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OPERATIONAL REVIEW

FOR

INTERIOR HEALTH AUTHORITY

KOOTENAY BOUNDARY REGIONAL HOSPITAL & GREATER TRAIL
BRITISH COLUMBIA

AUGUST 2006

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OPERATIONAL REVIEW
KOOTENAY BOUNDARY REGIONAL HOSPITAL & GREATER TRAIL

Medical Management Consulting (MMC), a division of The Medfall Group, was retained by Interior Health (IH) to carry out an Operational Review for Kootenay Boundary Regional Hospital and Greater Trail. The consultants assigned to this project were James, Murtagh, Dr. Ernie Higgs, Dr. Erdem Yazgonaglu, Pat Light and Mona Kines.

1 Introduction

Kootenay Boundary Regional Hospital (KBRH) functions as a community hospital for Trail and other nearby population centers, and also provides a range of secondary services for the greater Kootenay Boundary Health Service Area (KBHSA).

KBRH and components of the Home & Community Care (HCC) system have been the subject of two recent reports – the Ballem Report and the McMahon Report – both exploring circumstances surrounding the discharge of Mrs. Frances Albo from KBRH. In addition to issues specific to the Albo case, those reports also identified a number of general issues, and made recommendations concerning actions required to address organizational and/or care deficiencies.

Despite having taken action to identify and address organizational issues, Interior Health (IH) determined that an external, operational review was warranted to identify any outstanding issues and actions necessary to support the delivery of health services in Trail. Thus, the purpose of the current review was to ensure that appropriate organizational structures, processes and resources are in place to support the staff in Trail, both in the hospital and in the community, to provide care of the highest quality.

2 Project Mandate

Although the mandate of the current review was broader than either the Ballem or McMahon reviews and was not intended to reexamine the Albo case, the scope of the review was, by necessity, limited. The mandate was delineated as follows:

1. An evaluation of:
   a. Interdisciplinary working relationships within KBRH

   b. Interdisciplinary working relationships between KBRH personnel and those working in community health services

2. An evaluation of the medical staff, nursing and other health professional concerns relating to:
   a. Communications and relationships
   b. Accountability reporting
   c. Leadership and management
   d. Patient safety

3. Resource allocation with specific emphasis on community health and hospital services:
   a. An evaluation of access and availability to services for Greater Trail residents to the community based services as well as for all residents of KBHSA requiring specialized services available at KBRH.
   b. A review of the type and mix of health care services available with the assurance that these are aligned with community need.

In agreeing to undertake the operational review the Review Team expressed reservations regarding the level of specificity that could be achieved in respect to component 3 of the mandate.

3 Project Methodology

The selection of the Review Team as well as the planning and execution of the operational review occurred under the direction of, or relied upon input from, the Operational Review Task Team (ORTT). The ORTT included membership from senior management, staff, physicians and community representatives.

Data collection was based on a review of a wide range of documentation including Committee Minutes, financial and statistical reports, facility audits as well as a site visit and interviews. The site visit and interviews were conducted over a three-day period in June 2006. Prior to the site visit, a list of individuals who were to be interviewed was prepared by the Review Team, and the ORTT and support staff further supplemented the list while assembling focus groups. As a result, semi-structured individual or focus group interviews were conducted with more than 100 stakeholders including Board members, senior management, frontline staff from acute care and HCC, union representatives, physicians, community representatives and HCC clients. The number of persons interviewed far exceeded the Review Team's original expectations and was in excess of the interview patterns typical of most operational reviews.

The interview process itself was designed to identify issues/challenges and explore key relationship dimensions including trust and perceived alignment of interests. In addition, in keeping with a philosophy that it is better to discover and build consensus-based solutions as opposed to defining and 'installing' solutions, interviewees were challenged to identify solutions for the issues they identified and to think critically about their feasibility. Issues were validated by confirming their presence across multiple interviews.

4 Stakeholder Identified Issues

Participants in the interview process were generous with their time and frank, but respectful, with their input. Many of the issues identified were outside the mandate of this review and participants seemed to understand the limitations of the exercise as well as what might be accomplished immediately as a result of the review. It is difficult to provide a comprehensive

summary of all the observations made by stakeholders but the following themes and sub-themes stood out.

1. Communication

A range of internal and external communication issues were identified. Staff and physicians both commented on organizational changes, such as the move of corporate offices, occurring without notice of the change. Similar comments were made relating to the introduction of new policies or policy changes. Physicians commented that they do not receive any follow-up information related to HCC assessments, and some physicians outside Trail identified recurring problems related to receipt of discharge summaries from KBRH.
Community members expressed frustration related to a lack of information and understanding concerning program related decisions such as the closure of residential care beds. At the same time some doubt was expressed regarding the accuracy of IH messaging, especially those messages related to the capacity of the HCC system. Concern was also expressed regarding the absence of a consistent and local voice to respond to community questions or concerns.

*"It's a matter of communication style; people don't feel respected or heard by managemen*t"… *Staff Response*

"The problem is not only what is communicated to the communities but the way it is communicated"… Community Stakeholder

2. Decision Making

The most benign comments related to decision making suggested there is a lack of clarity as to who has authority for decisions and that senior management does not have sufficient time to invest in good decision making. Other perspectives suggested there is no local control with all decisions made by the Chief Operating Officer (COO) or by decision makers in Kelowna. Line staff, physicians and community members feel particularly disconnected from decision making.

"It's a listening issue; management are not interested in listening to us"… Staff Response

"There are questions about how decisions are made and how resources are allocated and this needs to be addressed. There doesn't seem to be any logical processes in place to get decisions made"… Middle Management Response

"Nobody has the authority locally to make decisions or implement change"… Physician Response

3. Leadership and Management

Comments concerning leadership and management issues showed considerable consistency across stakeholder groups. Above all, concerns were expressed regarding management vacancies, turnover, role clarity, and visibility within the organization. With regard to vacancies and role clarity, the Review Team repeatedly heard comments questioning as to who is in charge. These frustrations were compounded by a lack of senior management visibility in the organization, a situation that reportedly began to improve subsequent to the Albo case.

Many observations were also made concerning management styles and focus within the organization. Stakeholders perceive the dominant management style to be oriented toward a command and control approach. Clinical staff further commented that management is insensitive to clinical practice requirements.

Physicians echoed many of the general comments concerning leadership and management but also made comments concerning medical staff structures and the need for strong medical staff leadership.

"Continuous crisis and continuous change of management"… Community Stakeholder

"The vision isn't aligned with the service needs, not just in Trail, but in the whole Kootenay Boundary Health Service Area (KBHSDA)"… Management Response

"Management strategy is not working:

- *No one knows the strategy.*
- *No communication.*
- *Organizational structure changes continuously.*
- *Nothing is given time to work; too much change"… Staff Response*

"What authority does the Community Administrator (CA) have, what is the role of the CA, what is the role of the COO; nobody knows the answer to these basic questions"… Physician Response

4. Relationships

Relationship issues were the most common theme emerging from the stakeholder interviews and it is particularly difficult to concisely summarize all of the relevant comments. All stakeholder groups spoke of not being heard or respected. More disturbing, some groups repeatedly spoke of loud, impolite and rude, if not abusive, behavior in the context of staff/staff and staff/physician interaction. Staff relations across health sectors were described as strained, almost adversarial, although some improvements were also noted. Some physicians made similar comments regarding the interaction of physicians from differing communities. Staff also spoke of anxiety related to a sense of constant scrutiny from patient families and the public.

Concerns were raised regarding trust, the presence of local community rivalries and openness to alternative views within the management group itself.

Community stakeholders expressed significant distrust of IH which was widely seen as operating without regard to local interests. Although staff and others also expressed the view, community members, in particular, saw IH as being business oriented as opposed to care oriented. Performance bonuses for IH managers were repeatedly cited as evidence of an inappropriate 'bottom line' focus, despite the fact no such performance bonuses are available to IH managers at any level of the organization.

Inter-community competition and rivalry was also very evident and was identified by some stakeholders as a force that adversely taints a variety of relationships.

"People have exhibited bad behaviour due to anger"… Staff Response

"We know each other as providers and believe that everybody wants to do a good job but the system doesn't support us working effectively together"… Physician Response

"Big lack of communication between residential care, home care and home support"… Community Stakeholders

5. Resources

Comments related to resources varied. Some stakeholders expressed the view that the real issue is leadership rather than resources. Others focused on the distribution of resources, specifically the possibility that services based in Trail consume a disproportionate share of resources. On the other hand, adequate resources to support KBRH's regional role was also raised. Clinical and other staff raised issues related to staffing levels and workload although some also challenged this perspective.

HCC staff repeatedly raised issues related to community resources, especially the need for convalescent beds and enhanced services after 1600 hours. Community stakeholders were heavily focused on and very concerned about HCC resourcing but also raised some issues regarding support for the regional role of KBRH.

"Not enough support in the community for people being discharged back home"… Physician Response

"No convalescent space for elderly patients to go to after they are discharged from acute care."… Staff Response

"The hospital becomes a holding place for those needing services elsewhere"… Community Stakeholder

6. Vision and Planning

Numerous stakeholders expressed concern regarding the absence of any sub-regional plan for the organization and integrated delivery of services. KBRH staff in particular lamented the lack of locally developed vision and value statements and community stakeholders expressed concern regarding IH's plans for KBRH. Overall, there was a sense that the absence of a vision, values and plan contributed to a persistent sense of crisis.

"Clearer definition of the organizational structure is needed, not just for here but for the IH region. The matrix relations sometimes make the accountability difficult. Need to simplify the organization structure everywhere"… Management Response

"The integration of staff and services hasn't gone well"… Staff Response

"Management doesn't seem to be following a plan"… Physician Response

5 Review Team Observations

Although the Review Team heard reservations concerning the scope of the consultation process associated with previous reviews, it is worth noting that many of the dominant themes emerging from this more extensive consultation process are also evident in those earlier reviews. This serves to validate the input provided by stakeholders in the current process.

In terms of interdisciplinary working relationships (Mandate 1) the impression left with the Review Team is that health service delivery in Trail is polarized along management/staff, professional, health sector and geographic lines. The working environment in some respects resembles a return to the social hierarchies and structures more evident in health care 30 years

ago, albeit without the authority those hierarchies gave various professionals, and was repeatedly described as toxic. While it is easy and to some extent appropriate to blame management for this, it appears that many people throughout the local health system have abrogated their leadership responsibilities; comments concerning lack of respect and not being heard referenced professional or staff interactions just as often as they referenced interactions with management. Stakeholders attributed the health care culture to small town politics and Trail's history as a union town amongst other things. In many respects the system continues to successfully deliver care as did the system 30 years ago but without much of the personal satisfaction evident in the past. The Review Team has no definitive insight into why this culture exists but notes that widespread discontent with the status quo represents an opportunity for change. Change will require that senior management facilitate the development of team approaches to running the organization and delivering service, a focus on service delivery as opposed to the politics of service organization and a commitment by all providers and staff to demonstrate leadership in their personal and professional interaction with colleagues.

The volume of feedback provided by stakeholders regarding communications and relationships, accountability reporting, leadership and management and patient safety varied significantly (Mandate 2). The Review Team heard comments that suggested deficiencies in general (e.g., updates on organizational initiatives) and specific communication processes (e.g., provision of discharge summaries). Senior management has recently become more visible in the organization and some other steps to address communication processes (e.g., revamping of the committee structure) are underway. These steps are positive but appear to be ad hoc as opposed to deliberate components of a more comprehensive approach to facilitate essential communication. The Review Team heard a great deal about relationships. Interestingly, there was little overt hostility in the comments about relationships. On the other hand, there seemed to be a pervasive sense of disconnect between and sometimes within stakeholder groups. This seems to suggest that communication processes, or the lack thereof, may figure more prominently in the relationship issues than, for example, interpersonal conflicts.

