| | |
|---|---|
| **From:** | Marchbank, Michael |
| **To:** | Schroeder, Tracey |
| **Subject:** | FW: Data Request |
| **Date:** | Thursday, October 29, 2015 2:48:11 PM |
| **Attachments:** | Review of Fraser Health Other Bed Utilization.pdf |

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**From:** Hare, Kevin
**Sent:** Tuesday, July 07, 2015 11:59 PM
**To:** Marchbank, Michael
**Subject:** Data Request

Michael,

As requested here is the analysis of the other beds (inappropriate locations). Please let me know if there are questions and thanks for the opportunity to be involved in the analysis and review.

Regards,

Kevin Hare, BSN, RN, MBA
Executive Director – Clinical Effectiveness and Quality

Fraser Health - Central City
Suite 400 - 13450 102nd Avenue
Surrey, BC V3T 0H1

Desk – 604-930-5401 ext 768432
Cell - 778-968-0396
Kevin.hare@fraserhealth.ca
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Assistant: Nicole Hassan
Desk – 604-587-4675
Nicole.hassan@fraserhealth.ca

# Review of Fraser Health Other Bed Utilization (Inappropriate Locations)

Simple Review and Analysis of the Inappropriate Location Data

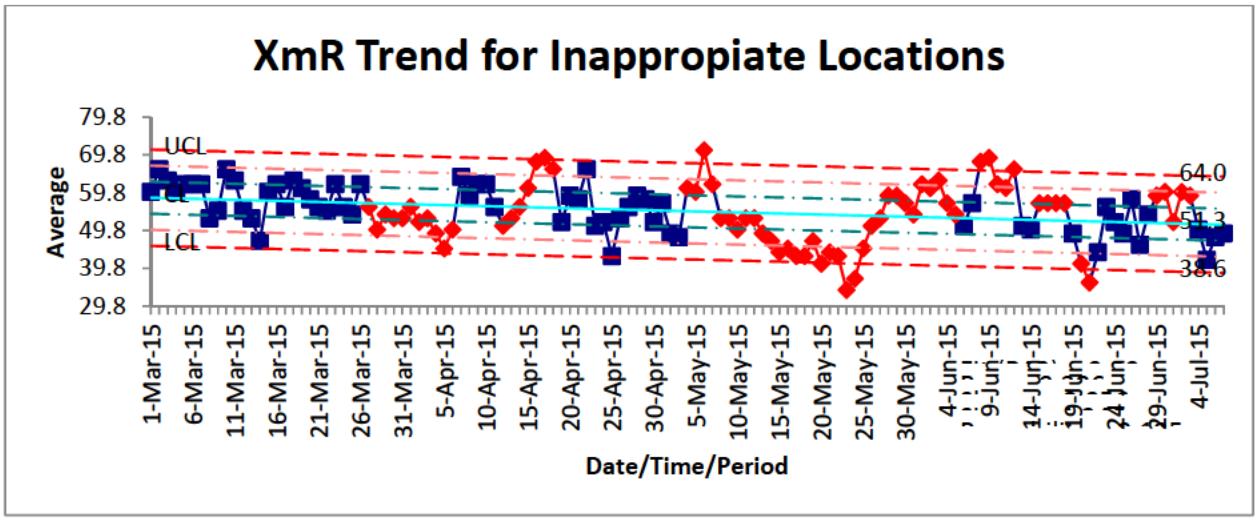
Review completed by Kevin Hare

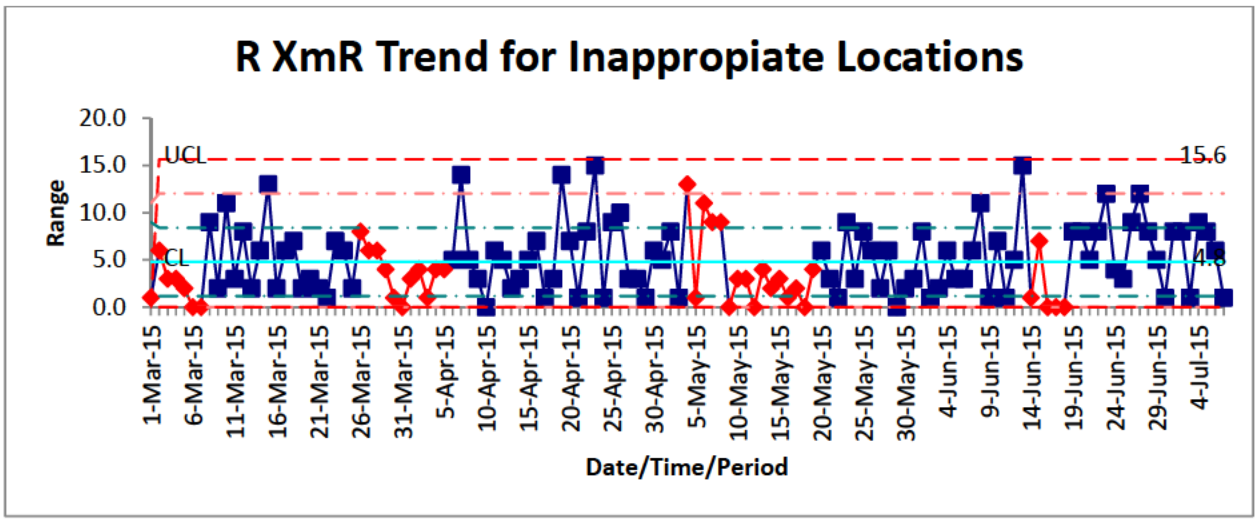
Based on the review of the data of the past 4 months there were a total of 6718 inappropriate locations used in Fraser Health. 5 sites (ARH, LMH, RCH, RMH, and SMH) generated a utilization rate of 92% of those locations. XmR analyses was employed to evaluate for trends and shifts in the data sets and determine what the system will continue to utilize if all conditions remain equal. Based on the XmR analysis there was a significant shift and then a trend to decreased utilization of inappropriate locations from May 5 to May 25, 20015. The system then shifted again after May 25, 2015 back to the mean, indicating a return to the utilization of the normal pattern of inappropriate locations by the system. If all conditions remain equal the system will continue to utilize a high of 64 inappropriate locations, a low of 39, and a mean of 52 daily across Fraser Health. The utilization of inappropriate locations is very consistent as the data set only exceeds the control limits 6 times in a four month period. This is classified as an in control stable system.

