vehicle management. The following table presents the FTE counts for Materials Management.

**Exhibit 6.100  
WHCC Materials Management FTEs**

	<b>2002/03</b>	<b>2003/04</b>
MM – General	2.48	2.41
MM – Stores	27.50	28.29
MM – Sterile processing	32.27	31.31
MM – Purchasing	4.09	4.22
<b>MM – Total</b>	<b>66.34</b>	<b>66.23</b>

**6.8.2.2 Organization Design**

The VP Corporate Services holds ultimate responsibility for materials management. A Manager, Institutional Supplies and a Manager of SPD services report through a Regional Director, Materials Management. Purchasing staff also report directly to the Regional Director (with the exception of a single buyer at STR who reports through the Manager, Institutional Supplies).

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<sup>75</sup> Measured in 2003/04 dollars.

### **6.8.2.3 Operations Review**

The following observations and findings are made:

- WHCC purchases a portion of its Pharmacy, Laboratory and medical/surgical supplies through the Province Wide Group Purchasing (PWGP) of the Newfoundland and Labrador Health Boards Association.
- For items where appropriate standards and specifications are met, WHCC also uses provincial government contracts available through the Central Purchasing Authority.
- Management has identified the need to reduce inventory levels across the region, but particularly in the Health Centres.
- A majority of purchasing activity has been consolidated at the WMRH site.
- Meditech is fully implemented at all locations allowing users to requisition on-line from all locations within the region.
- Management has introduced a vendor evaluation protocol to review service levels and performance.
- Management is considering opportunities to contract out transportation requirements.
- Sterile processing occurs in three locations: WMRH, STR and DCL. A fourth sterilizing function at Bonne Bay Hospital was recently discontinued. A review of the sterilization requirements for each location should be undertaken with the goal of consolidating activity in one location and serving the region from one Sterile Processing operation. Sterilization requirements for BBH, White Bay and the Northern Peninsula are presently processed at WMRH.

### **6.8.2.4 Productivity and Staffing**

The performance indicator for Materials Management is “net cost as a percentage of direct care cost.” The department’s performance is presented in the following exhibit.

**Exhibit 6.101  
Materials Management Productivity Comparison**

Materials Management		% of Direct Care Costs
WHCC	2000/01	3.97%
	2001/02	3.76%
	2002/03	3.70%
	2003/04	3.65%
Peer Range 2002/03	Best Quartile	2.85%
	Median	3.22%
	Worst Quartile	3.70%
	Number of Peers	9

Although productivity performance of Materials Management has been improving in 2003/04, it remains close to the worst quartile performance of the peer organizations. While the transportation challenges of the Western Region are unique in relation to many of the peers, there are significant opportunities to further improve efficiencies and overall service delivery as follows:

- Increasing standardization of medical surgical supplies as suggested by management;
- Reducing the number of non-inventory specialty items;
- Comprehensive review of stores items with a goal of eliminating low volume seldom used inventory;
- Aggressively integrate inventories, reduce inventory levels and improve inventory turnover targeting an initial inventory turnover target of 18 per year (current rate reported as 12-15);
- Complete the consolidation of purchasing activity;
- Complete the implementation of Electronic Data Interchange (EDI) such that purchase orders and invoices can be transferred electronically between the hospital and vendors;
- Review potential consolidation of separate management functions of equipment procurement (regional Director Biomed / Equipment) and purchasing;
- Consolidating Sterile processing to a single location.

These improvements should allow the functional centre to move toward best quartile performance of the peer hospitals.

**Recommendations:**

It is recommended that:

- (152) The Regional Director, Materials Management should establish a net operating cost performance target equivalent to 3.03% of total direct care net operating costs.**
- (153) The Regional Director, Materials Management should review the sterilization requirements for each location with the goal of consolidating activity to serve the region from one Sterile Processing operation.**

**6.8.3 Environmental Services****6.8.3.1 Departmental Description**

WHCC environmental services includes the areas of Housekeeping, Laundry & Linen, Security and waste management. Security services have been contracted out at both the STR and WMR sites while utility staff, largely in housekeeping, take on security responsibilities at the other sites. The major institutional laundry facility is located at the WMRH. Personal patient/resident laundry is primarily a site specific service for long term care residents. The resident laundry services at the O'Connell Centre in Corner Brook, however, also serve long term care residents at the LeGrow Health Centre in Port aux Basques as well as the residents of the 5<sup>th</sup> and 6<sup>th</sup> floors of WMRH. Institutional and resident laundry is combined in Port Saunders, Bonne Bay and Burgeo.

The following table presents the FTE counts for Environmental Services. No separate statistics for waste management or security are provided.

**Exhibit 6.102  
WHCC Environmental Services - Housekeeping FTEs**

	<b>2002/03</b>	<b>2003/04</b>
WMRH	73.46	72.52
Bonne Bay	9.40	8.81
Calder	8.84	8.33
STR	13.76	16.13
LeGrow	8.39	8.21
Rufus	9.34	9.60
BSG	17.10	17.02
Interfaith	32.61	31.63
<b>Total</b>	<b>172.90</b>	<b>172.26</b>



**Exhibit 6.103**  
**WHCC Environmental Services - Laundry FTEs**

	<b>2002/03</b>	<b>2003/04</b>
WMRH	30.92	28.42
Bonne Bay	1.82	1.29
Calder	1.40	1.23
STR	0.00	0.00
LeGrow	0.00	0.00
Rufus	1.93	1.40
BSG	4.08	4.48
Interfaith	8.75	8.52
<b>Total</b>	<b>48.90</b>	<b>45.33</b>

### **6.8.3.2 Organization Design**

Environmental Services are the responsibility of a Regional Director reporting to the VP corporate services and Chief Financial Officer. There are geographically located managers throughout the service reporting directly to the regional manager and a single Assistant Director located at the WMRH. The position of Regional Director, Laundry services was recently eliminated.

### **6.8.3.3 Operations Review**

The following observations and findings are made:

- Management reports that following the ‘action plan’ in 2001, the operating budget for environmental services was reduced by approximately \$1.1 million or 10%. This is evident in the productivity screening where environmental services net cost as a percentage of direct care cost has been reduced by approximately 2% over the past 4 years.
- Management recognizes that laundry operations are an area where economies of scale are achievable. Some progress has been made to consolidate laundry operations. Further consolidation raises concerns regarding reliability, cost of transportation, and the cost of maintaining contingency inventory and any potential required increases in inventory.
- Management has identified the need to perform a comprehensive waste audit with the potential to reduce the quantities of biomedical and confidential waste and to comply with a provincial directive to reduce all waste by 50% by 2010.
- The department has noted that there are several unmet capital equipment needs contributing to inefficiencies; acquiring

environmental capital equipment is problematic when it is competing with medical equipment.

- Workload and production assignments for housekeeping staff are based on guidelines from the Canadian Council of Ministries of Environment (CCME).

#### 6.8.3.4 Productivity and Staffing

The performance indicator for Environmental Services is “net cost as a percentage of direct care cost.” The department’s performance is presented in the following exhibit.

**Exhibit 6.104**  
**Housekeeping Productivity Comparison**

Housekeeping		% of Direct Care Costs
WHCC	2000/01	9.85%
	2001/02	8.83%
	2002/03	7.82%
	2003/04	7.80%
Peer Range 2002/03	Best Quartile	3.57%
	Median	5.18%
	Worst Quartile	5.78%
	Number of Peers	9

As many of the security and housekeeping operations of WHCC are combined and not separable for reporting purposes, the two areas were combined for comparative purposes as follows:

**Exhibit 6.105**  
**Housekeeping and Security Productivity Comparison**

Housekeeping & Security combined		% of Direct Care Costs
WHCC	2000/01	10.21%
	2001/02	9.21%
	2002/03	8.24%
	2003/04	8.22%
Peer Range 2002/03	Best Quartile	4.57%
	Median	5.45%
	Worst Quartile	6.42%
	Number of Peers	9

Using these measures, the housekeeping performance indicator identifies a level of performance well past the worst quartile performance in the productivity screening.

We have also prepared the performance indicator of “net cost per square meter”. Using a total for WHCC of 86,624 Square Meters that excludes penthouses and boiler rooms, the

housekeeping departments' performance is presented in the following exhibit.

**Exhibit 6.106**  
**Housekeeping Productivity Comparison based on area**

Housekeeping		Net Cost per Square Meter
WHCC	2000/01	\$73.42
	2001/02	\$72.67
	2002/03	\$73.20
	2003/04	\$76.15
Peer Range 2002/03	Best Quartile	\$46.32
	Median	\$49.45
	Worst Quartile	\$59.22
	Number of Peers	9

Using this indicator, housekeeping performance remains well past the worst quartile performance. An area of 88,432 square meters was used for a similar analysis on plant security. The results are presented in the following exhibit.

**Exhibit 6.107**  
**Plant Security Productivity Comparison based on area**

Plant Security		Net Cost per Square Meter
WHCC	2000/01	\$2.59
	2001/02	\$3.15
	2002/03	\$3.63
	2003/04	\$4.16
Peer Range 2002/03	Best Quartile	\$2.91
	Median	\$3.85
	Worst Quartile	\$4.34
	Number of Peers	9

Despite the fact that a number of the housekeeping and security functions are combined, on its own, the security productivity comparison identifies a level of performance between the median and worst quartile in net cost per square meter.

There are opportunities to improve efficiencies and overall service delivery as follows:

- Further consolidation of laundry services;
- Reducing quantities of bio-medical and confidential waste;
- Aggressively review workload and production assignments for housekeeping staff using comparisons and benchmarking with peer health care organizations from across Canada.

A minimum performance target of the median peer group performance should be established by the Regional Director, Environmental Services. Given the performance of the department, however, achieving such levels will require a concerted effort and benchmarking investigation about how peer facilities are able to achieve their performance levels. As a more realistic shorter-term goal, a 5% reduction in net housekeeping costs should be targeted and achieved.

**Recommendations:**

It is recommended that:

**(154) The Regional Director, Environmental Services should establish a cost reduction target equivalent to 5% of current departmental net operating costs.**

**(155) The Regional Director, Environmental Services investigate the business case and feasibility of further consolidating laundry and linen services.**

**6.8.4 Facility Services**

**6.8.4.1 Department Description**

WHCC Facility Services includes the areas of Plant Operations, Maintenance, Grounds, capital projects, Biomedical engineering and Equipment procurement. The following table presents the FTE counts for Facility Services.

**Exhibit 6.108  
WHCC Facilities Services – Plant Operations FTEs**

	<b>2002/03</b>	<b>2003/04</b>
WMRH	40.23	38.44
Bonne Bay	1.34	2.05
Calder	1.01	1.25
STR	15.01	12.31
LeGrow	8.52	7.91
Rufus	1.02	1.02
BSG	3.55	3.45
Interfaith	7.21	4.32
<b>Total</b>	<b>77.90</b>	<b>70.75</b>

**6.8.4.2 Organization Design**

Within facilities services there are two Regional Directors reporting to the VP Corporate Services and Chief Financial Officer: Regional Director Biomed / Equipment and Regional Director Facilities. There is a single manager in the

department responsible for the WMRH site with a dual reporting relationship to both Regional Directors. The Vice President Corporate Services and Chief Financial Officer should review of the responsibilities of these regional directors with an aim to consolidate these positions. The portfolio of the Regional Director, Environmental Services is addressed separately. These three Regional Directors represent the three services provided under the Department of Facilities.

#### ***6.8.4.3 Facilities, Equipment and Supplies***

Plant equipment is relatively new and up-to-date. New boilers as well as cold air chillers have been recently installed at the WMRH site. Much of the new equipment has been installed as a result of the Energy Performance Contract (EPC). STRH is a new facility.

#### ***6.8.4.4 Operations Review***

The following observations and findings are made:

- A computerized facilities Management System monitors indoor air quality conditions at the WMRH as well as the O’Connell Centre. Plans are in place to expand the system throughout the region.
- A maintenance management system is in place to manage preventative and predictive maintenance, track unscheduled maintenance, completed and outstanding work orders as well as equipment histories.
- Management has attempted to standardize service and response across the entire region by creating regional policies for all sites in the Western Region.

#### ***6.8.4.5 Productivity and Staffing***

The performance indicator for Facility Services is “net cost as a percentage of direct care cost.” The department’s performance is presented in the following exhibit.

**Exhibit 6.109**  
**Plant Operations & Maintenance Productivity Comparison**

Plant Operations & Maintenance		% of Direct Care Costs
WHCC	2000/01	8.93%
	2001/02	9.28%
	2002/03	8.84%
	2003/04	9.59%
Peer Range 2002/03	Best Quartile	5.50%
	Median	5.89%
	Worst Quartile	7.32%
	Number of Peers	9

We have also prepared a performance indicator for Facility Services of “net cost per square meter”. We have used 88,432 square meters. The department’s performance on this indicator is presented in the following exhibit.