Accountability was raised by stakeholders but the term seemed to be used in an inconsistent fashion. In some cases people seemed to be referring to accountability in the conventional sense of defining responsibility whereas in other cases people seemed to be focused on basic

decision making processes. Both are clearly problems and relate strongly to leadership and management. It appears a variety of factors have resulted in a perceived or real concentration or centralization of authority. IH is widely perceived as having essentially centralized some management functions such as finance and there seems to be a real disconnect between the strategic plan developed by IH and its support by front line staff and management. Management vacancies and/or turnover have had a similar effect at a local level in that decision making authority is perceived as having migrated out of local organizations such as KBRH. While decision making authority sometimes must move up in the hierarchy, such movement inevitably blurs accountability and requires very deliberate action if it is to be corrected. As much as subordinates might want to assume decision making responsibility, or to be accountable, it can only happen if senior management clearly re-delegates the authority that was once vested in local managers.

Patient safety was not explicitly raised by stakeholders during the interview process. It was raised indirectly in that some nursing staff suggested they did not receive orientation to KBRH's Code Blue policy. Numerous staff also commented they had no recollection of any fire drills with some suggesting no such drills had occurred in 2 years. There is documentation in the form of committee minutes and audit reports that suggest KBRH has processes in place to protect patients. Nonetheless, the status of the Code Blue and fire drill issues is not completely clear and is of grave concern.

One of the most challenging components of the Review Team's mandate relates to resources (Mandate 3). Assessing resource allocation has always been difficult. The comparability of data across organizations or geographic areas has always been difficult given concerns about reporting practices, data accuracy and the often dated nature of available data. These problems have become more pronounced with regionalization. Questions about 'community need' are particularly complicated. A careful examination of the history of health care indicates an almost constant tension between service demand and service supply.

The Review Team expressed reservations concerning resource questions from the very beginning of the project and our perspective has not changed. As is customary, a series of proxy measures were reviewed. These included a measure of self-sufficiency (e.g., the

proportion of hospital cases treated within KBHSA versus the proportion treated elsewhere) and measures of service equity (e.g., age-standardized case and day rates for acute and HCC services). The self-sufficiency results (see Appendix 1) indicate the overwhelming majority of KBHSA residents receive their hospital care within KBHSA and that those who travel outside KBHSA are doing so to access tertiary services. The self-sufficiency rate is similar to many other areas of British Columbia and suggests a good range of services are available locally.

The equity measures (see Appendix 2) indicate KBHSA residents' access acute and HCC services at a rate that meets or exceeds the average for both IH and BC residents, with the exception of physiotherapy and occupational therapy. These equity measures do not reflect the additional resources IH has added or committed to provide subsequent to the Albo case.

The proxy measures provide no clear indication of a significant resource issue and, in fact, suggest no issue exists. An appropriate range of services is available and access to services, as measured by utilization, is generally equal to or better than the average enjoyed by other IH or BC residents. The Review Team acknowledges the potential limitations of this observation. Many factors including physical plant issues, human resource patterns and deployment, allocation decisions etc can impact resource adequacy. These are details not captured in data comparisons and which external parties cannot gain an appropriate appreciation for in a short visit.

6 Recommendations

6.1 Communications

Stakeholders called for the establishment of effective internal communication processes including a stable and inclusive committee structure, as well as improved external communication. The need for a consistent 'local voice' to respond to issues of public concern was also emphasized.

Recommendation 1

That KBHSA consider establishing a quarterly internal newsletter and/or other formal communication tools, with an emphasis on providing information concerning new initiatives, updates on existing initiatives, committee activities and decisions emerging from committee processes etc.

Recommendation 2

That the restructuring of the Committee structure at KBRH continue as initiated by the acting CA. Attention should be paid to ensuring staff and provider input as appropriate plus cross-sector representation on Committees wherever possible. Committees should move expeditiously to review/revise their Terms of Reference as necessary and these should be circulated throughout the organization.

Recommendation 3

That the CA and line Managers ensure that general and/or departmental staff meetings occur on a regularly scheduled basis at each operating site.

Recommendation 4

That the CA, in consultation with the COO as necessary, be the routine public spokesperson on local service issues. The COO or their designate, such as a manager or clinician most responsible for the service in question, should be the routine public spokesperson on regional service issues.

6.2 Decision Making

Staff and physicians called for well-defined decision making processes, clearly articulated responsibilities and more engagement of staff in problem solving and decision making.

Recommendation 5

That the job descriptions of the COO, CA and Managers be reviewed and either modified or their content reinforced to emphasize the following responsibilities:

- ✓ ***The COO should focus on matters of strategic importance such as the provision of leadership in the development of plans related to regional management infrastructure and regional services.***
- ✓ ***The CA should focus on the coordination and delivery of integrated services in the local area and enjoy significant autonomy in that regard.***
- ✓ ***Managers should have full responsibility for day to day service delivery, including interpreting policy, and interfacing with other Managers to address areas of concern. Managers also have a unique responsibility to engage staff in the organization of service delivery.***

Recommendation 6

That there be decision making processes which:

- ✓ ***Are clearly articulated and communicated to all stakeholders***
- ✓ ***Identify at what level in the organization specific decisions can be made.***
- ✓ ***Are developed on a principle of inclusion of staff, physicians, and where appropriate, community participation.***
- ✓ ***Identify a feedback mechanism so that all stakeholders are aware of the outcomes of particular decisions.***

The Review Team is of the view that those in management positions must be sensitive to the fact staff and providers have invaluable insight to offer into the effective organization and delivery of service. Staff and providers must, for their part, manage the tension that may exist between what they perceive to be their professional obligations and the fiscal and other limitations of the system. Managers and non-managers alike must be pragmatic, objective, committed to an evidence based approach to managing services and prepared to fulfill their respective decision-making responsibilities.

6.3 Leadership and Management

Stakeholders called for a strong, visible and autonomous management presence with clearly defined responsibilities. Numerous persons mentioned the need for managers to be available locally and not constantly be on the road visiting countless operating sites or serving on IH committees. A culture of participatory leadership needs to be cultivated through every level of leadership in KBHSA.

Recommendation 7

> ***That the CA position in Trail must be filled on a permanent basis in an expeditious manner. The individual appointed must have strong leadership skills and the ability to bring disparate groups together. The CA must be supported by the COO to be the primary organizational leader in Trail.***

Recommendation 8

> ***That any vacant management positions must be filled promptly. Furthermore, managers must be able to commit a significant amount of time to the immediate Trail area at least in the medium term. If need be the organization structure should be reviewed and, if necessary, modified so as to ensure managers are able to have***

a real presence in their departments. This may have implications for the number of sites managers supervise and, in the medium term, their availability for corporate initiatives.

Recommendation 9

That matrix reporting relationships such as those which separate policy and operating responsibilities and other complex reporting relationships be reviewed and their relative benefits assessed. There is a need for clear lines of responsibility/accountability.

The Medical Staff requires strong leadership that will bring better coordination of medical services between sites in KBHSA and better cooperation amongst physicians in providing seamless secondary and tertiary patient care. Senior Medical Administration at the IHA and KBHSA level must also work with their colleagues in management as an integral part of the leadership team to rebuild positive relationships within KBRH, between hospital and community care teams, between KBRH and the public it serves and amongst the facilities of KBHSA.

Recommendation 10

That Senior Medical Administration of KBHSA, with other senior management involvement as necessary, must develop and support a clear administrative and medical leadership structure in order to promote a well functioning medical staff across the HSA. Physicians must be incorporated into the decision making structures and processes as primary stakeholders.

6.4 Relationships

Stakeholders identified a need to move away from professional and sector silos, address inappropriate behavior in the workplace and develop constructive avenues for community participation.

The Review Team was left with a sense that KBHSA is characterized by professional, health sector (i.e., acute care, HCC, etc.) and geographic silos. It is clear that people are fatigued and frustrated by constant organizational change. If greater integration can be achieved by attitudinal change as opposed to organizational change, so be it. However, there are a number of organizational structures that can be explored that can both help build relationships across sectoral boundaries and improve patient flow and care planning. Program management, as demonstrated by Mental Health Services, is one approach that can be a rewarding journey with improved patient care as a valuable end product. Program management, or other organizational structures, should not be seen as a panacea for the current issues which IH and KBRH must address but might serve as a model for longer term restructuring which could facilitate improved relationships, at least in some contexts. Some change to the current organizational structure may be unavoidable, but if the disruptive nature of organizational change is to be mitigated it is essential that those impacted be involved in the design and planning of the new structure.

Recommendation 11

> ***That management engage staff and physician stakeholders in a discussion and evaluation of the merits of the existing organizational structure versus implementing a program management or such other organizational structures as is deemed useful in promoting a more integrated approach to the delivery of health services.***

As identified, the Review Team heard a number of comments regarding expression of unprofessional behavior in the workplace. This type of behavior undermines both the quality of care and confidence in the care provided in Trail. Although IH has policies addressing workplace environment and standards of conduct the policies say very little about what is expected in terms of interpersonal behaviour.

Recommendation 12

> ***That a Workplace Wellness Committee or similar body with representation from staff, unions, physicians, management, volunteers and patient/clients be struck and charged with developing a Code of Conduct.***

The Review Team heard a number of comments related to patient safety and many comments related to food quality. While it may seem strange to think of these as relationship issues we believe it is reasonable to do so. Part of the fundamental commitment that health care providers/organizations make to patients/clients is to do no harm. Patient safety is thus a central element in the relationship between the health system and those who rely on it.

Recommendation 13

> ***That management proceed quickly to review the adequacy of staff orientation to the Code Blue policy and to establish regular fire drill procedures.***

The Review Team heard a great deal related to food quality, especially as it relates to residential care facilities. Union representatives reported being asked to develop a report related to food quality issues but received no response to the report. Similarly, community members suggested IH has not been forthcoming regarding reviews of food services.

While the Review Team is congnizant that hospital food quality is commonly cited as a criticism for most hospitals, it appears that satisfaction levels are even lower at KBRH as indicated by the recent satisfaction survey. Comments heard during the review suggest multiple reasons for this result including, but not limited to, the process of food preparation and distribution. Whatever the reason and regardless of any debate as to the validity of the perception, it is clear that food quality at KBRH has come to be a major issue in the community's perception of IH and that many believe IH has not moved to remedy quality issues.

Recommendation 14

> ***That IH respond to the concerns related to food quality by clarifying what has emerged in reviews to date and by providing a frank assessment of what further changes might occur and in what timeframe.***

6.5 Resources

Stakeholder solutions related to resource issues were generally vague although the need for additional HCC services was a common theme.

The allocation of resources has been and remains a highly fluid process related to priorities identified provincially and regionally. This is not an area where an external review necessarily brings greater insight as external parties are often insensitive to local values, needs and priorities. Any recommendation the Review Team might make concerning additional fiscal resources would be largely arbitrary as the funding of health services is not a science.

Steps can be taken, however, to enhance local decision making related to the allocation of a pool of resources which will always be too small. Internationally recognized expertise on program budgeting and marginal analysis (PBMA) exists within IH's boundaries. PBMA is a tool whereby organizations can, with the participation of local providers, make decisions about which

services will be funded and at what levels. PBMA recognizes that choice is unavoidable and that choices will be made on our behalf if need be.