If we were going to look at reducing the number of inappropriate locations, based on the current utilization and volume that this be utilized, it would be a recommendation that this be approached as a staged closure over several weeks. This staged closure would allow for system normalization and avoid batching, backlogs, and bottlenecks which can significantly increase the strain on the system and the resources within that system.

| | Other Bed utilization* | Other Bed Utilization | Other Bed Utilization | Other Bed Utilization | Mean | Median | 4 month Total | Sites Percentage of Total |
|---|---|---|---|---|---|---|---|---|
| | March 2015 | April 2015 | May 2015 | June 2015 | | | | |
| FH | 1798 | 1691 | 1565 | 1664 | 55 | 56 | 6718 | |
| ARH | 672 | 651 | 417 | 423 | 18 | 19 | 2163 | 32% |
| BGH | 6 | 48 | 43 | 36 | 1 | 1 | 133 | 1% |
| CGH | 29 | 35 | 40 | 27 | 1 | 1 | 131 | 2% |
| DH | 2 | 4 | 10 | 4 | 0 | 0 | 20 | .3% |
| ERH | 2 | 6 | 2 | 3 | 0 | 0 | 13 | .2% |
| FCH | 18 | 5 | 9 | 5 | 0 | 0 | 37 | .6% |
| LMH | 98 | 93 | 87 | 82 | 3 | 3 | 360 | 5% |
| MMH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PAH | 53 | 68 | 49 | 47 | 2 | 1 | 217 | 3% |
| RCH | 567 | 445 | 598 | 722 | 24 | 19 | 2332 | 35% |
| RMH | 102 | 78 | 81 | 66 | 3 | 3 | 327 | 5% |
| SMH | 249 | 258 | 229 | 249 | 8 | 8 | 985 | 15% |

*Definition Overflow – Other: A location that is not defined for patient care. Example: lounge, tub room, and hallway
Overflow – OCP: A location used for pt. only when designated by the Over Capacity Protocol
Overflow – Other and Overflow –OCP are combined for to create inappropriate location reporting structure.


XmR Trend for Inappropiate Locations
Average
79.8
69.8
59.8
49.8
39.8
29.8
UCL
CL
LCL
64.0
51.3
38.6
1-Mar-15
6-Mar-15
11-Mar-15
16-Mar-15
21-Mar-15
26-Mar-15
31-Mar-15
5-Apr-15
10-Apr-15
15-Apr-15
20-Apr-15
25-Apr-15
30-Apr-15
5-May-15
10-May-15
15-May-15
20-May-15
25-May-15
30-May-15
4-Jun-15
9-Jun-15
14-Jun-15
19-Jun-15
24-Jun-15
29-Jun-15
4-Jul-15
Date/Time/Period