**Exhibit 6.110**  
**Plant Operations & Maintenance Productivity Comparison based on area**

Plant Operations & Maintenance		Net Cost per Square Meter
WHCC	2000/01	\$65.41
	2001/02	\$74.95
	2002/03	\$81.19
	2003/04	\$90.78
Peer Range 2002/03	Best Quartile	\$57.27
	Median	\$67.42
	Worst Quartile	\$73.72
	Number of Peers	9

On both indicators, the Plant Operations performance screening identifies a level of performance well past the worst quartile performance.

Some the difference in performance may be a function of differences in reporting. The WHCC reporting includes expenses associated with capital projects that would typically be reported by peer facilities under a planning functional centre. In addition, the department provides facility services to Community Health Western through shared service agreements and also maintains several long-term care cottages not typical of peer facilities. Despite these differences, there are opportunities to improve efficiencies and overall service delivery.

The department has implemented a high level of automation intended to improve efficiencies and service levels. There have been some implementation challenges with the new plant

causing some short-term increases in operating costs. The automation and the major new equipment, however, should allow the department to operate at high levels of efficiency. These levels have not been achieved to date. Management should aggressively review staff workload and production assignments using comparisons and benchmarking with health care peer organizations. Management should also be diligent in working through implementation and installation challenges to fully realize the savings intended from the EPC.

There is a high degree of performance variability by site that may also assist with the investigation into methods to improve performance. This should also help identify particularly high cost areas. The department should initiate intra-organizational benchmarking of performance and processes. This information is presented below.

**Exhibit 6. 111**  
**Plant Operations & Maintenance**  
**Intra-Organizational Productivity Comparisons**

Plant Operations & Maintenance		% of Direct Care Costs
WHCC 2003/04	Bonne Bay	14.34%
	LeGrow	12.62%
	Calder	12.27%
	Rufus Guinchard	11.39%
	WMRH	11.08%
	STRH	9.45%
	Bay St. George	5.51%
	Interfaith/O'Connell	3.34%
Peer Range 2002/03	Best Quartile	5.50%
	Median	5.89%
	Worst Quartile	7.32%
	Number of Peers	9

Despite the potential differences in reporting by comparators, a minimum performance target of the median peer group performance should be established by the Regional Director, Facilities Services as a long-term goal. A full review of staff workload, production assignments and processes using comparisons and benchmarking with health care peer organizations will likely be a relatively long process to complete. However, a short term goal of a 5% reduction in plant operations should be targeted.

**Recommendations:**

It is recommended that:

- (156) **The Regional Director, Facilities Services should establish a cost reduction target equivalent to 5% of current departmental net operating costs.**
- (157) **The Regional Director, Facilities Services should initiate internal and external benchmarking of operational processes to identify approaches to further reduce the cost of plant operations and maintenance in the region.**

**6.9 Administrative Services****6.9.1 Financial Services****6.9.1.1 Departmental Description**

Financial services for WHCC encompasses general accounting, accounts receivable, accounts payable, budgeting as well as payroll. The following table presents the FTE counts for Financial services.

**Exhibit 6.112  
WHCC Financial Services FTEs**

<b>Financial Services</b>	<b>2002/03</b>	<b>2003/04</b>
WMRH	18.67	19.89
Calder	1.19	1.42
STR	3.34	2.91
LeGrow	2.14	2.14
BSG	2.19	2.69
Interfaith	0.95	1.01
<b>Total</b>	<b>28.48</b>	<b>30.06</b>

**6.9.1.2 Organization Structure**

Financial services fall under the authority of the Regional Director Financial Services / Budgeting reporting to the VP Corporate Services and Chief Financial Officer. The department includes a Director of Budgeting and special projects and a Director of Accounting. The responsibilities of the Director of Accounting include general ledger, accounts payable, accounts receivable for which there is a single manager as well as payroll where there is also a manager.

As a result, there are three management levels between the Unit Producing staff and the CFO (Manager, Director,



Regional Director). Although there are some financial staff located on the various campuses of the WHCC, the majority of the staff are physically located at WMRH. Consolidating all financial activity at a single location within WHCC would eliminate the need for one of the management levels and facilitate greater efficiency in operations. Provided a mechanism to address staff payroll inquiries and a method for patients to settle various accounts are established, there is no reason for finance staff to be located at more than one location.

### 6.9.1.3 Productivity and Staffing

The performance indicator for Finance is “net cost as a percentage of direct care cost.” The department’s performance is presented in the following exhibit.

**Exhibit 6.113**  
**Financial Services Productivity Comparison**

Financial Services		% of Direct Care Costs
WHCC	2000/01	2.02%
	2001/02	1.71%
	2002/03	1.58%
	2003/04	1.85%
Peer Range 2002/03	Best Quartile	1.80%
	Median	2.11%
	Worst Quartile	2.98%
	Number of Peers	9

The performance of financial services is close to the best quartile performance of the peer organizations (it was better than best quartile in both 2001/02 and 2002/03). Based on our on-site interviews, observations and analyses, there may, however, be opportunities to further improve efficiency and overall service delivery by consolidating activity at a single location and eliminating a level of management.

#### **Recommendation:**

It is recommended that:

**(158) The VP Corporate Services and Chief Financial Officer should consolidate Financial Services at a single location.**

## 6.9.2 Registration and Clinical Records

### 6.9.2.1 Departmental Description

The department includes Health records, switchboard, OR & procedure scheduling at the STRH site, and Admitting/Registration including appointment booking. Patient appointment booking is, however, decentralized at the WMRH site. Health records includes coding, transcription, chart completion, chart processing (retrieval, distribution, storage and maintenance), release of clinical information and data analysis and reporting. The following table presents the FTE counts for Health Records:

**Exhibit 6.114  
WHCC Health Records FTEs**

<b>Health Records</b>	<b>2002/03</b>	<b>2003/04</b>
WMRH	22.45	23.10
Bonne Bay	2.72	2.85
Calder	1.19	1.15
STR	6.06	6.29
LeGrow	5.40	5.17
Rufus	3.04	3.08
<b>Total</b>	40.86	41.63

**Exhibit 6.115  
WHCC Patient Registration FTEs**

	<b>2002/03</b>	<b>2003/04</b>
WMRH	7.57	7.31
STR	12.97	12.12
<b>Total</b>	20.54	19.43

Registration at the STR site includes OR & Procedure room scheduling as well as clinic appointment bookings. These functions are decentralized at the WMRH site.

The FTE increase in Health Records at WMRH was due to coding and abstracting of procedure room cases that were previously not captured.

#### **6.9.2.2 Organization Design**

The Regional Director for Health Records/Registration reports to the Corporate Director, Clinical Decision Support. WMRH has a site-specific manager health records/registration who reports to the Regional Director.

### **6.9.2.3 Facilities, Equipment and Supplies**

Records Storage is a significant problem for the department. A site visit of the health records storage and work areas was conducted and confirmed that storage space at the WMRH site is exhausted. Charts are filed beyond capacity on appropriately designed shelves while stand-alone filing cabinets and temporary shelves fill any available space. Facilities staff are investigating the load burden currently being placed on the facility floor. The situation has created a hazardous work environment for staff and leads to inefficiencies in chart retrieval. Off-site storage has not been considered due to concerns about the sensitivity of the information. Management has recently identified space in the old boiler plant area for dead storage of files.

Facilities for the coding and abstracting of patient charts are also inadequate. These functions are performed in the middle of the main work/storage area among chart storage. While adjacency of functions is important, the current arrangement does not allow any opportunity for concentration or freedom from distraction.

The Dictation system at the WMRH site is antiquated: it is no longer supported by the vendor and has no available replacement parts except those salvaged from the system that was replaced by the Central Health Region. The system was down during our site visit and being repaired after-hours. The system needs to be replaced.

### **6.9.2.4 Operations Review**

As has been discussed previously in other sections of this report, chart completion, although often problematic in hospitals, is a particular challenge for WHCC. Our site visit confirmed excessive volumes of incomplete charts; this situation creates inefficiencies in chart retrieval, affects coding and abstracting and ultimately results in poor patient care as charts, once retrieved to support care of a patient in the hospital, are incomplete.

### **6.9.2.5 Productivity and Staffing**

The performance indicator for Health Records is “net cost as a percentage of direct care cost.” The department’s performance is presented in the following exhibit.

**Exhibit 6.116  
Health Records Productivity Comparison**

Health Records		% of Direct Care Costs
WHCC	2000/01	2.11%
	2001/02	2.15%
	2002/03	1.96%
	2003/04	2.02%
Peer Range 2002/03	Best Quartile	2.15%
	Median	2.50%
	Worst Quartile	2.89%
	Number of Peers	9

Health Records performance is better than the best quartile performance of the peer organizations. However, based on our on-site interviews, observations and analyses, there may still be opportunities to further improve efficiencies and overall service delivery as follows:

- The Manager of Registration and Clinical Records should develop a business plan for alternative records storage options.
- The Corporate Director, Clinical Decision Support should implement a new Dictation Transcription system.
- The RMAC and The VP Medical Services should implement a system to enforce timely chart completion.

## **6.10 Information Technology**

### **6.10.1.1 Current Characteristics**

The Information Technology Department of the WHCC is managed by a Regional Director who reports to the Vice President of Corporate Services/Chief Financial Officer. The department comprises of 8 FTEs that report to the Regional Director. The IT function for WHCC is centralized to the Western Memorial Regional Hospital site. Other WHCC sites are serviced through online software and technical expertise originating from the Western Memorial site. Periodic site visits are conducted by IT staff for technical support and the hospital courier system is used to transport hardware if necessary.

The WHCC along with the rest of the province have chosen Meditech software as their primary health information system. All sites in the region have the ADT, medical records, laboratory and material management modules of the system. All sites with pharmacies also have the pharmacy module.

WMRH, as the regional referral centre, also has order entry, patient care enquiry, diagnostic imaging and community wide scheduling modules; plans are in place to extend these modules to all sites in the region

There is no computerized physician order entry (CPOE) as of yet, this will require further development of the existing order-entry capability, clinician education and a change management strategy.

The IT department has focused its efforts to date in providing technical solutions in the area of Electronic Health Records and developing a communications infrastructure to help support connectivity of the geographically dispersed sites of the WHCC. Currently, all sites (excluding medical clinics) are connected to the WHCC information network, albeit at varying degrees of speed.

#### ***6.10.1.2 Issues in Management and/or Operations***

The management structure seems to work well for the Information Technology Department. The function is quite centralized and leadership is provided through the Regional Director.

The 8 FTE primarily serve in a technical capacity, providing troubleshooting (help desk) and network support services to the corporation. There are several implementation projects slated for at WHCC that involve enhancing the corporation's Electronic Health Record. The following initiatives have been identified through the interview process:

- Nursing / Clinical documentation Module
- OR Management Module
- PACS
- PCI, Order Entry & DI (sites other than Western Memorial)
- Departmental Transcription Module
- Community-wide Scheduling Module

Most of these modules are already available as part of the Meditech suite of software. It is important to approach implementation of these modules within a project management framework that includes involvement and representation from user groups, including clinicians.

It was reported that the main barrier to initiation and implementation is the required human resources to undertake these projects.

There may be opportunities for redesign of roles and/or increased training of some of the individuals within the department in order to provide the base for a more effective project implementation team. For example, the interview process identified a Systems Manager, reporting directly to the Regional Director, who has a Meditech skill-set, but whose role is largely that of an office manager for the group. This individual may be able to act as a project manager for such projects while offloading office manager duties to human resources and/or other shared support staff. Re-designing roles of the current staffing complement to accommodate these projects should be the immediate-term step.

In order to continue both the development of the communication/network infrastructure and pursue EHR initiatives, there is a need to invest in more IT human resources to support future planned initiatives. Once the region has established a positive fiscal position, it should increase its ongoing spending and investments in information systems and technologies.

There is currently no up to date Information Technology strategic plan in place. The organization is still working from a plan that was written in 1996. The 1996 plan set out IT objectives for communications and network infrastructure and integration of systems that have largely been met. However, there are objectives such as the implementation of a decision support system on an enterprise level that the plan set out, but have not been met. The health care environment and IT requirements have changed since 1996 and new strategic plan is required. We have learned that there is an IT Steering Committee that has corporate and physician representation, charged with developing a strategy to commence various IT initiatives. This committee should develop a well-documented strategic plan that addresses the needs of the region. It is imperative that this plan be backed by both the corporate and clinician groups in the organization.