Recommendation 15

> ***That IH explore the possibility of using PBMA or similar tools to guide resource allocation decisions at the local level and thereby delegate responsibility for making choices to those most affected by the choice.***

Recommendation 16

> ***That IH move as quickly as is feasible to provide the additional resources pledged for transitional/convalescent care which will better support patients to transition from acute care to home or residential care***

6.6 Vision/Planning

Stakeholders almost universally called for the development of a strategic plan, definition of regional services and a multidisciplinary approach to planning.

The Review Team believes there is merit in developing a strategic plan that reflects and, where appropriate, goes beyond the IH strategic plan. Furthermore, the planning process should be multidisciplinary.

The Review Team has struggled with how this might be achieved. The local community is clearly passionate about the delivery of health services and takes a very active interest in the subject. This is clearly beneficial in some respects, such as the success of the Foundation, but potentially harmful in others. The Albo case has witnessed the emergence of community organizations whose existence seems premised on an ongoing distrust of IH. It is also

abundantly clear that KBHSA communities, or at least some communities, probably cannot have a constructive conversation regarding regional services.

These community dynamics influence the scope of the strategic planning process and who should play a dominant role. The scope must be broader than Trail given the distrust of IH evident in Trail and the implications this might have for a constructive planning process. Similarly, leadership cannot fall on the communities given the distrust that exists amongst them.

Recommendation 17

> ***That a KBHSA strategic plan be developed which reflects and builds on the IH strategic plan. Leadership and responsibility for developing and implementing the plan should rest with a steering committee having representation from KBHSA managers, staff and physicians and should be the prime focus of the COO. Opportunities for other staff and physicians to be involved should be explored and facilitated to the highest degree possible, recognizing the requirement to balance the need for a timely and effective process against the need for a plan that enjoys some considerable level of support. Community consultation regarding the drafted plan should be focused on local services as opposed to regional services.***

The above recommendation assumes that health care professionals can step out of the political and other debates regarding service provision and approach the matter in an objective, evidence based manner. The Review Team believes that all health services are important pieces of the continuum and while we appreciate that debates about services occur, the immediate focus for health professionals should be how best to use the existing resources to deliver services. Health professionals are in a unique position to provide leadership in these matters and in the absence of their considered and balanced participation, such planning and related decisions will invariably, and justifiably, be made more centrally.

7 Concluding Remarks

All organizations have moments of crisis and all organizations have operating challenges of one kind or another. It is often easy to lose perspective when one is immersed in a crisis or constantly exposed to challenging circumstances. To some degree people have lost perspective concerning health services in Trail.

The Review Team examined a mass of documentation that suggests KBRH and other components of the system are performing at an adequate or better level. There is certainly room for improvement but the facilities are clean, very well equipped, offer a very good range of services and recent patient satisfaction data indicates the majority of patients are largely satisfied with their overall care. The community is passionate in its support for local services.

Stakeholders were open and honest in their comments to the Review Team. There was generally little hostility evident as people spoke of their concerns regarding health services. Staff were unusually pragmatic in their comments and many acknowledged that the resource challenges faced in Trail may not be that unique. Although staff were often critical they also seemed hopeful that some things could change. Certainly all stakeholders offered possible solutions to issues, a response that would be inconsistent with a loss of hope.

The challenges faced by service providers in Trail are inter-related but can be described as largely people-related. These types of challenges take time to emerge and, once established, take time to resolve. Unlike a building or equipment issue, people issues do not lend themselves to simple, quick fixes. The Review Team believes leadership and relationships are the most critical components in resolving the full range of identified issues. The recommendations contained in this report are intended to provide a platform for addressing issues through increased participation and clarity within the organization.

While outsiders can provide assistance along the way, resolution of the issues ultimately rests in the hands of those working in the system. Success appears feasible but will depend heavily upon the willingness of people to commit the energy required to reduce the polarization that seems so evident. Moving forward, the Review Team suggests that the ORTT prioritize the

recommendations and begin developing implementation strategies. Although prompt action is required we encourage the ORTT not to be hasty. Changing the culture of an organization is complex and time consuming, and ill-considered efforts are more likely to reinforce the status quo than produce positive change.

8 Acknowledgements

We would like to thank past and current members of the Operational Review Task Team, Dieter Bogs, Lori Boothby, Spencer Buckland, Dr. Stephanie Cameron, Suzanne Campbell, Carol Markowsky, Martin McMahon, Don Nutini, Diane Russell, Glen Sutherland, Dr. Trudi Toews, for their input into the planning, execution and finalization of the operational review.

We would like to acknowledge Doreen Mailey and her colleagues for their efforts and patience in organizing and adjusting our interview schedule, and for collecting the thousands of pages of documentation we requested.

Finally but most importantly, we wish to acknowledge the 100+ individuals, staff, physicians and community representatives, who met with us and shared their perspectives in an open and constructive manner.

Respectfully submitted by:

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LIST OF RECOMMENDATIONS

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Recommendation 5

That the job descriptions of the COO, CA and Managers be reviewed and either modified or their content reinforced to emphasize the following responsibilities:

- ✓ ***The COO should focus on matters of strategic importance such as the provision of leadership in the development of plans related to regional management infrastructure and regional services.***
- ✓ ***The CA should focus on the coordination and delivery of integrated services in the local area and enjoy significant autonomy in that regard.***
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That there be decision making processes which:

- ✓ ***Are clearly articulated and communicated to all stakeholders***
- ✓ ***Identify at what level in the organization specific decisions can be made.***
- ✓ ***Are developed on a principle of inclusion of staff, physicians, and where appropriate, community participation.***
- ✓ ***Identify a feedback mechanism so that all stakeholders are aware of the outcomes of particular decisions.***

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That the CA position in Trail must be filled on a permanent basis in an expeditious manner. The individual appointed must have strong leadership skills and the ability to bring disparate groups together. The CA must be supported by the COO to be the primary organizational leader in Trail.

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That any vacant management positions must be filled promptly. Furthermore, managers must be able to commit a significant amount of time to the immediate Trail area at least in the medium term. If need be the organization structure should be reviewed and, if necessary, modified so as to ensure managers are able to have a real presence in their departments. This may have implications for the number of sites managers supervise and, in the medium term, their availability for corporate initiatives.

Recommendation 9

That matrix reporting relationships such as those which separate policy and operating responsibilities and other complex reporting relationships be reviewed and their relative benefits assessed. There is a need for clear lines of responsibility/accountability.

Recommendation 10

That Senior Medical Administration of KBHSA, with other senior management involvement as necessary, must develop and support a clear administrative and medical leadership structure in order to promote a well functioning medical staff across the HSA. Physicians must be incorporated into the decision making structures and processes as primary stakeholders.

Recommendation 11

That management engage staff and physician stakeholders in a discussion and evaluation of the merits of the existing organizational structure versus implementing a program management or such other organizational structures as is deemed useful in promoting a more integrated approach to the delivery of health services.

Recommendation 12

That a Workplace Wellness Committee or similar body with representation from staff, unions, physicians, management, volunteers and patient/clients be struck and charged with developing a Code of Conduct.

Recommendation 13

That management proceed quickly to review the adequacy of staff orientation to the Code Blue policy and to establish regular fire drill procedures.

Recommendation 14

That IH respond to the concerns related to food quality by clarifying what has emerged in reviews to date and by providing a frank assessment of what further changes might occur and in what timeframe.

Recommendation 15

That IH explore the possibility of using PBMA or similar tools to guide resource allocation decisions at the local level and thereby delegate responsibility for making choices to those most affected by the choice.

Recommendation 16

That IH move as quickly as is feasible to provide the additional resources pledged for transitional/convalescent care which will better support patients to transition from acute care to home or residential care

Recommendation 17

That a KBHSA strategic plan be developed which reflects and builds on the IH strategic plan. Leadership and responsibility for developing and implementing the plan should rest with a steering committee having representation from KBHSA managers, staff and physicians and should be the prime focus of the COO. Opportunities for other staff and physicians to be involved should be explored and facilitated to the highest degree possible, recognizing the requirement to balance the need for a timely and effective process against the need for a plan that enjoys some considerable level of support. Community consultation regarding the drafted plan should be focused on local services as opposed to regional services.

APPENDIX I
SELF-SUFFICIENCY MEASURES

Figure 1: Percent of Kootenay Boundary Residents by Health Authority of Acute Care Treatment (excludes Out-of-Province facilities)

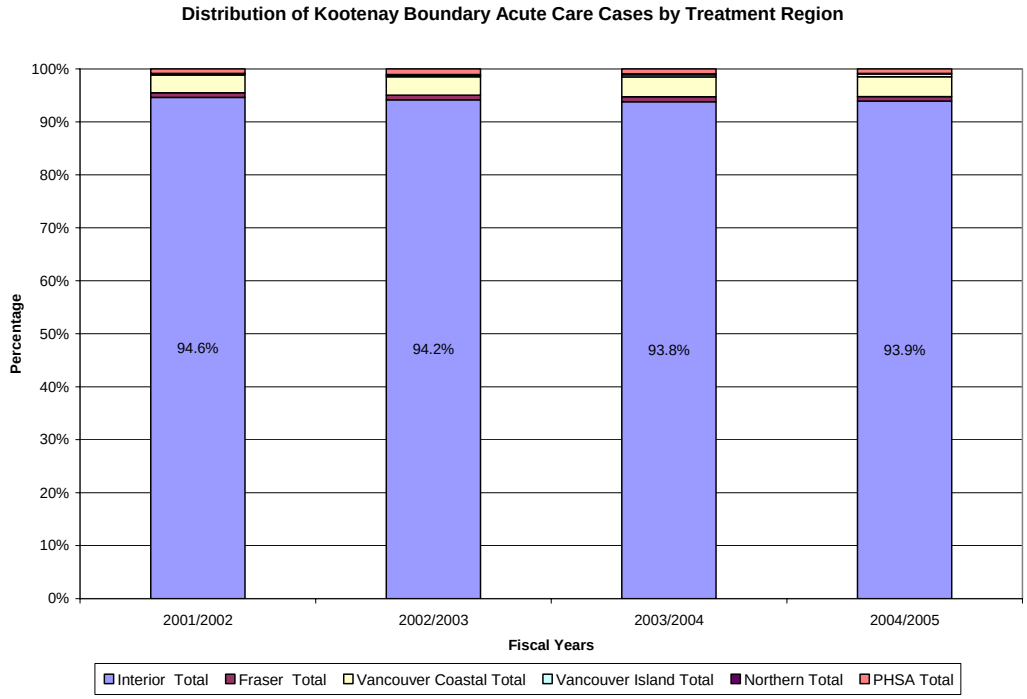


Figure 2: Percent of Kootenay Boundary Residents by Acute Care Treatment Interior Health HSDAs (excludes Out-of-Province facilities)