R XmR Trend for Inappropiate Locations
Range
20.0
15.0
10.0
5.0
0.0
UCL
CL
15.6
4.8
1-Mar-15
6-Mar-15
11-Mar-15
16-Mar-15
21-Mar-15
26-Mar-15
31-Mar-15
5-Apr-15
10-Apr-15
15-Apr-15
20-Apr-15
25-Apr-15
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20-May-15
25-May-15
30-May-15
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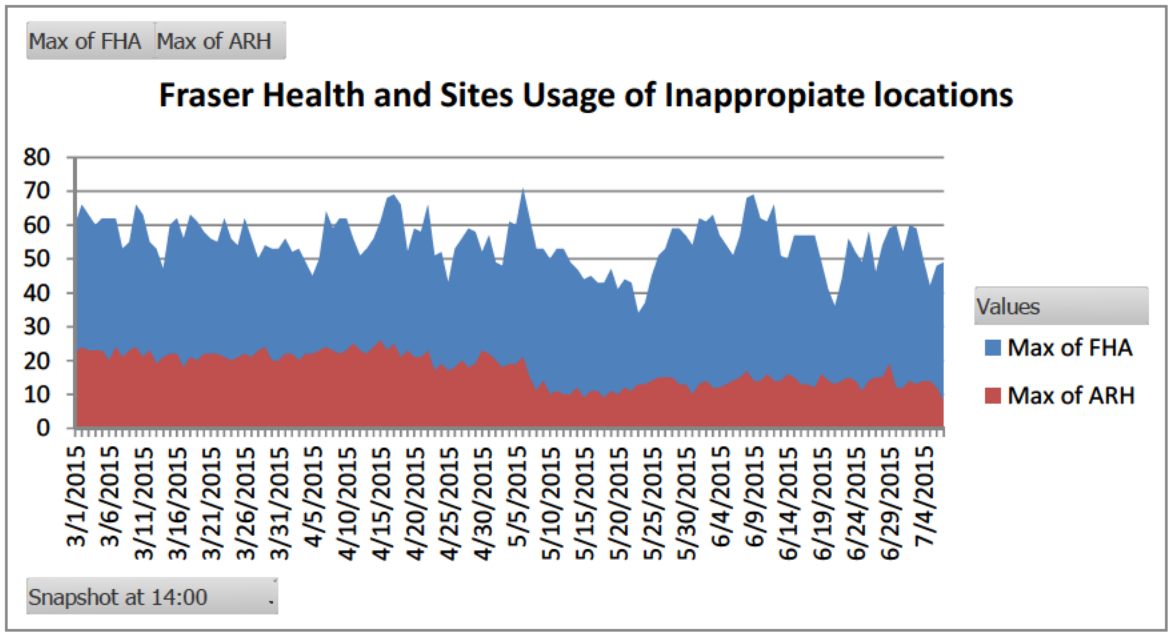
29-Jun-15
4-Jul-15
Date/Time/Period


Max of FHA
Max of ARH
Fraser Health and Sites Usage of Inappropiate locations
80
70
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0
3/1/2015
3/6/2015
3/11/2015
3/16/2015
3/21/2015
3/26/2015
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4/10/2015
4/15/2015
4/20/2015
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5/25/2015
5/30/2015
6/4/2015
6/9/2015
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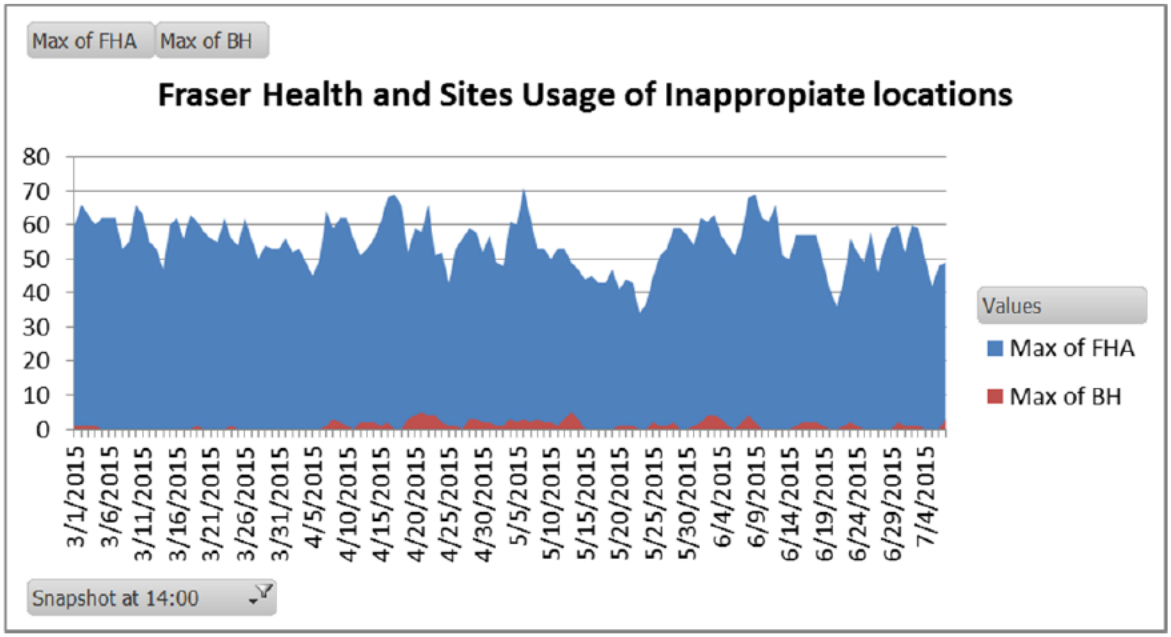
6/24/2015
6/29/2015
7/4/2015
Values
Max of FHA
Max of ARH
Snapshot at 14:00