Based on our review, we feel that any strategic plan should include the following information and communication technology initiatives that would significantly assist the corporation in the shorter term:

- **Video-Conferencing:** Enhance the video-conferencing capability for administrative and/or therapeutic

applications within the Corporation. Geography has been identified through the review process as a barrier to achieving efficiencies. Further investment in connecting all the sites via video-conferencing (where bandwidth is available) and using existing video-conferencing technology should be options to be considered in connecting the following groups of people:

- Regional Directors with Direct Reports located in sites different from their own. This can be done to maintain regular lines of communication and cut down on travel time which is costly and affects productivity.
  - Therapists/Clinicians in Corner Brook & Stephenville with patients in other sites of the Corporation to provide basic consultative sessions, where it may not be necessary to provide hands on care (ex. Social Work, Psychology, etc.).
  - Clinicians with their colleagues in other sites in order to provide practice support and maintain collegial linkages.
- **Information Management/Decision Support Function:** Enhance the decision support function in order to provide more timely and useful information for managers. We learned that there is a Meditech decision support system called ESS (Executive Support System). The ESS was described as being used occasionally by the Health Records department and Regional Utilization Coordinator to obtain Admission/Discharge statistics, and periodically by Pharmacy to view drug costs across the region. The ESS has the potential to be a valuable tool for managers as it has the ability to gather and assemble information from the following applications: Registration, Case Mix Management, Order Entry, Laboratory, Billing/Accounts Receivable, General Ledger, Accounts Payable, Payroll/Personnel, Staffing and Scheduling, Pharmacy and Physician's Practice Management. We feel that this kind of module should be deployed more widely across the organization to managers in order give them information to manage more effectively and efficiently. This will also assist in fostering a culture of managing with information within the organization. This is a shorter term solution, until a more robust data repository can be developed that will analyze and integrate both clinical and administrative data and provide regular reports to managers.

- **Corporate Intranet/E-mail policy:** A corporate intranet can serve as a valuable tool to communicate with employees, especially given the challenges that the corporation faces being located across a wide geography. For example, Clinical pathways and care maps published to the intranet can assist clinicians at other sites and standardize care across the corporation. There are currently two e-mail systems in place in the organization, one being an internet-based e-mail system, the other being a non-internet based, Meditech messaging system. Current e-mail policy provides internet e-mail addresses to only managers and clinical leaders. In some cases managers have both services. The corporation should adopt one e-mail system for all employees to ensure non-duplication and streamline communication.

The planned EHR initiatives discussed above are important initiatives and ones that we feel the corporation will benefit from in the longer term. These initiatives will also require future investment in IT human resources (especially with skills in health informatics) as a shift occurs in the current model of the IT department from one that is predominately help-desk/technical support based to one that is project-management based.

#### ***6.10.1.3 Performance & Staffing***

Assessing the performance of information technology departments in health care organizations is difficult. In contrast to other functional centres, the performance outcome is not as clear. There are outcomes such as level of automation, information flow, EPR development, access to information and improved patient care for example, that are difficult or even not possible to determine given the lack of data to support such measurement.

Alternatively, we have examined the level of spending of operating funds on information systems for WHCC and peers by calculating the Net Costs of the Information Systems Functional Centre (excluding Medical Staff and Equipment costs) as a percent of the Total Direct Care Net Costs.

In the case of this metric, we are not associating a low number with good performance; rather it provides a measure of where WHCC stands among its peers with respect to IS spending. As illustrated in Exhibit 6.117, WHCC spending on IS has declined since 2001/02. In 2003/04, IS net costs as a percent of total direct care net costs was 0.78%, this is below the 25<sup>th</sup>



percentile level of the peer hospital group. WHCC is spending significantly less on information technology than its peer hospitals.

**Exhibit 6.117  
Net Cost of Information Systems as a  
Percent of Total Direct Net Costs**

Information Systems		% of Direct Care Costs
WHCC	2000/01	0.76%
	2001/02	0.98%
	2002/03	0.71%
	2003/04	0.78%
Peer Range 2002/03	Minimum	1.06%
	Best Quartile	1.56%
	Median	1.79%
	Worst Quartile	1.94%
	Maximum	2.40%
	Number of Peers	9

It is important for hospitals to maintain their investments in information systems and technology both to enable better patient care and to automate and improve business processes. Once the organization has achieved an operating surplus and initiated repayment of its bank debt, it should increase its spending on Information and Communication Technology and Systems to more completely address clinical, operational and management information and communication needs of the organization.

**Recommendations:**

It is recommended that:

- (159) The Director of Information Technology should review the current IT staffing complement for potential to redesign roles and/or processes to address EPR implementation projects.**
- (160) The Director of Information Technology should develop an IT strategic plan that specifically addresses the short-term information and communication needs of the organization.**
- (161) The CEO should use available surplus funds to increase investments in acquiring information technologies and supporting and expanding information systems in the region.**

## 6.11 Summary Of Operating Efficiency Opportunities

Savings through improvements in operating efficiency are estimated at \$5,493,000. These savings are summarized in Exhibit 6.118.

**Exhibit 6.118**  
**Savings Through Improvements in Operating Efficiency**

Rec #	Department or Area	Action	Productivity		FTE Reduction	Cost Savings
			Current	Proposed		
77	WHCC Nursing	Develop and implement guidelines for the use of overtime.				\$ (39,000)
79	WHCC Nursing & Diag Services	Reduce Nursing call back expenditure by 20% from spending in 2003/04.				\$ (23,000)
97	WMRH Nursing - Medical Inpatient	Achieve productivity of 5.52 worked hours per patient day.	5.58	5.52	(1.08)	\$ (44,000)
106	WMRH Day Surgery	Achieve productivity of 1.86 worked hours per visit.	3.24	1.86	(2.46)	\$ (137,000)
110	WMRH Operating Rooms	Achieve productivity of 5.98 worked hours per case.	9.56	5.98	(12.58)	\$ (703,000)
111	WMRH PARR	Achieve productivity of 1.84 worked hours per case.	3.45	1.84	(5.26)	\$ (294,000)
114	WMRH Surgical Inpatient	Achieve productivity of 5.78 worked hours per patient day.	6.53	5.78	(9.39)	\$ (525,000)
115	WMRH ICU	Achieve productivity of 17.41 worked hours per patient day	18.75	17.41	(2.71)	\$ (152,000)
116	WMRH Birthing	Achieve productivity of 9.04 worked hours per patient day.	11.69	9.04	(7.02)	\$ (393,000)
117	WMRH Pediatrics	Achieve recommended minimum staffing levels (17.3 FTE).	11.70	7.94	(6.24)	\$ (349,000)
124	Home Care Clinic	Discontinue the Home Care (Dressing) Clinic at the WMRH.			(1.00)	\$ (80,000)
126	STRH Medical Inpatient Services	Achieve productivity of 5.23 worked hours per patient day.	6.59	5.23	(5.30)	\$ (297,000)
127	STRH Surgical Services	Achieve productivity of 5.43 worked hours per patient day.	6.69	5.43	(6.25)	\$ (350,000)
128	STRH ICU	Achieve recommended minimum staffing levels (5.9 FTE).	22.92	15.56	(0.38)	\$ (21,000)
129	STRH Combined OR/PARR	Achieve recommended minimum staffing levels (8.02 FTE).	18.90	6.89	(1.42)	\$ (80,000)
135	LTC - Rehabilitation	Achieve a productivity of 6.14 worked hours per patient day.	7.65	6.14	(2.29)	\$ (128,000)
141	WHCC Pharmacy	Achieve a target for WHCC drug costs at 2.33% of Net Operating Costs.	2.56%	2.33%		\$ (190,000)
142	WMRH Physiotherapy	Achieve productivity of 0.80 hours per attendance.	0.94	0.80	(1.36)	\$ (71,000)

Rec #	Department or Area	Action	Productivity		FTE Reduction	Cost Savings
			Current	Proposed		
143	STRH Physiotherapy	Achieve productivity of 1.05 hours per attendance.	1.24	1.05	(0.75)	\$ (38,000)
144	Bonne Bay & LeGrow PT	Achieve productivity of 0.76 hours per attendance.	0.86	0.76	(0.19)	\$ (9,000)
145	WMRH OT	Achieve productivity of 1.14 hours per attendance for OT services.	1.91	0.87	(1.75)	\$ (111,000)
146	LeGrow OT	Achieve productivity of 1.14 hours per attendance for OT services	3.46	1.14	(1.07)	\$ (68,000)
150	Nutrition Services	Achieve net operating cost of \$27.24 per inpatient and resident day.	\$29.70	\$27.24		\$ (157,000)
152	Materials Management	Achieve net operating cost equal to 3.03% of total direct care net costs.	3.65%	3.03%		\$ (503,000)
154	Environmental Services	Achieve 5.0% reduction of current departmental net operating costs.	8.24%	-5.00%		\$ (330,000)
156	Facility Services	Achieve 5% reduction of current departmental net operating costs.	9.50%	-5.00%		\$ (401,000)
					<b>(68.47)</b>	<b>\$ (5,493,000)</b>

## 7.0 Opportunities for Service Rationalization and Realignment

This section of the report focuses on an analysis of clinical services offered in the various modalities of care offered by the Corporation and opportunities for service rationalization that will allow the Corporation to best meet the needs of the population within the resources available to it. Our approach to service rationalization is designed to create a viable model for the future that optimizes access, quality and sustainability.

### 7.1 Primary Care Clinics

*WHCC has applied the Department's guidelines for allocation of services to develop a plan for restructuring clinic services in the region.*

The Corporation currently operates 22 primary care clinics throughout the Western Region. As recommended in the Government's Strategic Health Plan- "Healthier Together" the Corporation has reconsidered the distribution of clinics. It has applied the guidelines for allocation of services to develop a plan for restructuring clinic services in the region<sup>76</sup>. The Department's guidelines for the allocation of primary care services address issues such as population mass, travel distance and natural patient flow. Based on these guidelines the Board's preferred plan would consolidate its clinic activities into 13 sites:

Stephenville Crossing	Lourdes
Deer Lake	Woody Point
Jackson's Arm or Hampden	Jeffrey's
Clinics on Southwest Coast	Cow's Head

*WHCC should consolidate clinics to improve clinical services and reduce operating costs.*

The consolidation of clinic services would allow for more clinical resources and competence at the continuing sites, and thus, ultimately provide for more effective primary care for the people of the Western Region.

*Consolidation of clinics will save \$600,000 per year.*

The Board estimates that this plan for the consolidation of clinics would also provide for a savings of approximately \$600,000 per year<sup>77</sup>.

We agree with and support the Board's plan to consolidate clinic services. The Board should proceed with implementing

<sup>76</sup> Western Health Care Corporation, "Reply to Department of Health and Community Services Request of December 29, 2003", February 9, 2004.

<sup>77</sup> Additionally, one physician position could be eliminated that would reduce the cost of medical services to the department by approximately \$110,000.

its plan and realize both improvements in clinical services and operating cost savings.

***The Board should reconsider its site selection in White Bay.***

However, before implementation, we feel that the Board should reconsider its site selection in White Bay. In reviewing the supporting material for the White Bay decision, it is not apparent that the natural flow of patients was fully considered. There are three clinics in the White Bay area including those in Jackson's Arm, Sops Arm and Hampden. The current proposal would retain the clinic in Jackson's Arm and close the other two. Jackson's Arm is the furthest distance north and patients may be more inclined to travel south toward Deer Lake or Corner Brook than go to Jackson's Arm if they need to see a clinician. If the patient needed immediate consultation with a specialist he would be sent south after he had traveled north to visit the primary care physician. The Board should revisit its plan for the location of the continuing clinic in White Bay and ensure that adequate consideration has been given to the natural flow of patients.

#### **Recommendations:**

It is recommended that:

**(162) The VP, Rural should revisit its plan for the location of the continuing clinic in White Bay and ensure that adequate consideration has been given to the natural flow of patients.**

**(163) The Board should implement its plan to consolidate clinic services into 13 continuing sites in the region.**

## **7.2 Health Centres**

### **7.2.1 Charles L LeGrow Health Centre, Port Aux Basques**

The Port Aux Basques area has an effective population of about 10,000 people. However, during tourist season there may be as many as 40,000 additional people visiting the area.

***Nurse practitioners and physicians in the community share the responsibility of offering primary care services.***

The Dr. Charles L. LeGrow Health Centre offers a range of services including primary care, inpatient and outpatient acute care and inpatient and outpatient Long-Term Care.

The nurse practitioners and physicians in the community share the responsibility of offering primary care services to the broader region through local clinics in Rose Blanche, Doyles and LaPoyle. There is a budgeted complement of three salaried physicians and there are four fee-for-service general

practitioners and two nurse practitioners in the community at the moment.

The Health Centre has developed a relationship with Memorial University of Newfoundland to function as a training site for Family Practice Residents.

***The Centre has 14 acute care beds and 2 overflow beds.***

The Centre has 14 acute care beds and 2 overflow beds, telemetry capability and a two bed monitored ICU where staff are prepared to administer thrombolytic agents. The ER operates on a 24/7 basis with call back of physicians as needed.

***There is 1 OR and a four stretcher recovery area.***

There is 1 OR and a four stretcher recovery area. There are several minor procedure rooms including one that handles fractures. Unstable fractures are appropriately being transferred to Corner Brook. The GP Surgeon performs upper GI scopes and flexible sigmoidoscopies but does not perform colonoscopies. The outpatient area also has two rooms that accommodate chemotherapy and IV infusions, blood transfusions etc.