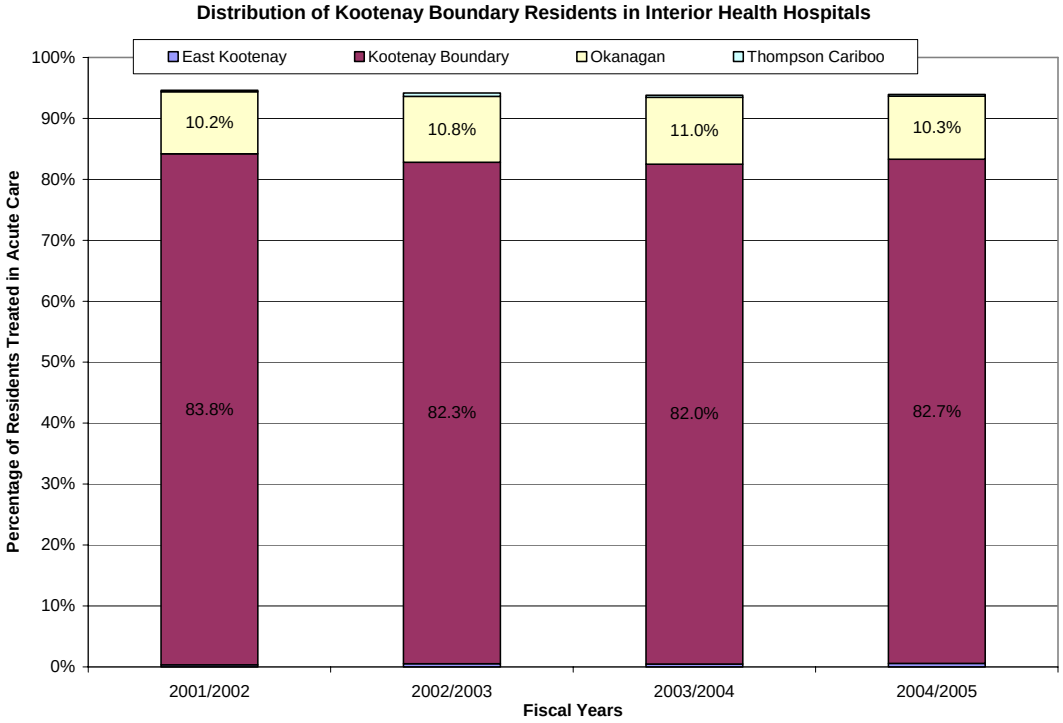


Figure 3: Percent of Acute Care Cases Treated within the HSDA, All BC HSDAs, Fiscal Years 2001/02 - 2004/05

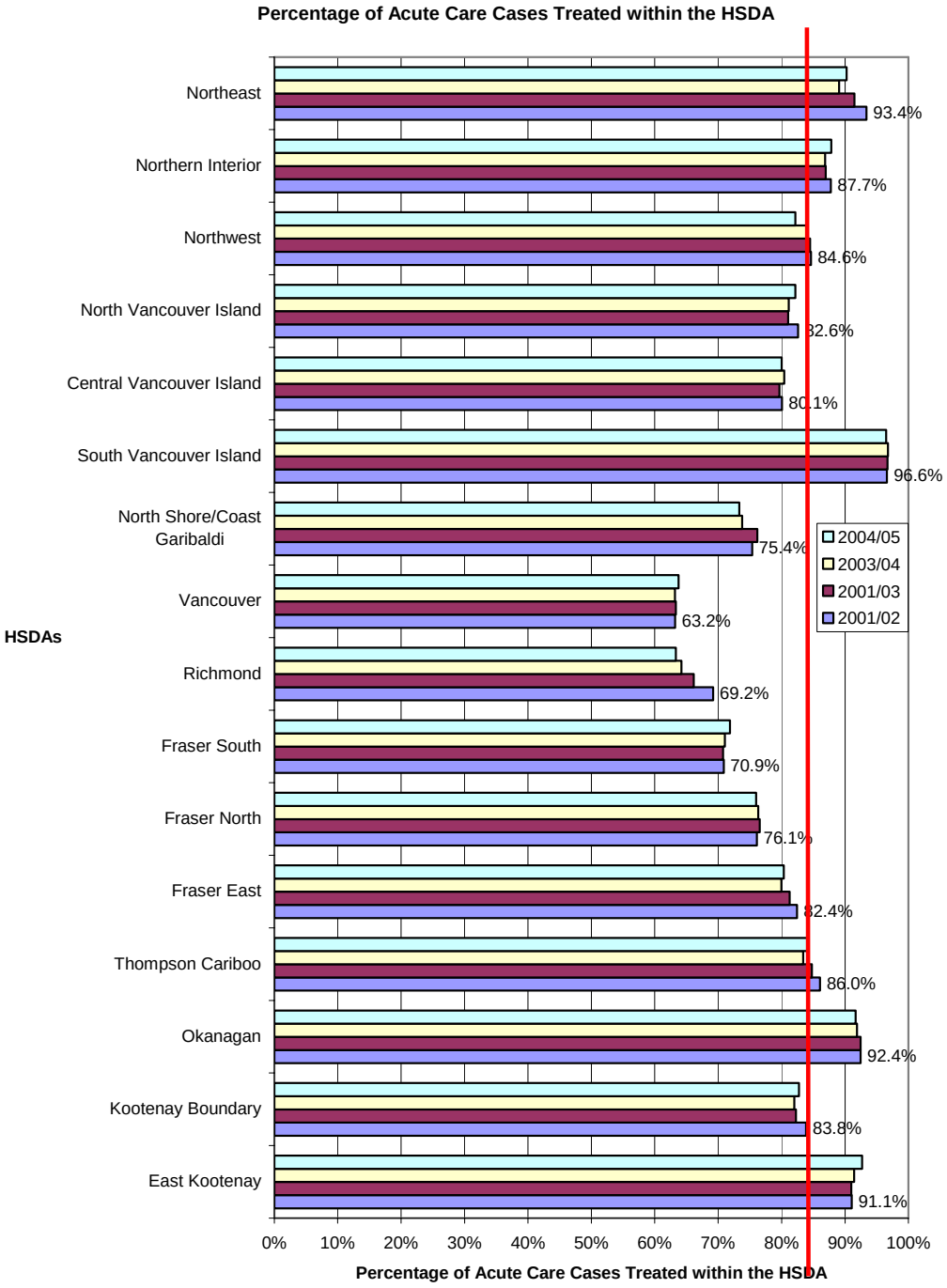


Figure 4: Percent of Kootenay Boundary LHA Residents by their Acute Care Treatment HSDA in 2004/05 (excludes Out-of-Province facilities)

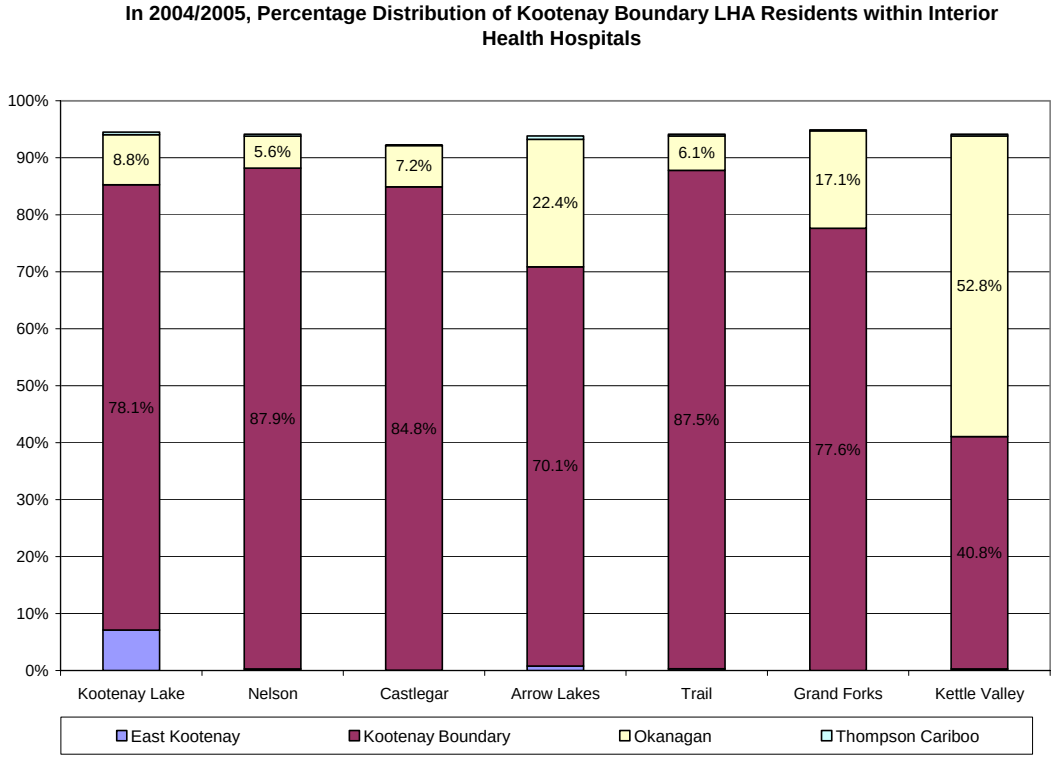


Table 1: Volume and Percent of Services Provided to KB HSDA residents locally or by other HSDAs by Physician Specialty, 2004/05 (ranked first by percentage of services and then by total number of services)

Specialty	Specialty Description	2004/05 MSP Services			Percentage of Other of Total
		Local	Other	Total	
29	Medical Microbiology		20,149	20,149	100.00%
7	Otolaryngology		2,977	2,977	100.00%
9	Neurosurgery		779	779	100.00%
1	Dermatology		733	733	100.00%
12	Cardiac Surgery		642	642	100.00%
47	Vascular Surgery		633	633	100.00%
44	Rheumatolgy		614	614	100.00%
19	Paediatric Cardiology		254	254	100.00%
48	Thoracic Surgery		146	146	100.00%
45	Clinic Immunization and Allergy		111	111	100.00%
24	Geriatric Medicine		77	77	100.00%
21	Public Health & Community Medicine		23	23	100.00%
23	Occupational Medicine		5	5	100.00%
5	Obstetrics & Gynaecology	675	1,689	2,364	71.45%
18	Anaesthesia	26,219	18,801	45,020	41.76%
20	Physical Medicine and Rehabilitation	608	358	966	37.06%
2	Neurology	2,952	1,638	4,590	35.69%
15	Internal Medicine	38,343	17,477	55,820	31.31%
3	Psychiatry	4,396	1,676	6,072	27.60%
13	Urology	3,587	1,046	4,633	22.58%
16	Radiology, Diagnostic and Therapeutic R	32,233	8,749	40,982	21.35%
6	Ophthalmology	15,751	4,050	19,801	20.45%
10	Orthopaedics	6,446	1,325	7,771	17.05%
28	Emergency Medicine	1,736	345	2,081	16.58%
17	Pathology and Bacteriology, Laboratory	468,696	85,692	554,388	15.46%
14	Paediatrics	4,714	836	5,550	15.06%
11	Plastic Surgery	3,090	488	3,578	13.64%
0	General Practitioner	379,502	49,951	429,453	11.63%
8	General Surgery	12,444	1,452	13,896	10.45%
33	Nuclear Medicine	13,169	1,217	14,386	8.46%
Total		1,014,561	223,933	1,238,494	18.08%

Table 2: Distribution of Residents who Received Acute Care Services by Service Provision Region and Fiscal Years (excludes Out-of-Province facilities)