Max of FHA
Max of BH
Fraser Health and Sites Usage of Inappropiate locations
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70
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3/1/2015
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3/11/2015
3/16/2015
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3/26/2015
3/31/2015
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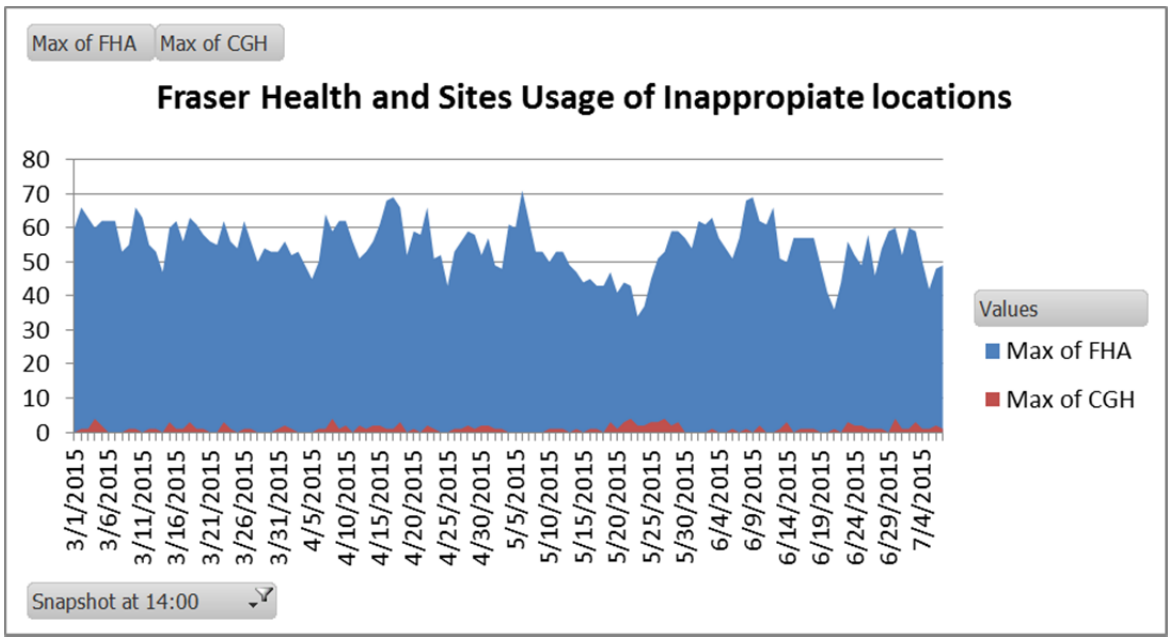
7/4/2015
Values
Max of FHA
Max of BH
Snapshot at 14:00


Max of FHA
Max of CGH
Fraser Health and Sites Usage of Inappropiate locations
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3/6/2015
3/11/2015
3/16/2015
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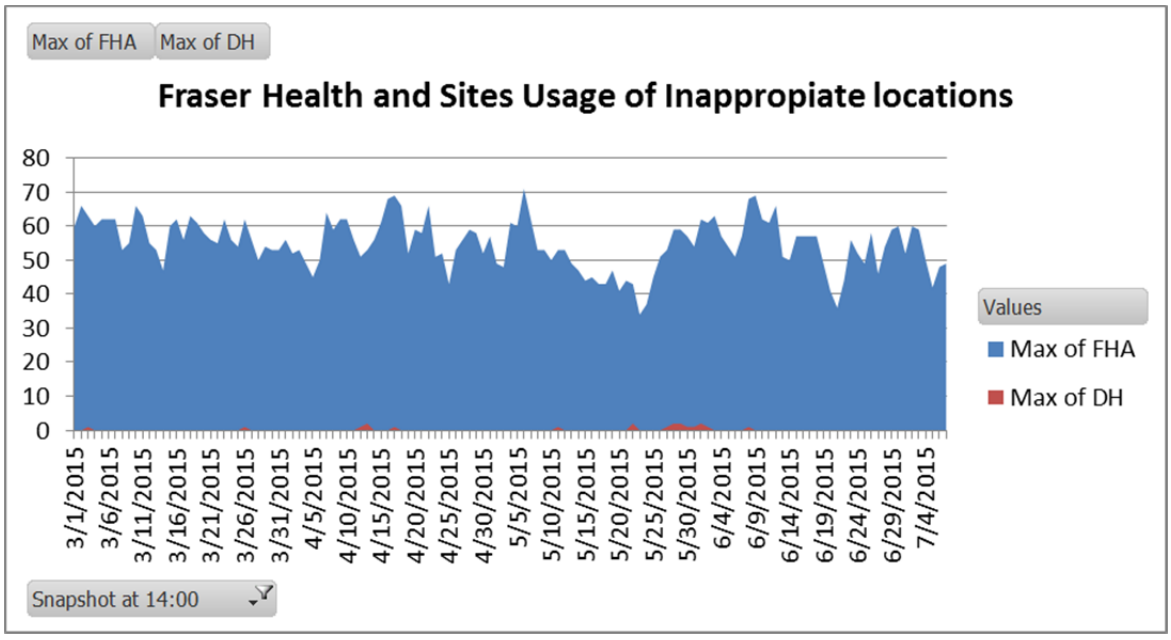
7/4/2015
Values
Max of FHA
Max of CGH
Snapshot at 14:00