Staff education is a very important consideration for the nursing staff of the Centre. They make an effort to maintain competence in such things as ACLS as well as Trauma management and Chemotherapy administration.

General Laboratory (including cross matching) and Diagnostic Imaging Services are also provided on a 24/7 basis through cross-trained technicians. There is capability for general abdominal, pelvic and obstetrical ultrasound and also routine IVP. All images are sent to Corner Brook for interpretation and verbal reports are available within an acceptable time frame. It should be noted that the PACs system has not yet been implemented in the region. With such a remote distribution of facilities this is an obvious disadvantage to the provision of patient care. Similarly laboratory tests other than general routine profiles are referred out and results are generally reported within 6 hours. Sterilization of supplies is conducted in house and laundry is transferred to Corner Brook for processing.

Therapy services at the Centre include occupational therapy, physiotherapy, recreational therapy and social work. There is also a pharmacist and pharmacy clerk. Medications are available in bulk quantities although the facility has the equipment to administer single dose narcotics but does not have the space to implement the program.

Some programs in the region have been established jointly with the Community Services Board. As a result of the work of ID Dysphagia Management working group, the two boards have implemented a Regional Dysphagia Management Program. This program is offered at the Centre in Port Aux Basques jointly by the Dietician from Acute Care and the Speech/Language Pathologist from Community Care.

Mental Health Services are managed through the Community Services Board.

Videoconferencing is available and its use is encouraged by the Region. This technology should be used as frequently as possible to facilitate education and training and to conduct meetings and avoid some of the regional travel. Every effort should be made increase the use of video conferencing for clinical, educational and administrative purposes.

The Long Term Care Wing has 30 beds including 26 LTC, 2 respite and 2 adult rehabilitation. Access to LTC in the region is managed through the regional single entry system. Wandering patients are not accepted into the facility but are transferred to the LTC facility in Stephenville Crossing. There is a team of professionals who decide on eligibility for the rehabilitation beds. A resident council has been established and is very active in fundraising.

A Day Outreach Program has been developed and the 10-12 clients are transported daily by the Centre's bus to participate in the Program. The Centre also manages 11 cottages and 21 apartments for seniors where admission is granted in accordance with established criteria.

***The Centre should continue to provide its current complement of primary care and long-term care services.***

The range of primary care services and long term care services seem appropriate and staff appear to be committed to maintaining acceptable levels of skill to execute on their responsibilities. The Centre should continue to provide its current complement of primary care and long-term care services.

***Elective deliveries should not be performed at the Dr. Charles L. LeGrow Health Centre.***

Obstetrical services in Port Aux Basques are handled by general practitioners with back up from the GP Surgeon and also a GP Anesthetist when one is available. High-risk obstetrical patients are referred to Corner Brook. The Centre defines high-risk patients as those where labor commences before 34 weeks gestation, those with potentially serious comorbid conditions and those who are primagravidas. There were 22 deliveries in 2003/04, including 3 Caesarean sections. The low volume of deliveries, the lack of local paediatric

back-up, the lack of obstetrical back up and the current absence of even a GP anaesthetist makes continued provision of even low risk births questionable; it is putting both mothers and babies at risk unnecessarily<sup>78</sup>. One study has found that the risk of neonatal death increased as the number of deliveries in an institution decreased below 2,000 a year. In institutions with less than 100 births/year the risk doubled<sup>79</sup>. Elective deliveries should not be performed at the Dr. Charles L. LeGrow Health Centre.

Surgical services in Port Aux Basques are not currently available because there is no anesthetist at the Health Centre. The Anesthetist left in September 2003. There is a GP Surgeon at the moment who would continue to offer surgical services if anesthetic services were available. It is unlikely however that another Surgeon and Anesthetist could be recruited to this community once the existing Surgeon retires. When the surgical service is available, the activity is low volume, low acuity and elective in nature for the most part. There is an approved list of surgeries that includes such procedures as Tubal Ligation, Dilatation and Cauterization, Appendectomy and low risk Caesarean Section.

***Surgical procedures requiring general or regional anaesthesia should not be offered at the Dr. Charles L. LeGrow Health Centre.***

The ability of the Dr. Charles LeGrow Health Centre to deliver surgical services on a best-practice basis must be questioned in light of this situation. And even if there were anaesthesia available, it will be difficult and expensive to maintain staff competence in surgical techniques, to maintain surgical facilities, to maintain surgical instruments and supplies with such low volumes. And there is no back up in the event of an unexpected adverse event. Surgical procedures requiring general or regional anaesthesia should not be offered at the Dr. Charles L. LeGrow Health Centre.

If surgical services are not available in Port Aux Basques, there is even more concern about the wisdom of continuing to perform deliveries at the Centre. There will be no surgical back up in the event of an unexpected adverse event. The Centre is a substantial distance from the closest specialty centre in the event of an obstetrical emergency arising during

<sup>78</sup> “Are we regionalized enough? Early-neonatal deaths in low-risk births by the size of delivery units in Hesse, Germany 1990-1999.” Heller G, Richardson DK, Schnell R, Misselwitz B, Kunzel W, Schmidt S. *Int J Epidemiol.* 2002 Oct; 31(5): 1069-70.

<sup>79</sup> “Relation between size of delivery unit and neonatal death in low risk deliveries: population based study.” Dag Moster, Rolv Terje Lie, Trond Markestad. *Arch Dis Child Fetal Neonatal Ed* 1999;80:F221-F225



the course of a delivery. Best practice suggests that if there is no back up from both surgery and Anesthesia, there should be no planned obstetrics, including low risk obstetrics.

### **Recommendations:**

It is recommended that:

**(164) The WHCC should discontinue elective deliveries at the Dr. Charles L. LeGrow Health Centre.**

**(165) The WHCC should discontinue elective surgeries requiring general or regional anaesthesia at the Dr. Charles L. LeGrow Health Centre.**

### **7.2.2 Rufus Guinchard Health Centre, Port Saunders**

The Rufus Guinchard Health Centre serves a population of approximately 3600 people but patients attend from beyond the defined boundaries. In general the Centre provides an appropriate range of services but does have some issues with availability of its physicians and in the provision of adequate support to the LTC residents.

The Centre has 7 acute care beds with an occupancy rate of 68% and 22 LTC beds with an occupancy rate of 85% (2003/04). The acute care patient profile runs the range of general medical diagnoses including myocardial infarction, stroke, and COPD. Unstable patients are transferred to Corner Brook with physician escort. Surgical emergencies are “medevac’d” by helicopter in the winter if necessary and obstetrics is referred out on a planned basis. If emergency transport is delayed due to weather conditions, patients are stabilized and transferred as quickly as possible. There are no outlying clinics serviced by the staff of this Centre.

***Too many patients at Rufus Guinchard H.C. are being held for extended observation when they should be admitted.***

Patients are being held at the center for observation, without being formally admitted or transferred to an inpatient bed on a nursing unit. There are some concerns about the availability of the physicians to provide ongoing assessment of the patients who are admitted for observation. In fact the staff of the Centre are uncomfortable with the fact that too many patients appear to be held for extended observation when the patient, more appropriately, should be admitted. These observation patients are often held in a trauma/treatment area where it is difficult for nurses to monitor their condition or provide care. This practice presents difficulties for the allocation of nursing resources in the center. Also, there are supplies and drugs stored in the area where these patients are sometimes held for

observation. When nurses are busy on the ward, they do not have the ability to monitor these items as closely as necessary.

The Centre provides general Diagnostic Imaging and Laboratory Services with cross-trained technicians who provide 24/7 on call coverage. Radiology films are sent to Corner Brook on a daily basis with good turnaround. Laboratory tests that are sent to Corner Brook are reported within 6 hours.

There is an ambulance operated by the Corporation<sup>80</sup>. There are no public transportation services so inpatients including LTC residents are transported by ambulance to Corner Brook for investigations not available at the Centre.

Patients using the LTC beds are primarily level 3 and some are level 4. Patients requiring protective care are sent to Corner Brook or Stephenville. The nearest personal care home or seniors apartments are in Cow Head. There is limited home support in the area.

Patients requiring occupational therapy are referred to Corner Brook or the occupational therapist from Corner Brook may visit the LTC residents once a year. A physiotherapist visits the LTC residents for one day on a monthly basis and a 0.5 FTE physiotherapy aide who is a LPN manages the LTC requirements. There are no occupational therapy or physiotherapy services available to the acute care patients.

HCSW staff that provide public, community health nursing and mental health services are co-located within the health centre. Likewise HCSW provides social services with a focus on children and elderly.

There are currently two physicians at the Centre with a quota for one additional physician. Also, there are two nurse practitioners that book clinics regularly but do not see walk-in patients. The physicians and nurse practitioners are comfortable with the level of primary care that they are able to provide to the community. However, the physicians are concerned about the ability to access specialists in Corner Brook when needed in situations other than emergencies. This may be leaving the physicians in this remote area with insufficient backup to manage complex patients.

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<sup>80</sup> The only other Corporation owned ambulance service is in Corner Brook. Private ambulances support the other sites

*It is difficult for only 2 physicians to provide sufficient availability to respond to the needs of this community throughout the year.*

*The VP Medical Affairs should review physician coverage and practices at Rufus Guinchard H.C.*

There are also concerns about the adequacy of the physician complement in the area, access to primary medical care and the manner in which the physicians are managing patient volume. It is difficult for only 2 physicians to provide sufficient availability to respond to the needs of the community throughout the year.

The VP Medical Affairs should review physician coverage and practices at the Centre to determine whether the physicians are fulfilling their obligations to the community and to the region...

Otherwise the range of services offered at the Rufus Guinchard Health Centre in Port Saunders appears appropriate for the community.

#### **Recommendations:**

It is recommended that:

**(166) The VP, Rural and the VP Medicine should ensure that patients are not held for observation at the Rufus Guinchard Health Centre but are either admitted to an inpatient bed or discharged.**

**(167) The VP Medical Affairs should ensure that the adequate medical coverage is provided for the community served by and the patients of the Rufus Guinchard Health Centre.**

**(168) The RMAC should review, develop guidelines and processes and improve the referral process between the more remote facilities within the Corporation and medical staff and services in Corner Brook.**

#### **7.2.3 Bonne Bay Health Centre, Norris Point**

The Bonne Bay Health Centre in Norris Point serves a population of about 5,000.

There are 8 acute care beds including palliative care with an average occupancy rate of 56% (in fiscal year 2003/04). There is an ED and provide 24/7 coverage to the ED on a call back basis.

*Too many patients at Bonne Bay H.C. are being held for extended observation when they should be admitted.*

There is a situation here similar to that in Port Saunders with 2 observation beds in the outpatient area that are sometimes occupied by patients who perhaps should be admitted. Nursing staff is having difficulty adequately covering this area. The use of the observation area for patients who are kept for 24-48

hours should be discontinued since it is putting a strain on the ability of nurses to adequately manage these patients and also attend to the inpatient units and ER.

A private ambulance services the Centre and is used to transport patients. RNs from the Centre however often accompany the ambulance because the private paramedic is only required to stay with the patient for 3 hours. This is reported to be a significant issue for the Centre because it places a strain on nurse resources

General Laboratory and Diagnostic Imaging services are available in the Centre and are provided by cross-trained technicians. Results are available through electronic reporting and turnaround is generally acceptable.

There is a 0.8 FTE physiotherapist and 0.8 physiotherapy aide. Physiotherapy is primarily an outpatient service with a limited amount of service provided to the LTC residents (only 16% of physiotherapy workload units were provided to LTC residents in 2003/04). A pharmacist visits three times a year and in the interim the nursing staff manage the pharmacy. (There is, however, a private pharmacist operating in Norris Point.) Patients in the Centre do not have access to occupational therapy, speech language pathology or social work. A dietician is shared with Port Saunders.

There are 14 LTC beds with an average occupancy rate of 99% LTC patients who are primarily level 3.

The LTC residents have access to a bus that was bought through donations from the staff and the community and is owned by the Corporation. The bus is shared with Port Saunders in the summer.

There are 3 physicians at the Centre in addition to one physician in Cow Head and another in Woody Point. There is also a nurse practitioner for the area. There are no specialist clinic visits and no specialists on staff. The complement of physicians in this area has been very stable over the years and there are no significant issues with the medical staff. If there is an occasional issue regarding the professional practice of a physician, the matter appears to be quickly addressed in an appropriate manner.

The Centre is one of 7 sites across the province to participate in the Primary Care Reform Project that supports the evolution of a team based model with all team members working at their optimum skill level, assesses the feasibility of new

compensation structures and other parameters. It is anticipated that this kind of an initiative can assist the Centre in continuing to attract well qualified professionals to the community.

In general terms the Centre provides an appropriate range of service with the exception of psycho-social support and activation for LTC residents.