Percentage of LHA Residents by their Service Provider Region			Health Authorities										
			Interior Health						Vancouver	Vancouver			
FY	LHA	LHA of Residence	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo	Interior Total	Fraser Total	Coastal Total	Island Total	Northern Total	PHSA Total	Total
2001/2002	006	Kootenay Lake	3.6%	85.0%	3.6%	0.5%	92.6%	1.4%	3.6%	0.0%	0.2%	2.1%	100.0%
	007	Nelson	0.3%	87.9%	5.3%	0.1%	93.6%	0.7%	4.1%	0.4%	0.1%	1.0%	100.0%
	009	Castlegar	0.2%	88.9%	5.2%	0.2%	94.5%	1.3%	3.5%	0.2%	0.0%	0.5%	100.0%
	010	Arrow Lakes	0.1%	73.8%	20.5%	0.9%	95.4%	1.1%	2.7%	0.5%	0.0%	0.3%	100.0%
	011	Trail	0.1%	89.7%	5.5%	0.1%	95.5%	0.4%	3.1%	0.2%	0.0%	0.7%	100.0%
	012	Grand Forks	0.3%	72.0%	22.6%	0.3%	95.2%	1.2%	2.4%	0.0%	0.1%	1.1%	100.0%
	013	Kettle Valley	0.0%	47.8%	46.7%	0.5%	95.0%	1.3%	2.1%	0.3%	0.0%	1.3%	100.0%
2001/2002 Total			0.3%	83.8%	10.2%	0.2%	94.6%	0.9%	3.3%	0.3%	0.1%	0.9%	100.0%
2002/2003	006	Kootenay Lake	6.7%	80.1%	6.9%	1.6%	95.3%	0.2%	3.6%	0.2%	0.0%	0.7%	100.0%
	007	Nelson	0.2%	86.8%	6.0%	0.4%	93.5%	0.6%	4.2%	0.4%	0.2%	1.1%	100.0%
	009	Castlegar	0.1%	85.7%	7.2%	0.4%	93.4%	1.3%	3.6%	0.5%	0.3%	0.9%	100.0%
	010	Arrow Lakes	0.1%	69.0%	23.3%	0.9%	93.3%	0.9%	4.0%	0.1%	0.1%	1.5%	100.0%
	011	Trail	0.3%	88.4%	6.0%	0.4%	95.1%	0.8%	2.8%	0.1%	0.0%	1.1%	100.0%
	012	Grand Forks	0.3%	73.1%	20.8%	0.8%	95.0%	1.2%	2.6%	0.3%	0.1%	0.9%	100.0%
	013	Kettle Valley	0.3%	43.9%	49.0%	0.6%	93.7%	1.7%	3.7%	0.0%	0.3%	0.6%	100.0%
2002/2003 Total			0.5%	82.3%	10.8%	0.6%	94.2%	0.9%	3.5%	0.3%	0.2%	1.0%	100.0%
2003/2004	006	Kootenay Lake	4.8%	79.8%	8.6%	0.6%	93.8%	1.0%	3.8%	0.6%	0.2%	0.6%	100.0%
	007	Nelson	0.4%	85.6%	6.8%	0.2%	92.9%	0.9%	4.0%	0.5%	0.2%	1.5%	100.0%
	009	Castlegar	0.4%	85.0%	6.7%	0.3%	92.4%	1.8%	4.2%	0.6%	0.2%	0.8%	100.0%
	010	Arrow Lakes	0.3%	69.5%	25.1%	0.5%	95.3%	0.2%	3.2%	0.6%	0.3%	0.5%	100.0%
	011	Trail	0.2%	88.9%	5.1%	0.3%	94.5%	0.9%	3.7%	0.2%	0.3%	0.4%	100.0%
	012	Grand Forks	0.0%	74.9%	19.2%	0.7%	94.8%	0.6%	3.1%	0.3%	0.0%	1.2%	100.0%
	013	Kettle Valley	0.3%	39.5%	56.0%	0.0%	95.7%	0.9%	3.1%	0.0%	0.0%	0.3%	100.0%
2003/2004 Total			0.5%	82.0%	11.0%	0.3%	93.8%	0.9%	3.7%	0.4%	0.2%	0.9%	100.0%
2004/2005	006	Kootenay Lake	7.1%	78.1%	8.8%	0.5%	94.5%	0.7%	3.1%	0.7%	0.0%	1.0%	100.0%
	007	Nelson	0.3%	87.9%	5.6%	0.3%	94.1%	0.7%	3.7%	0.6%	0.1%	0.8%	100.0%
	009	Castlegar	0.1%	84.8%	7.2%	0.1%	92.3%	1.7%	3.9%	0.2%	0.3%	1.6%	100.0%
	010	Arrow Lakes	0.8%	70.1%	22.4%	0.6%	93.9%	0.5%	3.6%	0.8%	0.5%	0.8%	100.0%
	011	Trail	0.3%	87.5%	6.1%	0.3%	94.1%	0.8%	4.1%	0.2%	0.0%	0.7%	100.0%
	012	Grand Forks	0.0%	77.6%	17.1%	0.2%	94.9%	0.5%	3.2%	1.1%	0.1%	0.2%	100.0%
	013	Kettle Valley	0.3%	40.8%	52.8%	0.3%	94.1%	0.9%	3.2%	0.6%	0.3%	0.9%	100.0%
2004/2005 Total			0.6%	82.7%	10.3%	0.3%	93.9%	0.8%	3.8%	0.5%	0.1%	0.8%	100.0%

Table 3: Major Clinical Categories that Kootenay Boundary Residents were treated out of HSDA, 2004/05 (excludes Out-of-Province facilities)

		FISCAL YEARS				Percent of total in
MCC	Major Clinical Cateogry Description	2001/2002	2002/2003	2003/2004	2004/2005	2004/05
05	Diseases and Disorders of the Circulatory System	377	334	383	396	24.5%
06	Diseases and Disorders of the Digestive System	137	152	150	161	10.0%
08	Diseases and Disorders of the Musculoskeletal System and Connective Tissue	141	163	190	152	9.4%
01	Diseases and Disorders of the Nervous System	88	90	104	121	7.5%
04	Diseases and Disorders of the Respiratory System	99	95	103	105	6.5%
25	Multiple Significant Trauma	133	118	104	90	5.6%
11	Diseases and Disorders of the Kidney and Urinary Tract	60	73	84	78	4.8%
03	Diseases and Disorders of the Ear, Nose, Mouth and Throat	56	79	71	61	3.8%
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period	85	59	71	58	3.6%
23	Other Reasons for Hospitalization	69	68	49	57	3.5%
14	Pregnancy and Childbirth	98	52	77	53	3.3%
13	Diseases and Disorders of the Female Reproductive System	57	52	87	51	3.2%
19	Mental Diseases and Disorders	33	49	49	47	2.9%
07	Diseases and Disorders of the Hepatobiliary System and Pancreas	70	49	46	42	2.6%
21	Injury, Poisoning and Toxic Effect of Drugs	50	48	49	38	2.4%
10	Endocrine, Nutritional and Metabolic Diseases and Disorders	20	22	20	25	1.5%
09	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	54	59	40	18	1.1%
18	Multisystemic or Unspecified Site Infections	14	19	12	17	1.1%
17	Lymphoma, Leukemia or Unspecified Site Neoplasms	37	42	37	16	1.0%
16	Diseases and Disorders of Blood and Blood Forming Organs and Immunological Disorders	8	13	24	10	0.6%
22	Burns	2	3	2	6	0.4%
02	Diseases and Disorders of the Eye	18	11	8	5	0.3%
12	Diseases and Disorders of the Male Reproductive System	9	7	3	4	0.2%
99	Ungroupable data	2	3	1	2	0.1%
24	HIV Infections (AIDS)	1	4		2	0.1%
Total		1718	1664	1764	1615	100.0%

APPENDIX II
EQUITY MEASURES

ACUTE CARE

Figure 1 Acute Care Cases Rate (excluding Newborns and Surgical Day Care Cases) by HSDA and Fiscal Years, 2001/02 - 2004/05

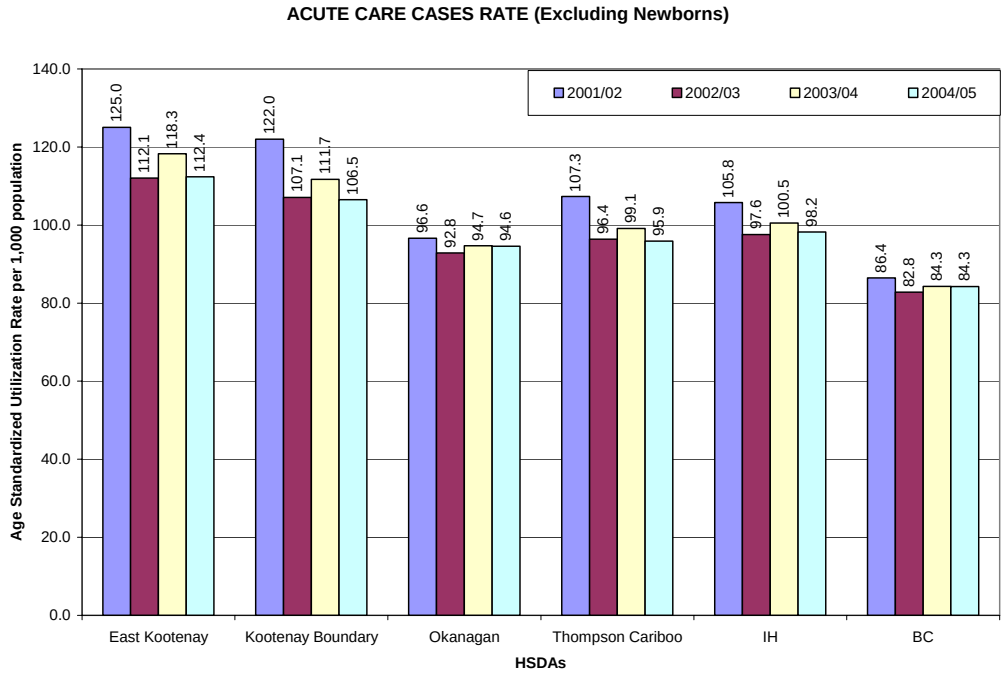


Figure 2 Acute Care Inpatient Days Rate (excluding Newborns, ALC and Rehabilitation day s) by HSDA and Fiscal Years, 2001/02 - 2004/05

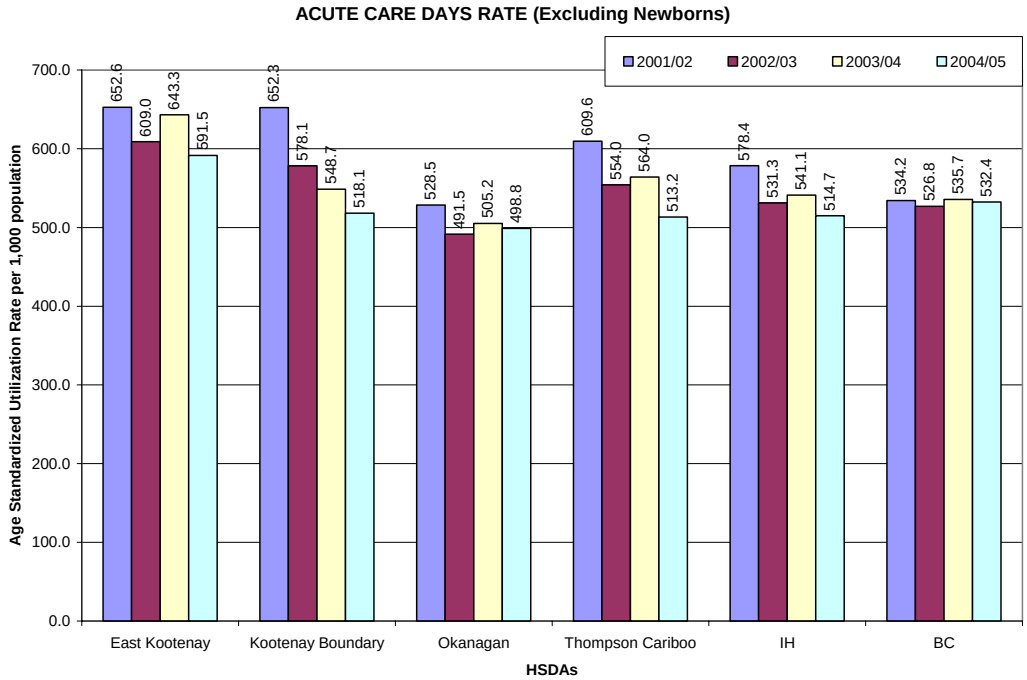


Figure 3 Surgical Day Care Cases Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