Max of FHA
Max of DH
Fraser Health and Sites Usage of Inappropiate locations
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3/6/2015
3/11/2015
3/16/2015
3/21/2015
3/26/2015
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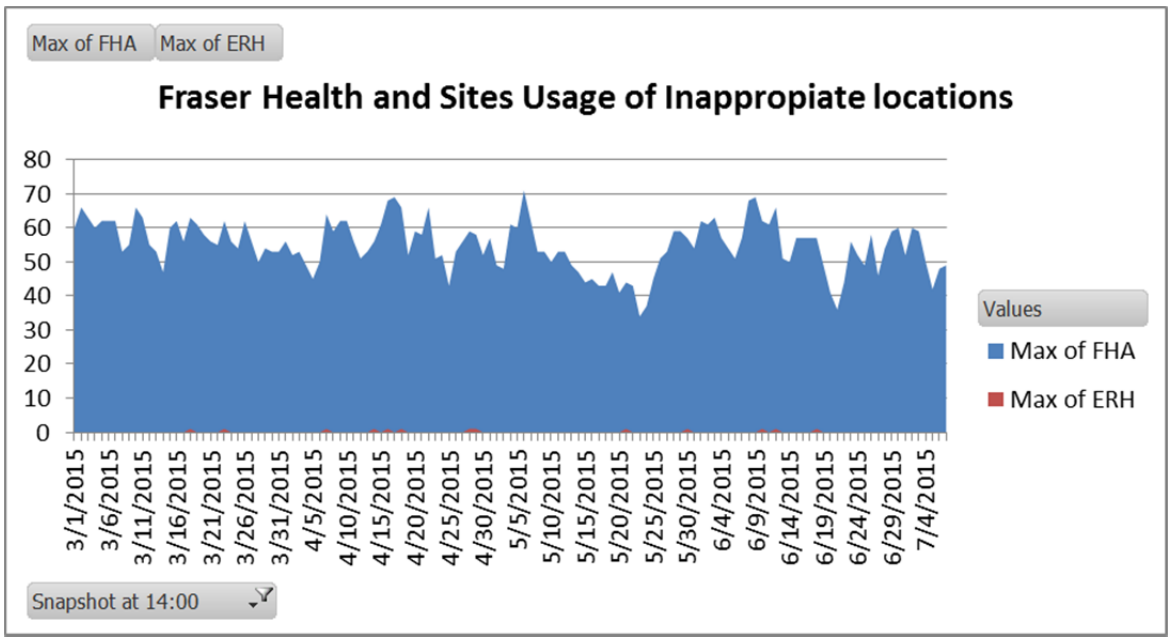
7/4/2015
Values
Max of FHA
Max of DH
Snapshot at 14:00


Max of FHA
Max of ERH
Fraser Health and Sites Usage of Inappropiate locations
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3/11/2015
3/16/2015
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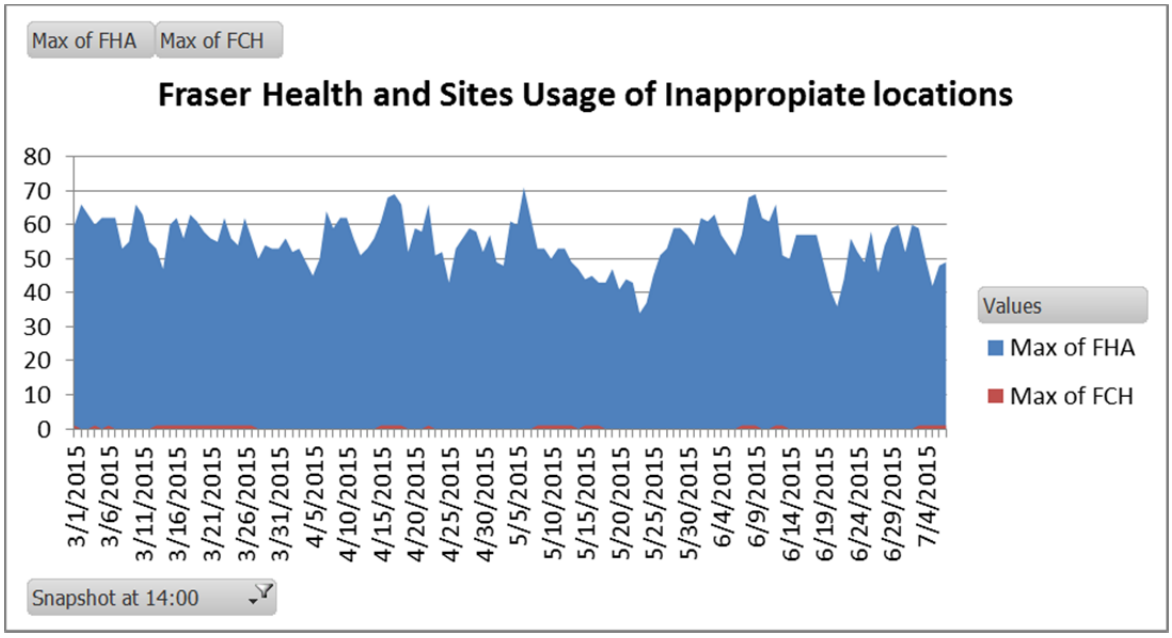
Values
Max of FHA
Max of ERH
Snapshot at 14:00