**Recommendation:**

It is recommended that:

**(169) The VP, Rural should eliminate the observation area at the Bonne Bay Health Centre and patients should be either admitted to an inpatient bed or discharged.**

**7.2.4 Calder Health Centre, Burgeo**

The Calder Health Centre in Burgeo is about 2.5 hours drive from the Corner Brook. There are approximately 2500 to 3000 people in the area with 1500 in Burgeo itself and 1,000 to 1500 people from outside Burgeo in communities as remote as Ramea Island which is accessible only by boat served by the Centre. There are 2 nurse practitioner positions designated for Ramea Island although they are not fully occupied at the moment. They provide services to the region through the coastal clinics.

There are 3 acute care beds (including 1 palliative care bed) and 18 LTC beds. Two physicians have offered an excellent and stable service in this community for the last 15 years. The profile of patient admissions ranges from Myocardial Infarction to Cancer, COPD and other general medical problems. The physicians perform minor surgery requiring only local anesthetic and chemotherapy is provided to cancer patients.

It is reported that the CHC has difficult accessing hospital services in Stephenville for acutely ill patients. As a result, the centre transports acutely ill patients primarily to Corner Brook. Neurosurgical patients are sent to the Health Sciences in St. John's.

The Centre provides a general laboratory and Diagnostic Imaging Service with the support of one cross-trained technician. There is a visiting physiotherapist and the site employs 0.5 FTE physiotherapy aides. There is also a visiting dietician. The site employs 1.0 FTE recreational therapy

worker, but there is only limited ADL and recreational programming at the site.

The range of services provided by this Health Centre appear appropriate for the community

### **7.3 Hospitals**

#### **7.3.1 Sir Thomas Roddick Hospital**

##### ***The Sir Thomas Roddick Hospital opened in 2003.***

The Sir Thomas Roddick Hospital opened in 2003 with a capacity for 50 beds. Forty-four beds are operational with 84% occupancy in 2003/04. The population of the immediate area is approximately 10,000 with a larger catchment area of about 19,000 people.

The community has 9 general practitioners, 7 of whom are associated with the hospital. The family practitioners are supported by a cadre of specialists including 2 obstetrician/gynecologists, 2 surgeons, 2 anesthetists, 2 internists, 2 psychiatrists, and 1 ophthalmologist. There is no paediatrician or radiologist on staff.

##### ***There are currently 44 acute care beds in operation at STRH.***

There are currently 44 acute care beds in operation at STRH. The allocation of these beds is reported to be:

- Medicine/Surgery: 22
- ICU: 3
- Obstetrics/Gynaecology: 5
- Mental Health: 4
- Rehabilitation/ALC: 6
- Palliative Care: 4

All rooms are private or semi private and there are 2 negative pressure isolation rooms. There are also 4 dialysis stations supporting dialysis of patients 6 days a week.

The ED is open 24/7 and there are approximately 75 visits per day. Fifty to seventy-five percent of these visits (40-55 visits) are categorized as triage class 5 visits.

There is a respiratory therapist, an occupational therapist who visits once weekly, 2 physiotherapists and 1 physiotherapy aid as well as 2 pharmacists and a pharmacy technician, 3.5 social workers and 1 dietician.

There are neurology and Orthopaedic clinics on a weekly basis for the specialists visiting from Corner Brook and EEGs are now available as a result of the Neurologist's support.

The ORs at the hospital may be closed for extended periods at holiday seasons because nurses are not available for coverage. The OR weekly schedule is shared among the surgeons and gynecologists but one day per week the general practitioners perform minor procedures in the OR. There is a dental day once per month. It is reported that wait lists for surgery are 3-4 months but there are relatively few people on the lists. This may be attributable in part to the short day of the salaried specialist who schedule short OR lists and/or the scheduling and wait list management practices of the surgeons.

***Elective deliveries should not be performed at the Sir Thomas Roddick Hospital.***

There are only approximately 135 obstetrical deliveries annually at STRH. These are attended by the obstetricians and 2 of the family practitioners. High-risk obstetrical patients are referred to Corner Brook. Research and professional opinion<sup>81</sup> suggest that the low volume of deliveries, the lack of local paediatric back-up and the relatively close proximity of a regional centre, make continued provision of even low risk births questionable; it is putting both mothers and babies at risk unnecessarily. For example, one study found that for low-risk births, early-neonatal death is substantially higher in very small delivery units (<500 births/year) than in larger delivery units (>1500 births/year)<sup>82</sup>. Another study found that the risk of neonatal death increased as the number of deliveries in an institution decreased below 2,000 a year. In institutions with less than 100 births/year the risk of neonatal death doubled<sup>83</sup>. Elective deliveries should not be performed at the Sir Thomas Roddick Hospital.

***Surgical procedures requiring general or regional anaesthesia should not be performed at the Sir Thomas Roddick Hospital.***

The surgical service in Stephenville is a low volume, low acuity service and is primarily elective in nature. In 2003/04, there were only 720 surgical cases in the STRH ORs. There are two surgeons providing a range of surgical services requiring general and regional anesthetic. There are two

<sup>81</sup> GTA Child Health Network, Independent Review Committee, July 2004.

<sup>82</sup> "Are we regionalized enough? Early-neonatal deaths in low-risk births by the size of delivery units in Hesse, Germany 1990-1999." Heller G, Richardson DK, Schnell R, Misselwitz B, Kunzel W, Schmidt S. Int J Epidemiol. 2002 Oct; 31(5): 1069-70.

<sup>83</sup> "Relation between size of delivery unit and neonatal death in low risk deliveries: population based study." Dag Moster, Rolv Terje Lie, Trond Markestad. Arch Dis Child Fetal Neonatal Ed 1999;80:F221-F225

anaesthetists supporting the surgical service (along with obstetrics and other anaesthesia activity.) It is difficult and expensive to maintain staff competence in surgical techniques, to maintain surgical facilities, to maintain surgical instruments and supplies with low volumes. And there is limited back up in Stephenville in the event of an unexpected adverse event.

While there are not currently major concerns about the quality of surgical services offered in Stephenville, the increased risk and the high cost of a low volume service makes continuation current configuration of surgical services economically infeasible for this Region.

Stephenville is less than an hour drive from the Regional Referral Hospital in Corner Brook. It is quite expensive for the region to maintain two surgical services within a relatively short distance. There is sufficient physical space is available in the Operating Suites at WMRH to accommodate all surgical activity from Stephenville that requires regional or general anaesthesia.

Surgical procedures requiring general or regional anaesthesia should not be performed at the Sir Thomas Roddick Hospital.

And if the surgical Service and supporting anaesthesia is consolidated in Corner Brook, best practice suggests definitively that if there are low volumes, no back up from paediatrics and no back up from surgery and anaesthesia, there should be no planned deliveries at STRH.

If, as is recommended, the hospital no longer provides inpatient care for surgical or obstetrical patients, there will be excess inpatient bed, nursing and allied health staff capacity in the hospital. WHCC could use this freed up capacity to accommodate ALC patients from WMRH who are expected to have an extended wait for appropriate accommodation.

The radiology service at Sir Thomas Roddick Hospital performs general radiography, IVP if the physician is available to do the IV push, ultrasound and diagnostic mammography. Cross-trained staff work in Diagnostic Imaging as well as Laboratory Services. There is no PACs system in the Region and basic Meditech is not yet fully implemented. This obviously reduces the functionality of the Region and the services in Stephenville.

Corner Brook provides interpretation of radiology examinations and support for more complex investigations such as echocardiograms and CT Scans. It is reported that



some radiology examinations are being sent to St. John's for interpretation because Corner Brook has limited staff and limited time to manage the volume of films generated in the region. It is also reported that an urgent outpatient CT scan has an average wait time of 6-8 weeks whereas an inpatient CT scan is generally completed in 1-2 days. Appointments for Barium studies are reported to take as long as 3-4 months: consequently physicians are replacing barium studies with endoscopic procedures. The VP Medical Services should review the WMRH handling of Radiology examinations from Stephenville and ensure that service patients from Stephenville receive equitable access to Imaging Technologies and Radiologist services.

There is a mix of fee for service and salaried physicians in Stephenville but no performance agreements exist for the salaried physicians. The salaried physicians can also bill fee-for-service for such activities as ED coverage, On-Call Coverage and OR assistance. This combination of compensation and the lack of performance agreements have caused problems with access to physician office services and specialty services for patients in the community. The Corporation, in concert with the Department of Health and Community Services should review the compensation structure and performance agreements for physicians in this Region and determine a formula that improves upon the existing situation.

#### **Recommendations:**

It is recommended that:

**(170) The WHCC should discontinue elective deliveries at the Sir Thomas Roddick Hospital.**

**(171) The WHCC should discontinue elective surgeries requiring general or regional anaesthesia at the Sir Thomas Roddick Hospital.**

#### **7.3.2 Western Memorial Regional Hospital, Corner Brook**

*Secondary level hospital services in the Western Region are delivered at the Western Memorial Regional Hospital.*

Secondary level hospital services in the Western Region are delivered in Corner Brook at the Western Memorial Regional Hospital and this centralization of secondary services is entirely appropriate.

The Western Memorial Regional Hospital averaged 172 staffed beds (excluding bassinets and the ALC beds on 3D) in

2002/03 and has a broad range of primary and secondary level medical services. These include:

- Family Medicine
- General Internal Medicine
- General Surgery
- Critical Care
- Neurology
- Nephrology
- Obstetrics and Gynecology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pediatrics
- Plastic Surgery
- Psychiatry
- Respiriology
- Rheumatology
- Urology
- Anesthesiology
- Diagnostic Imaging
- Pathology and Laboratory Medicine

***Appropriately, there is no substantive tertiary care such as neurosurgery, cardiac surgery or thoracic surgery at WMRH.***

There is no dedicated plastic or vascular surgeon in the region. Appropriately, there is no substantive tertiary care such as neurosurgery, cardiac surgery or thoracic surgery at WMRH. The range of services provided at the WMRH is quite appropriate to its role within the health care system in Newfoundland and Labrador. There is no intent in the province to develop a second tertiary Centre outside St. John's.

There are approximately 20,000 visits to the ED annually and another 10,000 visits to the general practice area adjacent to the ED. Patients with a (CTAS) triage score of 5 flow to an area where General Practitioners provide coverage on weekends and after 6pm on weekdays. A casualty officer sees patients in the ED.

***ED patients awaiting admission are often held in the outpatient recovery area.***

There are no admitted patients on stretchers in the ED. However, patients from the ED awaiting admission are often held in the 9 bed outpatient recovery area in the immediate vicinity. There can be as many as 6 admitted patients in the OPD recovery area and, on average these patients stay in the area for almost 36 hours. The OPD recovery area is intended be reserved for patients requiring chronic pain management, endoscopy, and radiology procedures such as myelograms. The area is also used for medical day care. Additional nursing staff is called back to care for these admitted patients after the regular day shift of nurses has finished. Holding patients in this area is an obvious problem. Patients cannot get the ongoing care they need in a busy OPD setting and the activities intended to occur in the OPD recovery are compromised. When the ALOS issues are dealt with in the hospital there will be sufficient bed capacity to admit these patients and free up the area for its intended purpose.

The use of the OPD recovery area for ED patients waiting admission is inappropriate. More effective management of the beds within the hospital would allow these patients to be admitted and free up the OPD area for its intended purpose.

The average bed allocation and occupancy at WMRH over the past 6 years is presented in the following Exhibit.

**Exhibit 7.1  
Occupancy data from WMRH Occupancy Rate  
by Service Report, generated June 26, 2004**

Service	1998/99		1999/00		2000/01		2001/02		2002/03		2003/04	
	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.
Medicine	52	132%	54	124%	52	124%	60	116%	56	129%	58	126%
Surgery	75	69%	77	66%	66	75%	56	83%	55	80%	54	79%
Obstetrics	19	45%	18	47%	11	63%	11	69%	11	57%	9	68%
Paediatrics	16	67%	16	68%	13	70%	12	79%	12	68%	12	62%
Psychiatry	23	82%	23	72%	21	73%	21	75%	21	82%	21	88%
Palliation	-		-		-		-		9	40%	8	44%
Total (excl. ICU & 12 bed ALC unit)	184	86%	188	82%	163	89%	159	93%	164	92%	162	93%

***Almost 20% of the hospital's beds are occupied by ALC patients.***

There is a wide array of operational issues at the Western Memorial Regional Hospital and many of these have been addressed previously in this report. In particular bed management is a major problem. There are approximately 30 Alternate Level of Care patients, almost 20% of the beds staffed and in operation, throughout the facility who cannot be

adequately cared for in the midst of an acute medical setting and they continue to disrupt the flow of acute medical patients. These patients would be best served if they could be discharged more expeditiously to the appropriate level of care. If they remain in an acute care setting they would be better served if they were clustered so that an appropriate care regimen could be established by the appropriate number of nursing staff with the appropriate training and skills. There are a number of options for co-location of ALC patients including the creation of ALC capacity at the Sir Thomas Roddick Hospital in Stephenville.