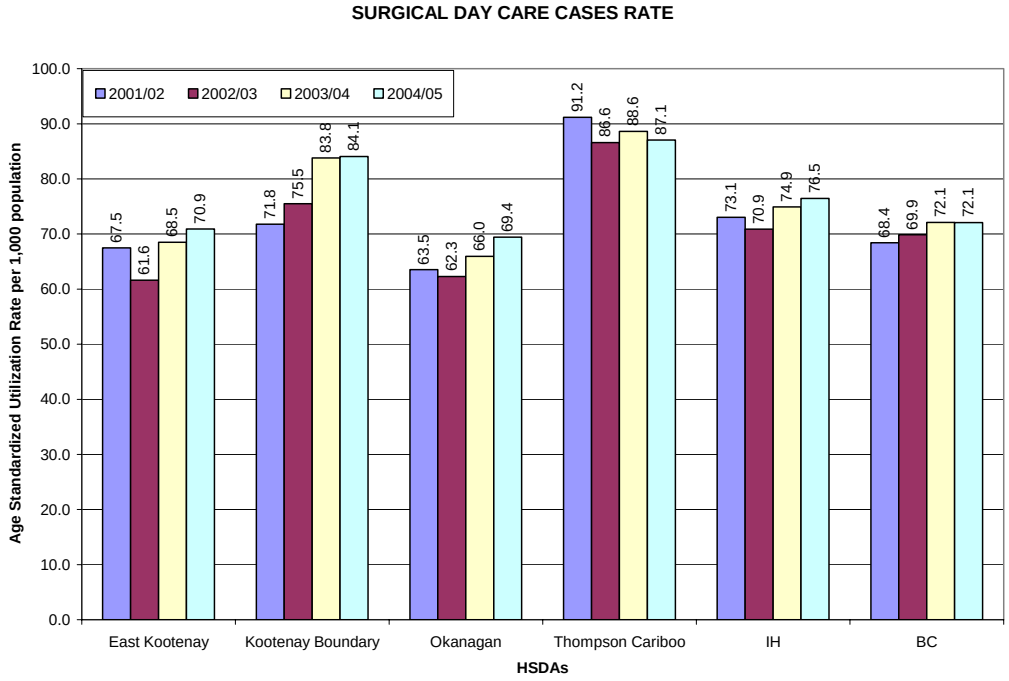


Figure 4 Rehabilitation in Acute Care Setting - Cases Rate (excluding Newborns and Surgical Day Care Cases) by HSDA and Fiscal Years, 2001/02 - 2004/05

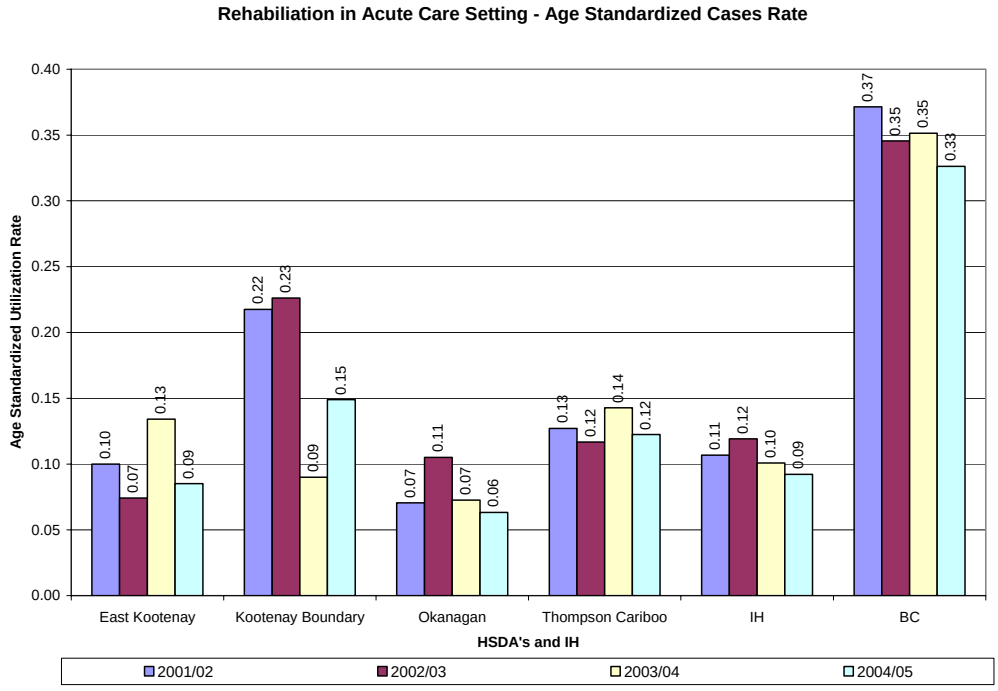


Figure 5 Rehabilitation in Acute Care Setting - Days Rate (excluding Newborns and Surgical Day Care Cases) by HSDA and Fiscal Years, 2001/02 - 2004/05

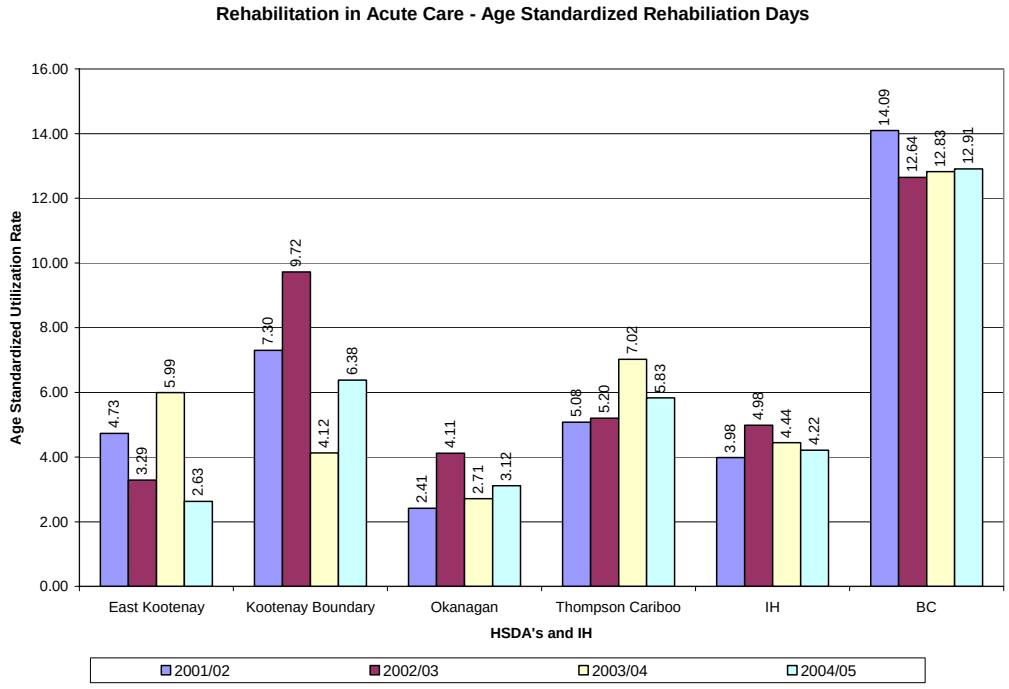


Figure 6 Alternate Level of Care Cases Rate (excluding Newborns and Surgical Day Care Cases) by HSDA and Fiscal Years, 2001/02 - 2004/05

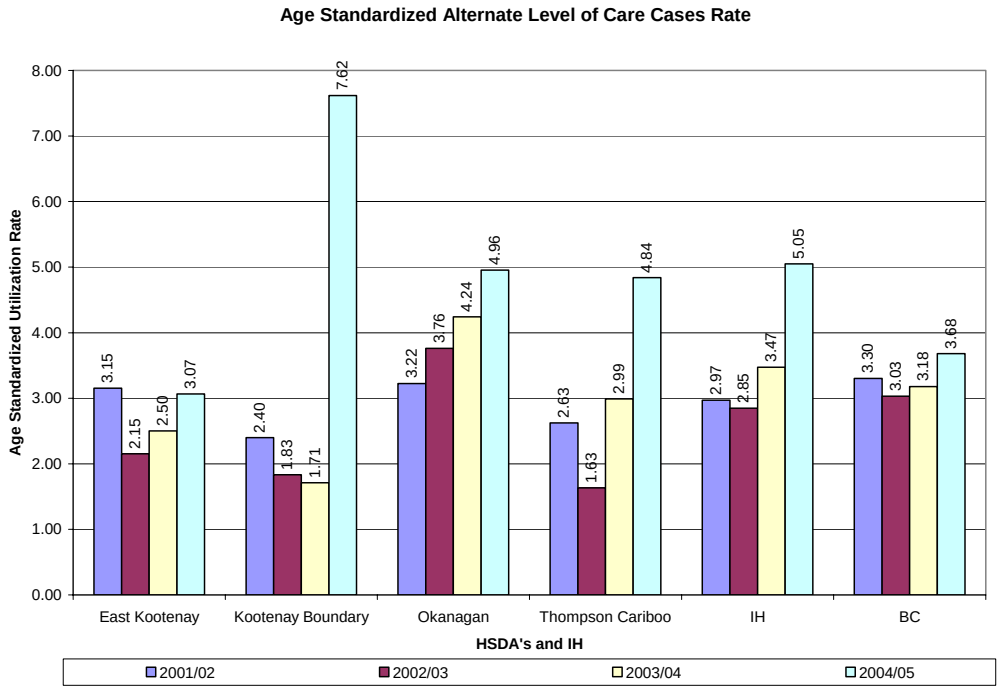
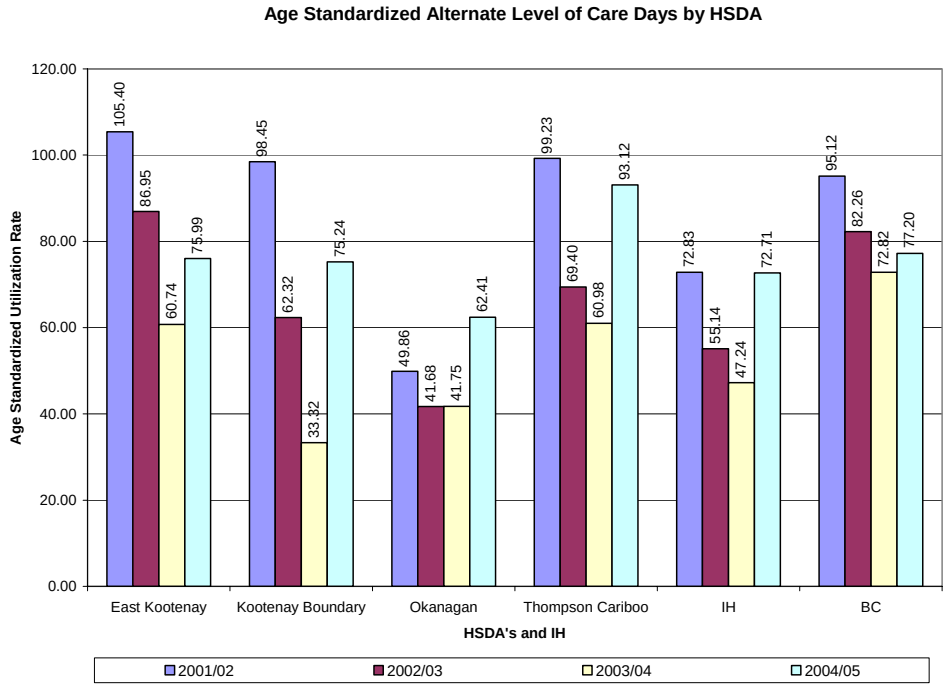