Max of FHA
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Fraser Health and Sites Usage of Inappropiate locations
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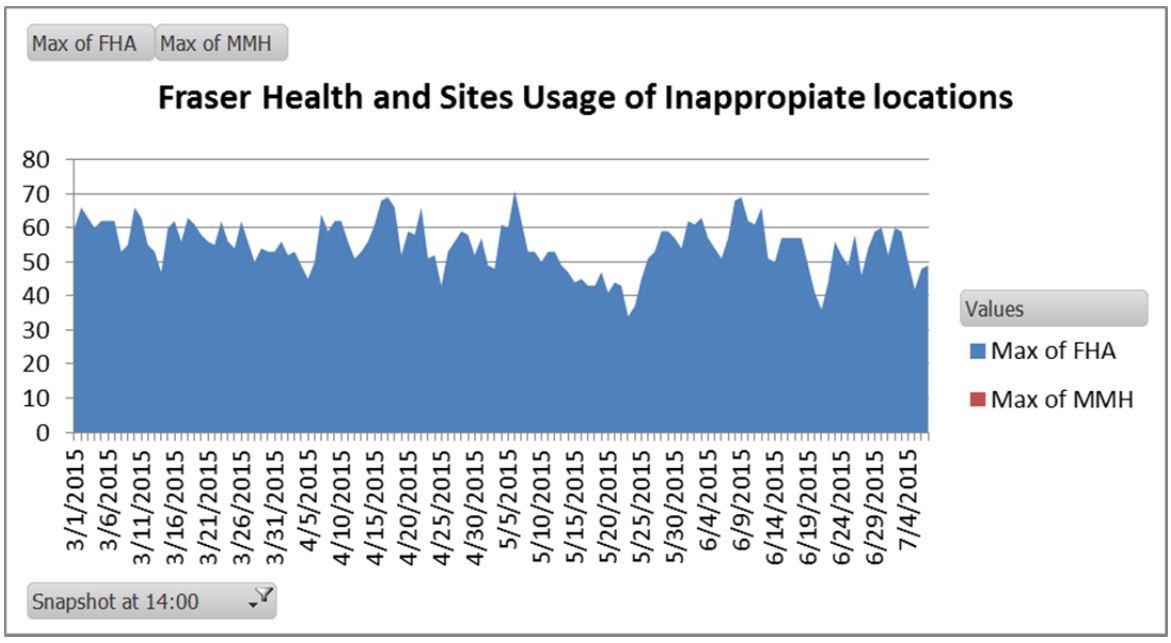
Values
Max of FHA
Max of FCH
Snapshot at 14:00


Max of FHA
Max of MMH
Fraser Health and Sites Usage of Inappropiate locations
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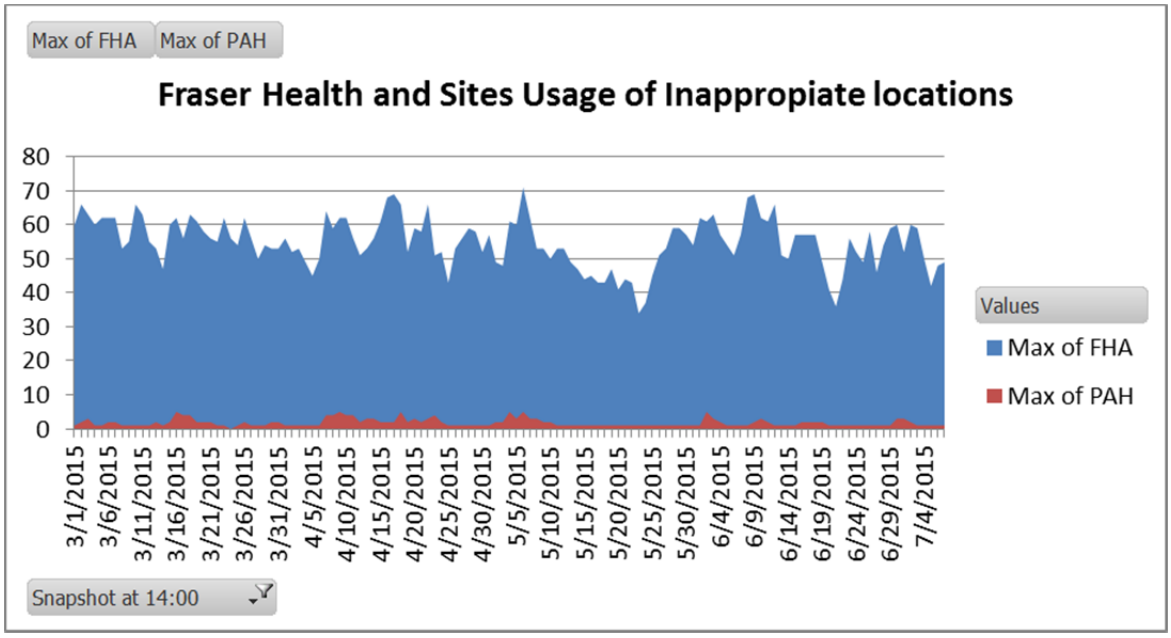
Values
Max of FHA
Max of MMH
Snapshot at 14:00