*ALC patients who will have extended waits for placement should be transferred STRH for care while waiting placement.*

It is recommended that WMRH ALC patients who will have extended waits for placement in an appropriate facility should be cared for at STRH. This will reduce the number of ALC patients at WMRH and thus free-up capacity to care for acute care patients

**Recommendation:**

It is recommended that:

**(172) The VPs Operations for Bay St. George, Rural and Corner Brook should develop processes for the transfer of ALC patients from WMRH to STRH.**

*Medical units at WMRH are running at an average occupancy rate of more than 120%.*

Medical units at WMRH are running at an average occupancy rate of more than 120%. This is driven by decisions of the medical staff to admit patients regardless of the availability of beds. This situation places a great strain on the hospital and could be avoided if the medical staff would focus more on managing and reducing length of stay for their patients, participate more actively in discharge planning and develop and implement clear guidelines for patient admission so that the number of MNRH is reduced. In particular there should be active scrutiny of elderly patients presenting to the Emergency Department to avoid admission if possible. If the patient requires admission discharge planning should begin immediately. Discharge planning is inadequate at best and often non-existent at WMRH. A concerted effort must be made and fully supported by the RMAC and Discipline Chiefs to develop a comprehensive approach to discharge planning. The Most Responsible Physician should be actively involved in discharge planning for his/her patients. Discharge planning should begin before the patient is admitted to hospital.

**Recommendation:**

It is recommended that:

- (173) The RMAC should require Most Responsible Physician participation in discharge planning that begins at, or before, the time of patient admission to the hospital.**

As has been discussed, the Corporation should consolidate planned deliveries and surgeries requiring general or regional anaesthesia at the WMRH. The VP Medical and the RMAC should make the necessary arrangements for the consolidation of these services at the Western Memorial Regional Hospital. As part of these arrangements surgical equipment and instruments from the STRH and CLLHC sites should be relocated to the WMRH site. At the same time, WHCC should consider expanding its outreach programs of visiting surgeons to communities throughout the region. This program might include mobile clinical facilities equipped to provide endoscopy and other technology-based diagnostic and therapeutic services.

**Recommendations:**

It is recommended that:

- (174) The VP Medical and the RMAC should arrange for the consolidation of all obstetrical deliveries in the Region at the Western Memorial Regional Hospital.**
- (175) The VP Medical and the RMAC should arrange for the consolidation of all surgical services requiring general or regional anesthetic in the Region at the Western Memorial Regional Hospital.**

*There are significant issues in medical management of psychiatric patient care processes.*

General practitioners and psychiatrists are admitting to the psychiatry ward. Issues on this ward include the high ALOS, many MNRH patients, delays in attending physicians' evaluation of patients who are admitted from the ED and on occasion, an inappropriate routine for assessing patients who are on constant observation.

*There is very low occupancy of the palliative care unit.*

The palliative care unit has developed strict criteria for admission where end-of-life patients are accepted. End of life is defined as death anticipated within 6-8 weeks. The unit had an average occupancy of only 40% in 2002/03. There are a number of chronic palliative patients occupying acute medical beds throughout the hospital who could benefit from the care

provided in a well managed palliative care unit and at the same time a more appropriate use could be made of the acute medical bed. Consideration should be given to broadening the admission criteria for this unit.

The 12 bed pediatric unit is a combined medical, surgical and mental health unit with an average occupancy rate of about 80%.

### 7.3.3 Savings from Realignment of Hospital Care

*Realignment of hospital services in WHCC will improve care and provide savings of \$215,000.*

The proposed realignment of hospital services in WHCC will provide for better quality of care and improved patient safety. It will also reduce the cost of care:

- Consolidation of hospital birthing services at WMRH will reduce risk and improve the quality of care but it will not provide any net savings to WHCC<sup>84</sup>.
- Consolidation of surgical services requiring general and regional anaesthesia at WMRH will provide savings of approximately \$215,000<sup>85</sup>.
- Creation of an ALC unit at STRH will not reduce WHCC operating costs but it will:
  - free up capacity on the medical surgical units at WMRH to accommodate the consolidation of surgery requiring general or regional anaesthesia.

<sup>84</sup> Staffing related to birthing and the related costs will need to be transferred from STRH to WMRH to provide care for the births being transferred from STRH to WMRH. In this analysis, any direct cost savings related to birthing have already been recognized in the calculation of savings at both sites from achieving best quartile operating efficiency targets for birthing. Thus there will be no additional net savings to WHCC from the consolidation of birthing. Experience suggests, however, that service consolidation facilitates and provides the catalyst for achieving efficiencies.

<sup>85</sup> After achieving the recommended operating efficiency target, the OR/PAR at STRH would have an operating cost of \$776,562 that would be eliminated when surgery requiring general or regional anaesthesia is consolidated at WMRH. The cost of accommodating these additional surgeries at WMRH, after achieving the proposed operating efficiencies in the WMRH OR/PARR, would be \$561,800.

We are estimating no changes in costs of the nursing units at either WMRH or STRH since surgical patient days at STRH will be replaced with ALC patient days and ALC patient days at WMRH will be replaced with surgical patient days. Although the content of care for these patients will be different, the amount and cost of nursing care will be similar. Thus the net savings from reducing surgical activity at STRH will be approximately \$215,000.

- make use of available capacity at STRH created from the consolidation of birthing and surgeries at WMRH at no additional cost.

## **7.4 Long-Term Care Facilities**

### **7.4.1 Bay St. George Long-Term Care Centre, Stephenville**

The Bay St. George Long Term Care Centre has 114 beds, 110 LTC and 4 outreach beds. There is no age limit placed on admission and patients are primarily levels 3 and 4. Units are equipped with “Wanderguard Technology” and there is a 22-bed protective care unit as well as a chronic care unit with 26 beds, 24 are private rooms, 4 outreach beds and two wards of 33 beds. Occupancy is in the range 90-94%. The Centre primarily supports the Sir Thomas Roddick Hospital and is not as strongly linked to the Western Memorial Regional Hospital.

The staff of the Bay St. George Centre are an excellent resource to the Region and their skills should be consulted more widely to assist the acute care system in dealing with its elderly patients. There is a good range of services and a strong interdisciplinary model of care that was highlighted by the Accreditation surveyors for its excellence in team planning and charting. Programs include home care, meals on wheels, palliative care, adult day hospital, short stay respite, slow rehabilitation, seating and adaptive aids among others.

***The Regional Dysphagia Management Program is an important and impressive effort of WHCC and HCSW.***

Some programs in the region are established jointly with the Community Services Board. As a result of the work of the ID Dysphagia Management working group, the two boards implemented a Regional Dysphagia Management Program. This program is offered jointly by the Dietitians from WHCC and the Speech/Language Pathologist from Community Care. The Accreditation surveyors indicated that the regional implementation of this program was an impressive achievement for LTC<sup>86</sup>.

The Centre has a bus that transports outreach clients. The Centre also prepares all meals for the Sir Thomas Roddick Hospital.

Three physicians who share 1:3 call support the Centre. In addition to the nursing staff, there are supports from recreational therapy, social work, dietician and physiotherapy.

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<sup>86</sup> This program is provided to both residents of BSG LTC facilities and patients in STRH.

The Centre has developed an excellent linkage with the community pharmacist who visits every day to support the medication needs of the residents, provide clinical pharmacy and attend team planning meetings. Medications are reviewed every three months for all residents.

There could and should be more involvement of the staff of the Centre with the EDs and with the discharge planning processes in the hospitals. LTC residents are sometimes referred into the Centre prematurely and the hospitals may be admitting Elderly patients inappropriately from the hospital EDs. The Hospital Emergency Departments should consider supports available in the Region from LTC facilities to better assess elderly patients presenting to the ED so that admission can be avoided whenever possible and, if patients are admitted, discharge planning can start in the ED.

The Centre also manages 38 cottages that are provided on the basis of a flat rate fee and the Emile Benoit House for seniors that are occupied on a % of income basis.

#### **7.4.2 Corner Brook Long Term Care Services**

*WHCC has proposed replacement of all existing LTC Beds in Corner Brook with a new LTC facility.*

There are 225 LTC beds in Corner Brook under the jurisdiction of the Corporation. Some of these beds are vacant because the rooms don't fit with the requirements of the patients needing LTC placement. The beds are distributed across 3 facilities. There are two 31 bed units at the Western Memorial Regional Hospital, 66 beds at the O'Connell Centre and 103 beds (including 2 respite beds) at the Interfaith Home. The O'Connell Centre houses the veterans' unit. There is a single entry assessment and placement system in place for the Western Region. All facilities have resident councils and there are varying degrees of organized programming for residents.

The Corporation has submitted a proposal for a new \$53M LTC facility for Corner Brook that would replace all existing LTC beds in Corner Brook under the Corporation's jurisdiction. The new facilities would provide a more effective setting for the delivery of long-term care services and thus would hopefully facilitate reduction in the number of ALC patients and the number of ALC days for WMRH patients requiring discharge to a long-term care treatment setting in Corner Brook. The new facility is also intended to house the kitchen requirements for the Western Memorial Regional Hospital. As a result, this initiative would also facilitate further cost reductions in food services for WHCC.



#### **7.4.2.1 LTC Corner Brook 5<sup>th</sup> and 6<sup>th</sup> Floors WMRH Site**

The WMRH 5th floor LTC unit is a locked unit with “Wanderguard” technology. When patients are no longer mobile they are moved to another facility. The unit has a 31 bed capacity including 2 beds for assessment and all rooms have 2 or 3 beds. The WMRH 6th floor LTC unit is a combination of LTC and CCC. The unit is not locked. A number of pilot projects have been initiated by the nursing staff on this unit for the purpose of increasing the role of the LPN and focusing more of the role of the RN on coordination and supervision of patient care. Patients are heavy care and may have tracheotomies or require ventilation or GI feeding and some patients are post-op hip fractures. There have been some growing pains with the new care models but staff is moving in the right direction.

#### **7.4.2.2 O’Connell Centre**

The O’Connell Centre has 66 beds. There are two LTC units that are 26 beds and 22 beds respectively. The 26 bed unit is primarily reserved for residents with dementia. There is an 18 bed DVA unit where admission to is decided by DVA. There is additional staff on the DVA unit to provide for the care of dementia patients. There is a TEC Committee (Toward Excellence Committee) that has been established through support from DVA. The Committee’s mandate is to identify process improvement opportunities across all units.

The Centre also houses an 8 bed provincial rehabilitation unit that is under the management of rehabilitation services and offers programs to patients from throughout the province for amputees, seating program, stroke program, speech program and specialized programming for individuals with multiple sclerosis. There is also an outreach program.

#### **7.4.2.3 Interfaith Home**

This facility was constructed in the 1960s and has a total of 103 beds across 3 units. There are independent living cottages nearby that are managed by WMRH and not by the Interfaith Home. St. Luke’s Unit has 24 beds including 2 respite beds and a special need room for residents who may require palliation or have some form of special care requirement. Most of the residents have dementia but their care needs are not as heavy as residents on other units in the facility.

The Good Samaritan unit has 24 beds and the Newfoundland Memory Lane Unit has 45 beds. This latter unit has two sides

that are covered by a common nursing staff. There is a cluster of 21 beds on one side and a cluster of 24 beds on the other side.

#### **7.4.2.4 Protective Care Units**

***WHCC should consider consolidation of its protective care units to a single site.***

There are two protective care units within the Corporation including a 31 bed unit at WMRH that had 5 vacancies at the time of the review and another unit at the Bay St. George LTC facility with 22 beds. There may be some merit in considering the consolidation of these units in order to maximize the efficiency and create further critical mass of patients and therefore opportunities for focused staff expertise.

## 8.0 Summary of Savings

*This review has identified opportunities to improve the quality and effectiveness of services and to achieve \$9.4 million in savings through changes to operating practice and realignment of services*

This review has identified many opportunities to improve the quality and effectiveness of services and to achieve savings through changes to operating practice. The identified savings opportunities amount to \$9,936,000 million in total.

Implementation of recommendations relating to achievement of improved hospital utilization and clinical efficiency could lead to annual savings of \$2,228,000:

- Reduce rate for admission of potentially avoidable hospitalization conditions to 103 admissions per 10,000 population. \$337,000
- Review of appropriateness of acute care gynaecology services. \$213,000
- Reduce use of inpatient days through improvements in clinical efficiency. \$1,678,000

Implementation of recommendations relating to achievement of improved operational efficiency could lead to annual savings of: \$5,493,000

Moderate reduction in sick time usage would provide savings of approximately: \$1,400,000

Implementation of recommendations relating to restructuring and realignment of clinical services could lead to annual savings of \$815,000:

- Consolidate clinic services into 13 continuing sites in the region. \$600,000
- Consolidate all surgical services in the Region requiring general or regional anesthetic at WMRH. \$215,000<sup>87</sup>

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<sup>87</sup> Net savings, OR/PARR only.