Figure 7 Alternate Level of Care Days Rate (excluding Newborns and Surgical Day Care Cases) by HSDA and Fiscal Years, 2001/02 - 2004/05



HOME AND COMMUNITY CARE

Figure 8 Adult Day Care Clients' Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

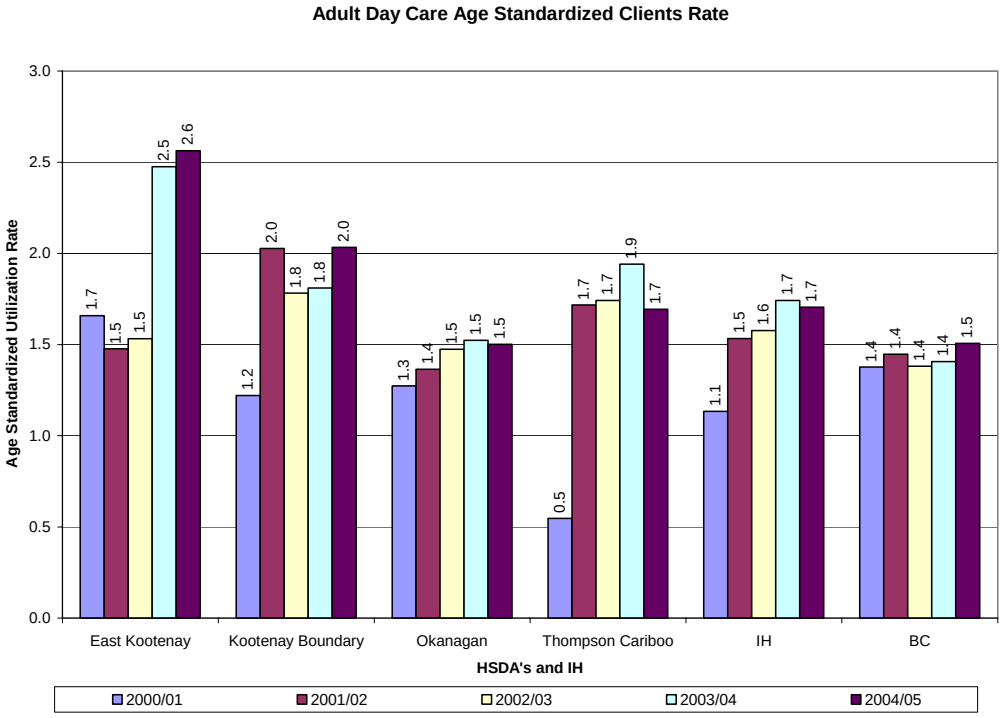


Figure 9 Adult Day Care Days Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

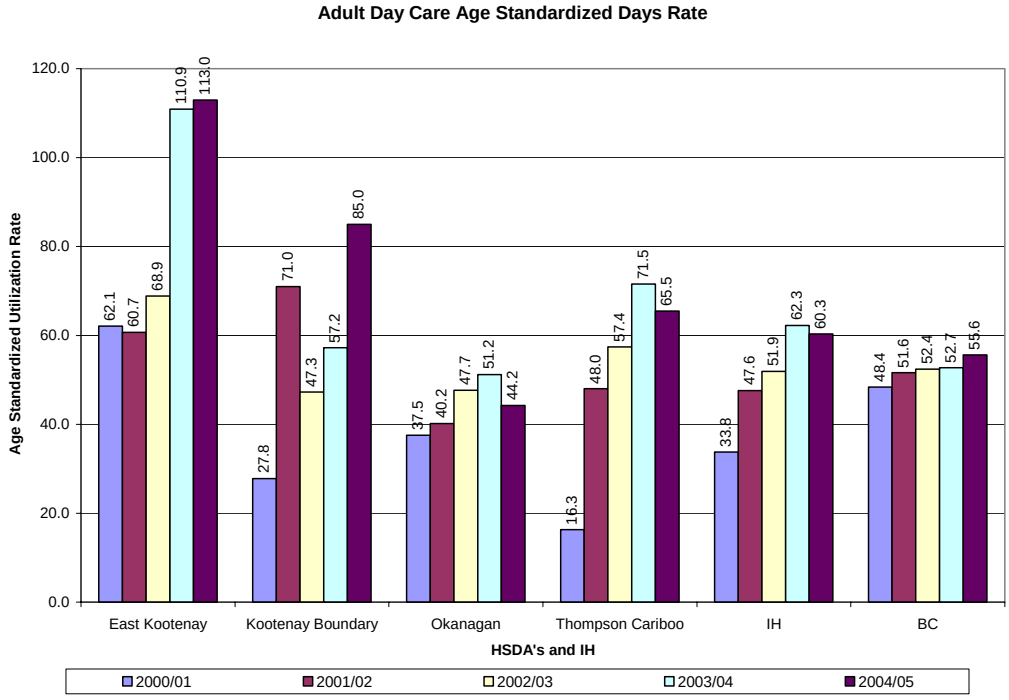


Figure 10 Home Nursing Care Clients' Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

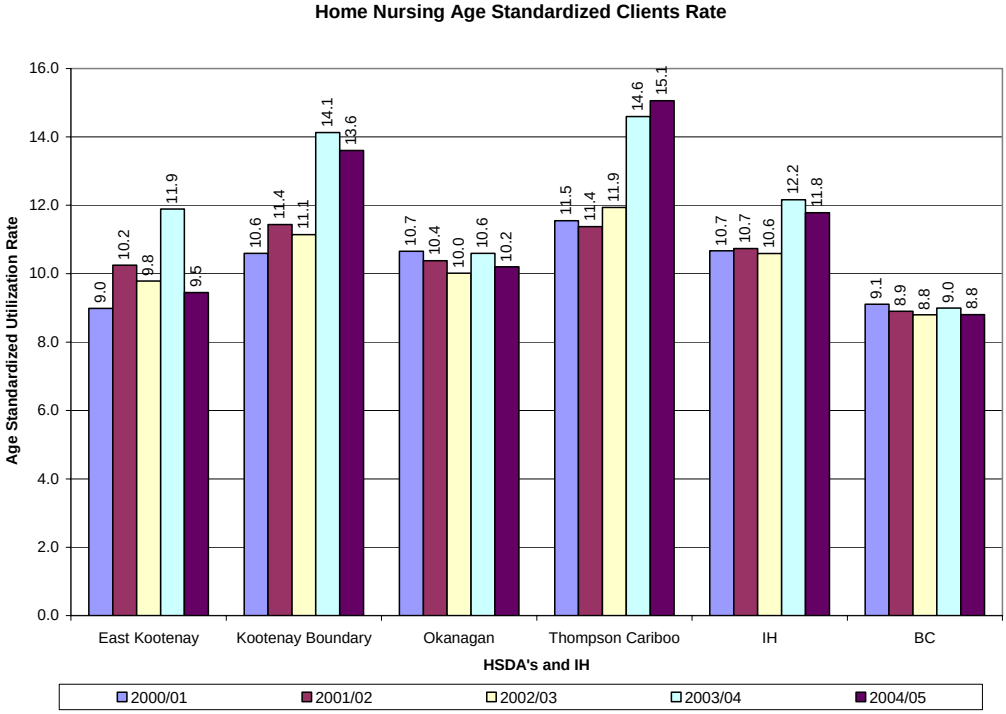


Figure 11 Home Nursing Care Visits Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

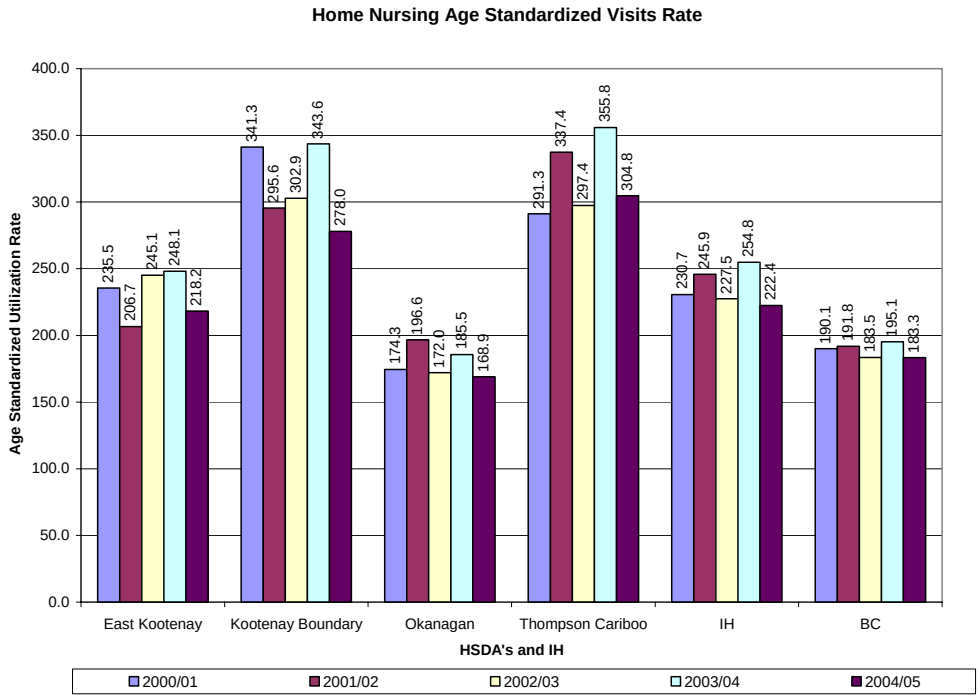


Figure 12 Physiotherapy and Occupational Therapy Clients' Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