Max of FHA
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Fraser Health and Sites Usage of Inappropiate locations
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Values
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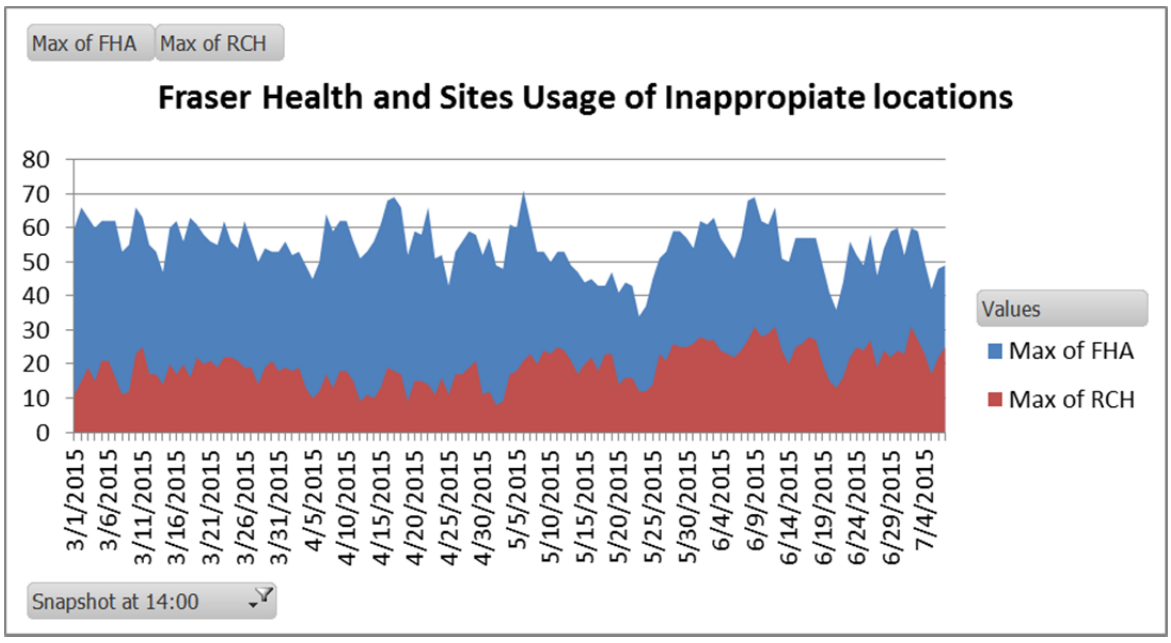
Max of PAH
Snapshot at 14:00


Max of FHA
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Fraser Health and Sites Usage of Inappropiate locations
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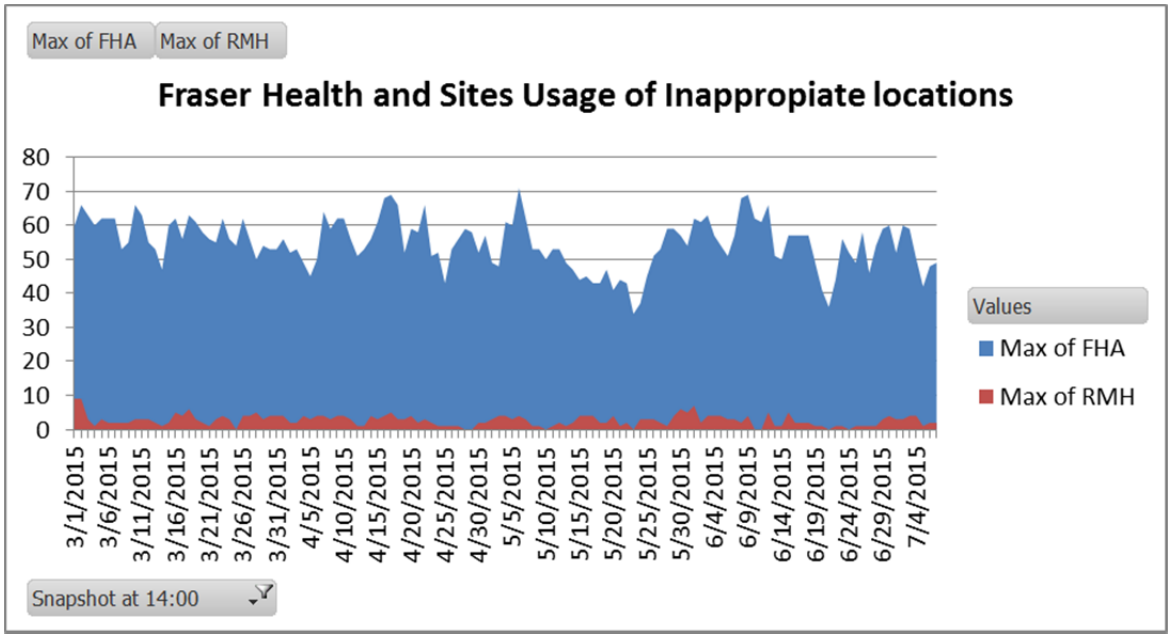
Values
Max of FHA
Max of RCH
Snapshot at 14:00