***If WHCC moves expeditiously to implement the recommendations of this report, we are confident that it can improve the quality and safety of patient care, achieve an operating surplus, eliminate the accumulated operating deficit, retire the bank debt and restore the fiscal integrity of the corporation.***

If WHCC were to achieve these \$9.94 million in operating savings:

- The annual operating deficit would be eliminated. If these savings had been achieved, the projected 2004/05 operating deficit of \$4.1 million<sup>88</sup> would be converted to an annual operating surplus of approximately \$5.8 million.
- The accumulated operating deficit of \$22.5 million (and the projected annual operating deficit at the end of 2004/05 of \$26.6 million) could be addressed within ten years, as required by the DOHCS.
- The bank overdraft of \$15.3 million could be retired.
- There would be internally generated funds available for reinvestment to both improve services to the community and support achieving even greater efficiencies. Several areas for reinvestment have been recommended in this report, including:
  - Implementation of a single unit-dose distribution system across the organization Introduction of PACS.
  - Redevelopment of the endoscopy suite at WMRH
  - Implementation of comprehensive capital equipment replacement and renewal for Diagnostic Imaging.
  - Consolidation of sterilization activity to one Sterile Processing operation
  - Acquisition or development of an appropriate nursing workload measurement system
  - Enhancement to clinical education/practice support for the ADN's
  - Replacement of manual beds in the medical program
  - Augmentation of recreation services to provide more psycho-social stimulation for LTC residents
  - Consolidation of protective services for LTC residents in the region onto one site
  - Replacement of LTC facilities in Corner Brook
  - Enhancements and expansion of community services to support patient discharge

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<sup>88</sup> As reported by the Department of Health and Community Services in November 2004.

- Increased investments in clinical, operational and management information and communication technologies and systems.
- Acquisition of HRIS software to support human resources management
- Enhancements in occupational health and safety programs
- Enhancement in management reporting to Board, Senior Management and Front-Line Managers.
- Introduction of advanced food production technologies.

As has been indicated in the body of the report, most of the savings opportunities can be realized by the second fiscal year following this report. A small number that will require changes in staff behaviour may take an additional two years to be realized fully. Also a number of recommendations will require capital investments that will be dependant on either or both Department approvals and generation of sufficient funds to cover the investments. However, if WHCC moves expeditiously to implement the recommendations of this report, we are confident that it can improve the quality and safety of patient care, achieve an operating surplus, eliminate the accumulated operating deficit, retire the bank debt and restore the fiscal integrity of the corporation.

***Appendix:***  
***Listing of Recommendations***

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## **Recommendations**

### **1.0 Background & Objectives**

No Recommendations

### **2.0 Financial Review**

No Recommendations

### **3.0 Governance and Management**

#### **3.3 Governance Structures and Processes**

- (1) The Minister of Health should ensure that appointees to the WHCC are aware that they are appointed to reflect the interests of, not represent or advocate for their home communities.**
- (2) The Board of WHCC should modify the orientation process for new Board members so that they are clearly made aware of their responsibilities to the Corporation.**
- (3) The Board should develop and implement a formal, comprehensive program for the orientation of Board members.**
- (4) The Board should make participation in the Board orientation program mandatory for all Board members.**
- (5) The Board should develop a Board evaluation process that includes input from Board members and key stakeholders.**
- (6) The Corporation should establish a policy that opens meetings of the Board of WHCC and of its committees to the public.**
- (7) The Board should establish a clear policy that articulates a narrowly defined set of subject matters that will be discussed in camera by the Board and its committees.**
- (8) The Board Chair should direct management to enhance the information supplied to the Board related to the Board's critical governance responsibilities.**

- (9) The Board of WHCC should revisit its articulation of ‘strategic issues’ to focus on the desired directions for the organization.**
- (10) The Board should draw upon its Strategic Plan to formally articulate annual objectives for the organization.**
- (11) The Board should formally articulate the organization’s parameters for its annual operating plan and budget.**
- (12) The Board should take more responsibility for the financial health of the Region by insisting that management aggressively pursue opportunities to minimize costs and maximize non-government revenues.**
- (13) The Board should take more responsibility for the financial health of the Region by implementing reasonable service restructuring to achieve necessary cost savings.**
- (14) The CFO should further expand and enhance financial and statistical reporting to the Board to include more comprehensive analyses of variances from plan that provide not only the cause of the variance but also planned potential corrective actions.**
- (15) The CFO should expand financial reporting to the Board to include reporting of the clinical and operational performance underlying the region’s financial performance.**
- (16) The CFO should further expand and enhance statistical performance reporting to the Board to provide comparisons with similar organizations in Canada.**
- (17) The Board should direct that management further enhance the Board’s Corporate Performance Improvement Program to provide for more comprehensive monitoring of quality, for comparisons with external benchmarks and for more focused and structured reporting to the Board.**
- (18) The Quality Council should ensure that important utilization and quality issues identified during**



Performance Improvement Team presentations or corporate indicator reviews are referred to the appropriate individuals or groups and followed up at subsequent meetings to ensure that appropriate action has been taken.

- (19) The Board should set annual performance expectations and objectives for the CEO that incorporate the objectives for the organization.

#### **3.4 Management Structures & Processes**

- (20) The CEO should develop a refined model for organizing and managing the services delivered by the corporation.
- (21) The Chair of the Board should direct management to establish a process for setting annual objectives for the health care organization.
- (22) The CEO and the CFO should modify the operational planning and budgeting process to more formally and explicitly include consideration of patient volume, content of care, departmental workload and productivity targets.
- (23) The CEO, CFO and Corporate Director Clinical Decision Support should introduce a Quarterly Review Process to provide for better performance management and expenditure control.
- (24) The CFO and the Corporate Director Decision Support should extend management reporting to include measures that will better support identification and explanation of variance from plans.
- (25) The CFO should ensure that all analysis of variance includes consideration of corrective action and/or the implications of the variance for year-end departmental, program and corporate results.
- (26) The Vice President, Human Resources should acquire HRIS software to support human resources management at WHCC.
- (27) The Vice President Human Resources should provide for occupational health resources for employee health triage for employees who become ill while at work, employee wellness program planning and for

early return to work for employees off due to non-work related illness/accident.

### **3.5 Medical Staff Involvement in Governance and Management**

- (28) The Board should modify its medical staff bylaws to create the role of Regional Chief of Staff.**
- (29) The Board should modify its medical staff bylaws so that the Regional Chief of Staff serves as Chair of the RMAC.**
- (30) The Board should modify its medical staff bylaws to clearly articulate that Local Chiefs of Staff and the Regional Chiefs of Disciplines are responsible to the Regional Chief of Staff for all aspects of the quality of medical care and professional practice.**
- (31) The Board should review, revise and update its Medical Staff Bylaws.**
- (32) The Regional Chief of Staff and the Vice President Medical Services should develop and implement a more formal recruitment and selection process for the Regional Discipline Chiefs and local Chiefs of Staff.**
- (33) The VP Medical Services should develop a strategy to make educational sessions related to leadership and management skills a priority for physician leaders.**
- (34) The CEO should make the Chair of RMAC a member of the Senior Management Team.**
- (35) The RMAC should develop and implement policies and procedures for dealing with unacceptable absenteeism of members of the RMAC.**
- (36) The Chair of the RMAC should restructure the RMAC agenda to provide for more time for discussion related to critical decisions.**
- (37) The Chair of the RMAC and the VP Medical Services should ensure that items on the RMAC agenda have sufficient information to support decision making.**

- (38) The VP Medical Services should develop a process to ensure that outstanding items are brought forward for resolution in a timely manner.**
- (39) The Board should eliminate all Local Medical Advisory Committees.**
- (40) The VP Medical Services and the RMAC Chair should move immediately to establish a Credentials Committee as provided for in the Bylaws.**
- (41) The RMAC Chair must ensure that a reliable and comprehensive process is established to ensure implementation of professional performance directives of the RMAC.**
- (42) The RMAC Chair should ensure that the RMAC is the only entity that can authorize changes to the formulary or policies regarding drug substitution.**
- (43) The Pharmacy and Therapeutics Committee should develop criteria for the introduction of new drugs into the formulary.**
- (44) The Chair of the RMAC should ensure that the financial impact of a proposed new drug is approved by the Senior Management before the drug is approved by the RMAC for introduction into the formulary.**
- (45) The Chair of the Board should reactivate and establish a regular meeting schedule for the Joint Conference Committee.**
- (46) The Bylaws Committee should immediately review and recommend to the Board appropriate revisions the Medical Staff Bylaws.**
- (47) The RMAC should work with the CME Committee to develop and implement a strategy to ensure that CME is attended across the Corporation.**
- (48) The Chair of the RMAC and the VP Medical Services should work with the CME Committee to develop and deliver educational sessions for physician leaders.**
- (49) The RMAC Chair should establish a means of receiving timely and relevant information from the**

**Infection Control Committee as part of a full and comprehensive Medical Quality Review Initiative.**

- (50) The RRUC should establish specific targets for key corporate utilization management indicators each year and monitor performance on a regular basis.**
- (51) The RRUC should establish targets for length of stay performance based on the Best Practice Review clinical efficiency targets and expressed in terms of CIHI ELOS performance.**
- (52) The RMAC should expand the mandate of the Regional Resource Utilization Committee to include a more comprehensive look at all aspects of the impact of medical care on the resources of the corporation.**
- (53) The VP Medical Services should establish a process to facilitate review all aspects of the impact of medical care on the resources of the corporation.**
- (54) The Chief of Surgery should take action to stop the inappropriate use of the surgical suite for elective cases.**
- (55) The RMAC Chair and the VP Medical Services should develop and implement an appropriate and relevant Medical Quality Improvement Program.**
- (56) The RMAC should suspend the privileges of Medical Staff that do not complete medical records in a timely fashion.**
- (57) The RMAC should appoint an appropriate member of the Medical staff to participate in the Corporate Quality Council.**
- (58) The RMAC Chair and VP Medical Services should formalize the process for development of medical care and medical staff policies.**
- (59) The RMAC should establish a policy and process for transfer of patients between and within the various facilities of the Corporation.**
- (60) The VP Medical Services and the RMAC should review the medical manpower plan on annual basis.**

- (61) The VP Medical Services should ensure that appropriate impact analysis is completed for all new and replacement physicians.**
- (62) The VP Medical Services should maintain contact with sponsored physicians and ensure that obligations are fulfilled.**
- (63) The VP Medical Services should develop and negotiate service agreements with all salaried physicians.**
- (64) The Chiefs of Discipline should ensure that Physicians' attendance at Meetings of the Discipline is a part of annual performance assessment before re-appointment.**
- (65) The VP Medical Services should develop job descriptions for the role of Discipline Chief.**
- (66) The VP Medical Services should negotiate contracts and performance expectations with each Discipline Chief.**
- (67) The RMAC Chair supported by the VP Medical Services should evaluate the performance of each Discipline Chief annually.**

### **3.6 Nursing Management**

- (68) The Chief Executive Officer (CEO) should create a non-rotating Chief Nursing Officer (CNO) position separate from the role of Vice-President.**
- (69) The CNO should add advanced practice and/or education roles at WHCC to support best practice nursing care in the region.**
- (70) The CEO should change the titles of the nursing administrative roles to better reflect the work content of these positions.**
- (71) The Chief Nursing Officer should streamline the operations of the Regional Nursing Advisory Council and ensure appropriate representation of front-line nursing staff on this council.**
- (72) The CEO should review the management and committee structures to ensure clarity of roles and to reduce the number of meetings.**

- (73) The CEO should develop structures and processes that improve the timeliness of policy approvals.

#### **4.0 Programs & Services**

- (74) The WHCC Board should establish a target rate for admission of potentially avoidable hospitalization conditions of 103 admissions per 10,000 population.
- (75) The WHCC MAC should coordinate a review of appropriateness of acute care gynaecology services and expand the use of standardized protocols.

#### **5.0 Clinical Efficiency Analysis**

- (76) The WHCC Board should establish a target for reduction of use of inpatient days based on the results of the clinical efficiency analyses conducted during the Best Practices Review.

#### **6.0 Operations Analysis**

##### **6.1 Overarching Issues in Nursing Services**

- (77) The Chief Nursing Officer and Directors of Nursing should develop and implement guidelines for the use of overtime.
- (78) The Chief Nursing Officer and Chief of Staff should develop guidelines to control the use of callback.
- (79) The Chief Nursing Officer should ensure that implementation of nursing callback guidelines reduces expenditure by 20% from spending on nursing callback in 2003/04.
- (80) The Department of Health and Community Services should revise its transport/escort guidelines such that care requirements determine who accompanies the patient.
- (81) The Chief of Staff and the Chief Nursing Officer should develop and implement guidelines for assigning staff to patient escort based on patient need and acuity.