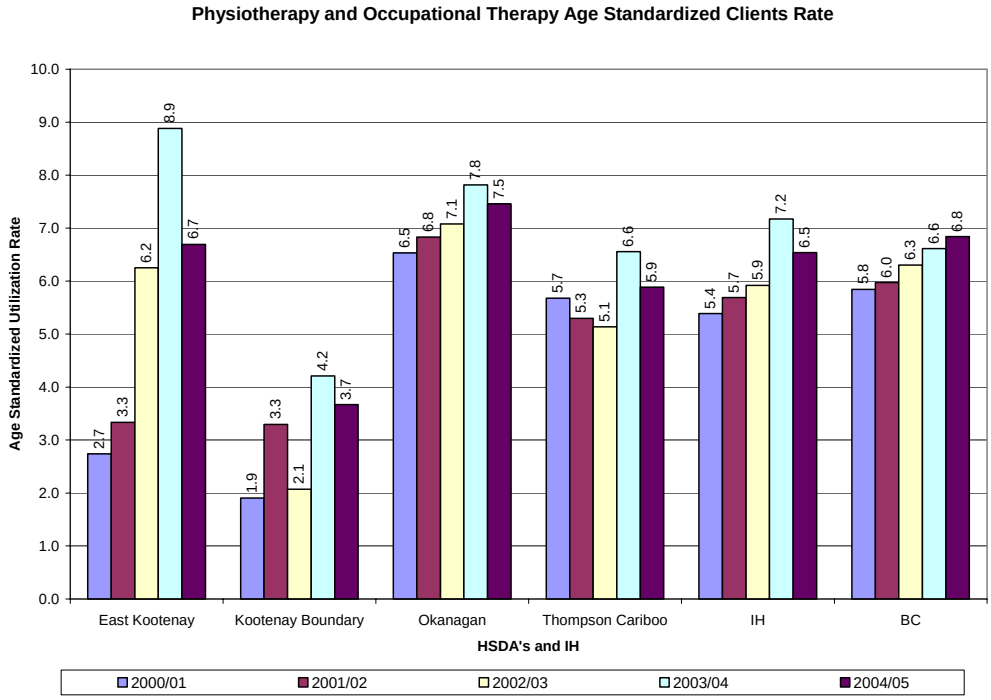


Figure 13 Physiotherapy and Occupational Therapy Visits Rate by HSDA and Fiscal Years, 2001/02 - 2004/05

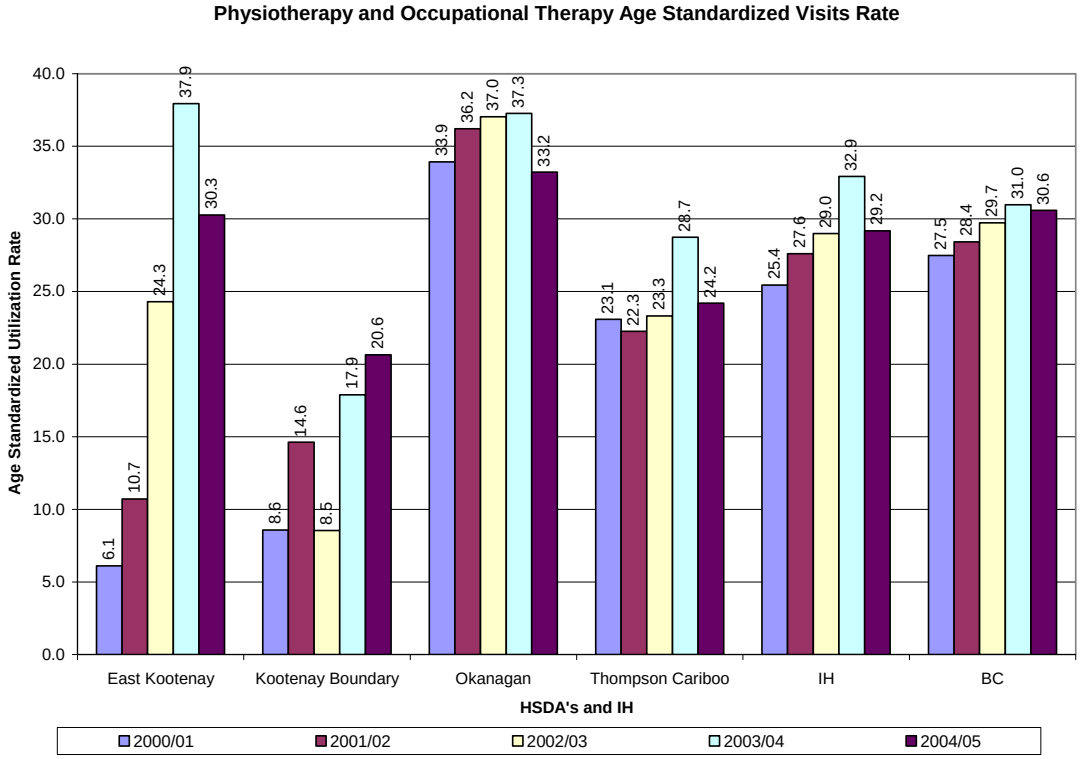


Figure 14 Home Support Clients' Rate for All Care Levels by HSDA and Fiscal Years, 2001/02 - 2004/05

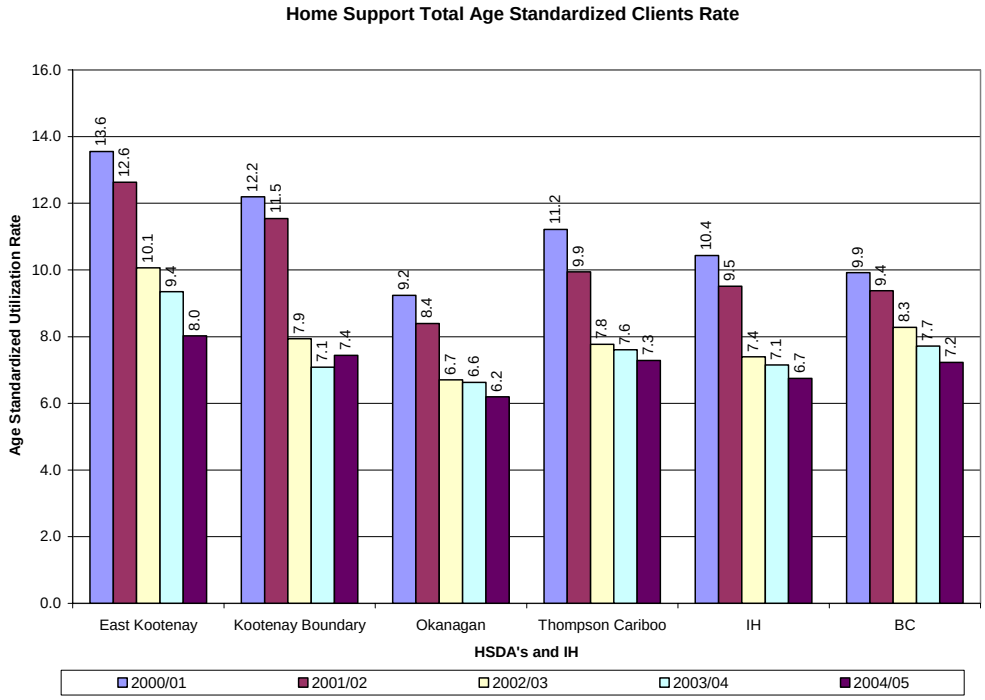


Figure 15 Home Support Hours Rate for All Care Levels by HSDA and Fiscal Years, 2001/02 - 2004/05

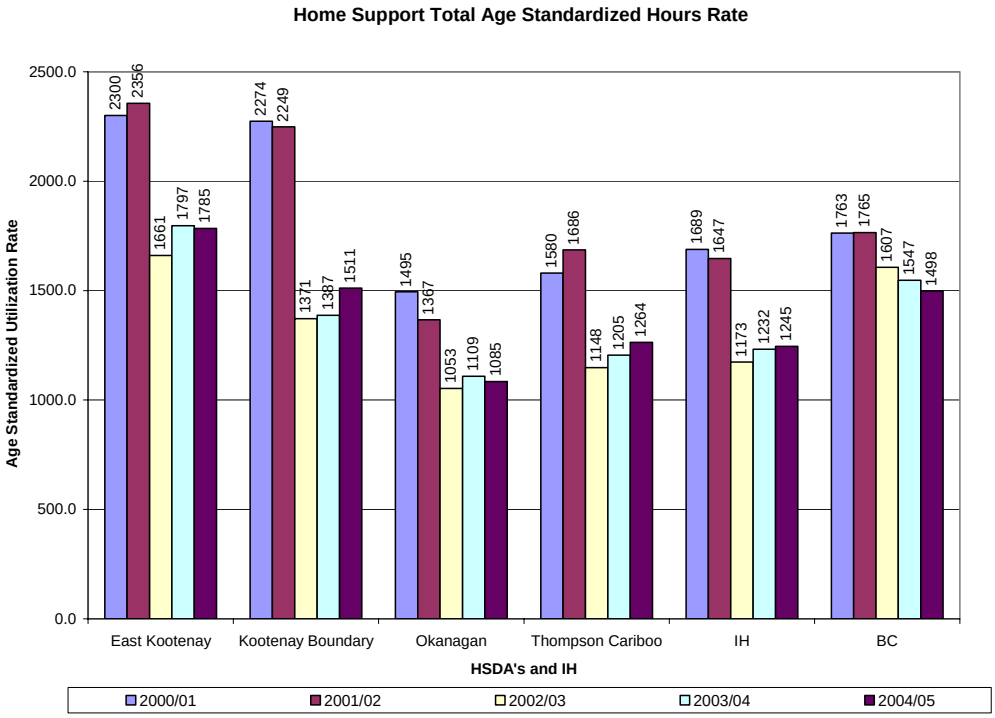


Figure 16 Residential Care Clients' Rate for All Care Levels by HSDA and Fiscal Years, 2001/02 - 2004/05

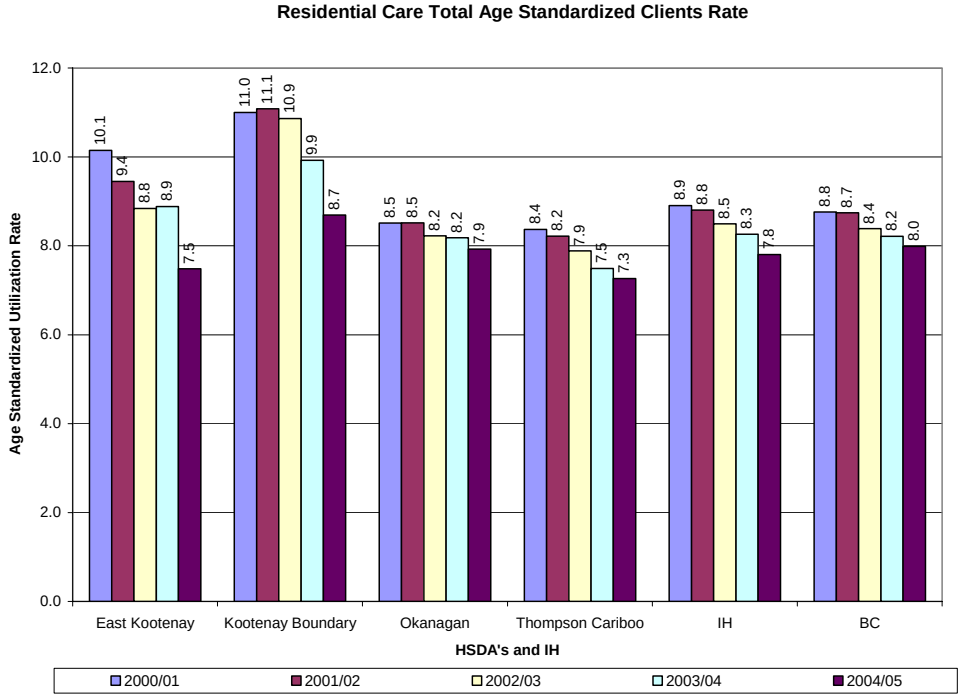


Figure 17 Residential Care Days Rate for All Care Levels by HSDA and Fiscal Years, 2001/02 - 2004/05