- (82) The Chief of Staff and the Chief Nursing Officer should establish and maintain standards and guidelines for the use of constant observation.**
- (83) The RMAC should reconsider its decision that constant care is a medical rather than a nursing decision.**
- (84) The CNO should acquire or develop an appropriate workload measurement system for use at WHCC.**

**6.2 *Western Memorial Regional Hospital Nursing***

- (85) The CEO and the VP-Medical Services should eliminate the use of overflow beds.**
- (86) The CEO and the VP-Medical Services should develop and implement a plan to co-locate WMRH ALC patients in a single nursing unit.**
- (87) The VP Clinical Operations, the CNO, and the Director of Nursing for WMRH should advance the implementation of a model of total patient care on the inpatient units at WMRH.**
- (88) The VP Clinical Operations and the Director of Nursing should improve the understanding and acceptance of the authority and responsibility of the PCC.**
- (89) The VP Clinical Operations and the Director of Nursing should ensure adequate clinical education/practice support for the ADNs.**
- (90) The VP Clinical Operations should ensure that nursing is provided with the basic equipment for nursing care.**
- (91) The VP Clinical Operations should replace the manual beds in the medical program as soon as feasible.**
- (92) The VP Clinical Operations should ensure that nursing input is included in equipment acquisition decisions affecting nursing care.**
- (93) The VP Clinical Operations should ensure that there is adequate orientation to and training in the use of new equipment.**

- (94) The CEO should initiate a process to plan for and implement renovations of WMRH nursing units to provide for improvements in the efficiency and quality of nursing care.**
- (95) The VP Corporate Services, Regional Director of Environmental Services working with the VP Clinical Operations and Director of Nursing should review and redesign work processes for laundry services to improve support for the patient care units.**
- (96) The CEO and the VP-Medical Services should close 4B as soon as possible.**
- (97) The Director of Nursing should adjust staffing on the medical units at WMRH to achieve nursing productivity of 5.52 worked hours per patient day.**
- (98) The VP Medical Services should establish and implement an improved process for booking and scheduling surgical procedures.**
- (99) The VP Medical Services and the Chief of Surgery should establish definitions for the types of cases that may have access to the ORs at WMRH for after hours surgery.**
- (100) The VP Medical Services should establish policies and procedures for controlling after hours access to the ORs at WMRH.**
- (101) The VP Medical Services should establish a process for monitoring, reporting and enforcing the after-hours surgery rules at WMRH.**
- (102) The Chief of Surgery should ensure that the after hours surgery rules at WMRH are enforced.**
- (103) The OR Committee should review OR utilization by each surgeon on a quarterly basis.**
- (104) The VP-Medical Services should institute a clear discharge policy that requires all surgeons to have their patients discharged by 11:00 am daily.**
- (105) The VP Clinical Operations should establish the PAC as a stand-alone unit dedicated only to the evaluation and education of patients for surgery.**



- (106) The Director of Nursing should reduce staffing on the Same Day Surgery Unit at WMRH to achieve productivity of 1.86 worked hours per visit.**
- (107) The Assistant Director of Nursing Perioperative Program and the Chief of Surgery should establish a process to improve the start time and turn around times.**
- (108) The VP Medical Services and the Chief of Anaesthesia should develop a manpower plan to recruit sufficient additional anaesthetists to provide staffing for the PAC and to conform with accepted standards for on-call coverage.**
- (109) The Assistant Director of Nursing Perioperative Program and the Chief of Surgery should ensure implementation of the recommended processes to improve operating efficiencies.**
- (110) The Director of Nursing Acute Care should reduce staffing of the ORs at WMRH to achieve a productivity of 5.98 worked hours per case at such time as the major issues associated with the OR have been addressed.**
- (111) The Director of Nursing Acute Care should reduce staffing of the PARR at WMRH to achieve productivity of 1.84 worked hours per case.**
- (112) The VP Clinical Operations should develop and implement plans to redevelop the endoscopy suite at WMRH.**
- (113) The Director of Nursing Acute Care should review and revise booking processes for the OPD/RR at WMRH.**
- (114) The Director of Nursing Acute Care should adjust operations and staffing of inpatient surgery at WMRH to achieve a productivity target of 5.78 worked hours per patient day over the next two years.**
- (115) The Director of Nursing should reduce staffing in the ICU at WMRH to achieve nursing productivity of 17.41 worked hours per patient day.**

- (116) The Director of Nursing should reduce staffing for Birthing at WMRH to achieve productivity of 9.04 worked hours per patient day.**
- (117) The Director of Nursing should reduce staffing for paediatric nursing at WMRH to the recommended minimum staffing levels until such time as workload increases beyond the capacity for workload of this level of staffing and then 7.94 worked hours per patient day should be used as the productivity target.**
- (118) The Director of Nursing should maintain the current productivity performance of 5.40 worked hours per patient day of the Psychiatry Unit at WMRH.**
- (119) The Director of Nursing should reduce staffing for palliative care at WMRH to the recommended minimum staffing levels until such time as workload increases beyond the capacity for workload of this staffing and then 5.82 worked hours per patient day should be used as the productivity target.**
- (120) The Director of Nursing should maintain the current productivity performance of 1.0 worked hour per visit of the ED at WMRH.**
- (121) The VP Clinical Operations and the VP Medical Services should eliminate the practice of holding admitted patients in the Medical Day Care Area.**
- (122) VP Clinical Operations should explore alternative locations for Medical Day Care to ensure a better quality of patient care.**
- (123) The Director of Nursing should maintain the current productivity performance of 2.09 Worked Hour/Visit of the Medical Day Care Unit at WMRH.**
- (124) The VP-Medical Services and the Director of Nursing should discontinue the Home Care (Dressing) Clinic at the WMRH.**
- (125) The Director of Nursing should maintain the current productivity performance of 1.25 worked hours per visit of the Ambulatory Care Clinics at WMRH.**

### **6.3 Sir Thomas Roddick Hospital**

- (126) The Director of Nursing should reduce staffing for the medical unit at STRH to achieve productivity of 5.23 worked hours per patient day.**
- (127) The Director of Nursing should reduce staffing for the surgical services nursing unit at STRH to achieve productivity of 5.43 worked hours per patient day.**
- (128) The Director of Nursing should reduce staffing to the recommended minimum staffing levels for ICU at STRH.**
- (129) The Director of Nursing should reduce staffing to the recommended minimum staffing levels for the OR/PARR at STRH.**
- (130) The CNO and VP Rural along with the recreation staff should review recreation services to determine how they might be augmented to provide more stimulation for LTC residents.**
- (131) The VP Rural should review the allocation of staff resources among the Health Centres in the region and rebalance staffing to ensure equity among the Centres.**

### **6.5 Long Term Care Services**

- (132) The Chief Nursing Officer and the Directors of Nursing should develop and implement a new model of nursing care delivery for LTC that includes RN and LPN providers working to their full scope of practice and that introduces the role of PCA.**
- (133) The Chief Nursing Officer should establish a professional resource role for nursing staff in LTC.**
- (134) The VP Clinical Operations (BSG) and the VP Human Resources should reallocate education resources to support site-specific needs.**
- (135) The Director of Nursing should reduce staffing for the rehabilitation service to achieve productivity of 6.14 worked hours per patient day.**
- (136) The Vice Presidents for Clinical Operations should consolidate protective services for LTC residents in the region onto one site.**

## 6.6 *Therapeutic Services*

- (137) The Director of Pharmacy should work with the P&T Committee to develop additional policies to strengthen physician compliance to the region's formulary.
- (138) The Director of Pharmacy should work with the P&T Committee to improve drug utilization and monitoring.
- (139) The Director of Pharmacy should implement a single unit-dose distribution system across the organization.
- (140) The Director of Pharmacy should work with the P&T Committee to reduce the amount of medication being provided to hospital outpatients.
- (141) The Director of Pharmacy should establish a target for WHCC drug costs at 2.33% of Net Operating Costs.
- (142) The Regional Director should adjust staffing to achieve productivity of 0.80 hours per visit for physiotherapy services at the WMRH & RGHC.
- (143) The Regional Director should adjust staffing to achieve productivity of 1.05 worked hours per visit for physiotherapy services at the STRH & supported sites.
- (144) The Regional Director should adjust staffing to achieve productivity of 0.76 worked hours per visit for physiotherapy services at Bonne Bay and LeGrow Health Centres.
- (145) The Regional Director should adjust staffing for Occupational Therapy at Western Memorial Regional Hospital to achieve productivity of 1.14 worked hours per visit.
- (146) The Regional Director should adjust staffing for Occupational Therapy at Charles L. LeGrow Health Centre to achieve productivity of 1.14 worked hours per visit.

## 6.7 *Diagnostic Services*

- (147) The Regional Director, Laboratory services should review and revise as necessary the proposed test

menus and equipment requirements, in relation to the clinical service adjustments arising out of this review.

- (148) The VP Clinical Operations and the Regional Director, Diagnostic Imaging services should expedite acquisition and implementation of a regional PACS in WHCC.
- (149) The VP Clinical Operations and the Regional Director, Diagnostic Imaging services should develop a comprehensive capital equipment replacement and renewal strategy.

## **6.8 Support Services**

- (150) The Regional Director, Nutrition services should establish a net operating cost performance target equivalent to \$27.24 net cost per inpatient & resident day<sup>89</sup>.
- (151) The Regional Director, Nutrition services should investigate the business case and feasibility of migrating away from conventional production either through capital investment or outsourcing arrangements including retail operations.
- (152) The Regional Director, Materials Management should establish a net operating cost performance target equivalent to 3.03% of total direct care net operating costs.
- (153) The Regional Director, Materials Management should review the sterilization requirements for each location with the goal of consolidating activity to serve the region from one Sterile Processing operation.
- (154) The Regional Director, Environmental Services should establish a cost reduction target equivalent to 5% of current departmental net operating costs.
- (155) The Regional Director, Environmental Services investigate the business case and feasibility of further consolidating laundry and linen services.

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<sup>89</sup> Measured in 2003/04 dollars.

(156) The Regional Director, Facilities Services should establish a cost reduction target equivalent to 5% of current departmental net operating costs.

(157) The Regional Director, Facilities Services should initiate internal and external benchmarking of operational processes to identify approaches to further reduce the cost of plant operations and maintenance in the region.

#### **6.9 Administrative Services**

(158) The VP Corporate Services and Chief Financial Officer should consolidate Financial Services at a single location.

#### **6.10 Information Technology**

(159) The Director of Information Technology should review the current IT staffing complement for potential to redesign roles and/or processes to address EPR implementation projects.

(160) The Director of Information Technology should develop an IT strategic plan that specifically addresses the short-term information and communication needs of the organization.

(161) The CEO should use available surplus funds to increase investments in acquiring information technologies and supporting and expanding information systems in the region.

### **7.0 Opportunities for Service Rationalization and Realignment**

#### **7.1 Primary Care Clinics**

(162) The VP, Rural should revisit its plan for the location of the continuing clinic in White Bay and ensure that adequate consideration has been given to the natural flow of patients.

(163) The Board should implement its plan to consolidate clinic services into 13 continuing sites in the region.

#### **7.2 Health Centres**

(164) The WHCC should discontinue elective deliveries at the Dr. Charles L. LeGrow Health Centre.

- (165) The WHCC should discontinue elective surgeries requiring general or regional anaesthesia at the Dr. Charles L. LeGrow Health Centre.
- (166) The VP, Rural and the VP Medicine should ensure that patients are not held for observation at the Rufus Guinchard Health Centre but are either admitted to an inpatient bed or discharged.
- (167) The VP Medical Affairs should ensure that the adequate medical coverage is provided for the community served by and the patients of the Rufus Guinchard Health Centre.
- (168) The RMAC should review, develop guidelines and processes and improve the referral process between the more remote facilities within the Corporation and medical staff and services in Corner Brook.
- (169) The VP, Rural should eliminate the observation area at the Bonne Bay Health Centre and patients should be either admitted to an inpatient bed or discharged.

### **7.3 Hospitals**

- (170) The WHCC should discontinue elective deliveries at the Sir Thomas Roddick Hospital.
- (171) The WHCC should discontinue elective surgeries requiring general or regional anaesthesia at the Sir Thomas Roddick Hospital.
- (172) The VPs Operations for Bay St. George, Rural and Corner Brook should develop processes for the transfer of ALC patients from WMRH to STRH.
- (173) The RMAC should require Most Responsible Physician participation in discharge planning that begins at, or before, the time of patient admission to the hospital.
- (174) The VP Medical and the RMAC should arrange for the consolidation of all obstetrical deliveries in the Region at the Western Memorial Regional Hospital.
- (175) The VP Medical and the RMAC should arrange for the consolidation of all surgical services requiring general or regional anesthetic in the Region at the Western Memorial Regional Hospital.

## **8.0 Summary of Savings**

No Recommendations