Max of FHA
Max of RMH
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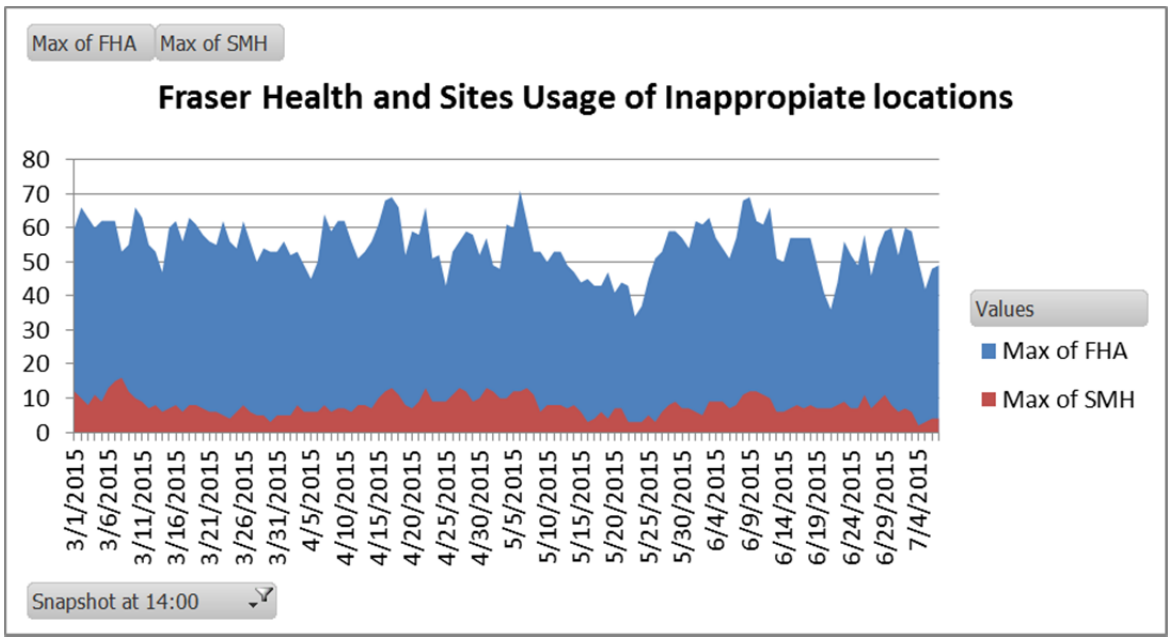
Values
Max of FHA
Max of RMH
Snapshot at 14:00


Max of FHA
Max of SMH
Fraser Health and Sites Usage of Inappropiate locations
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6/24/2015
6/29/2015
7/4/2015
Values
Max of FHA
Max of SMH
Snapshot at 14:00

**From:** Marchbank, Michael
**To:** Schroeder, Tracey
**Subject:** FW: Other Bed Utilization
**Date:** Thursday, October 29, 2015 2:49:40 PM

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**From:** Hare, Kevin
**Sent:** Wednesday, June 24, 2015 4:24 PM
**To:** Marchbank, Michael
**Subject:** RE: Other Bed Utilization

Michael,

I have reviewed the reporting logic that I have provided to you and I have followed the logic that we use for the public score card and reports to the MoH. The logic includes OF-other plus OF-OCP, the inclusion of the OCP was a request from the MoH (I believe in the 150 challenge) as they know that you do not clear these temporary locations and use as capacity. I wanted to make sure that if you carry these numbers forward in conversation that there was alignment with the logic and reporting that we currently have out for consumption.

I can pull out the OCP locations if desired.

Regards,

Kevin Hare, BSN, RN, MBA
Executive Director – Clinical Effectiveness and Quality

---

**From:** Marchbank, Michael
**Sent:** Tuesday, June 23, 2015 4:09 AM
**To:** Hare, Kevin
**Subject:** Re: Other Bed Utlization

Thanks Kevin it looks good. I will be interested to see June as my perception is it has dropped considerably??

Michael

Sent from my iPhone

On Jun 22, 2015, at 8:11 PM, Hare, Kevin <Kevin.Hare@fraserhealth.ca> wrote:

> Mr. Marchbank,
>
> As discussed here is the analysis of the other bed utilization in Fraser health and each site (March, April, May, June pending). The analysis is not completed as I need to include June 2015 and then add the comments of the analysis. I want to just get you

this first draft to make sure that I provide you a view that made since for your review and future discussions.

Please let me know if there are questions.

Regards,

*Kevin Hare* - BSN, RN, MBA
Executive Director – Clinical Effectiveness and Quality

Fraser Health
Central City Tower
13450 - 102nd Ave, Surrey, BC V3T 0H1

Mobile: 778-968-0396

Kevin.hare@fraserhealth.ca



<Review of Fraser Health Other Bed Utilization.pdf>

| | |
|---|---|
| **From:** | Marchbank, Michael |
| **To:** | Schroeder, Tracey |
| **Subject:** | FW: Other Bed Utlization |
| **Date:** | Thursday, October 29, 2015 2:49:39 PM |
| **Attachments:** | Review of Fraser Health Other Bed Utilization.pdf |

---

**From:** Hare, Kevin
**Sent:** Monday, June 22, 2015 5:11 PM
**To:** Marchbank, Michael
**Subject:** Other Bed Utlization

Mr. Marchbank,

As discussed here is the analysis of the other bed utilization in Fraser health and each site (March, April, May, June pending). The analysis is not completed as I need to include June 2015 and then add the comments of the analysis. I want to just get you this first draft to make sure that I provide you a view that made since for your review and future discussions.

Please let me know if there are questions.

Regards,

*Kevin Hare* - BSN, RN, MBA
Executive Director – Clinical Effectiveness and Quality

Fraser Health
Central City Tower
13450 - 102nd Ave, Surrey, BC V3T 0H1

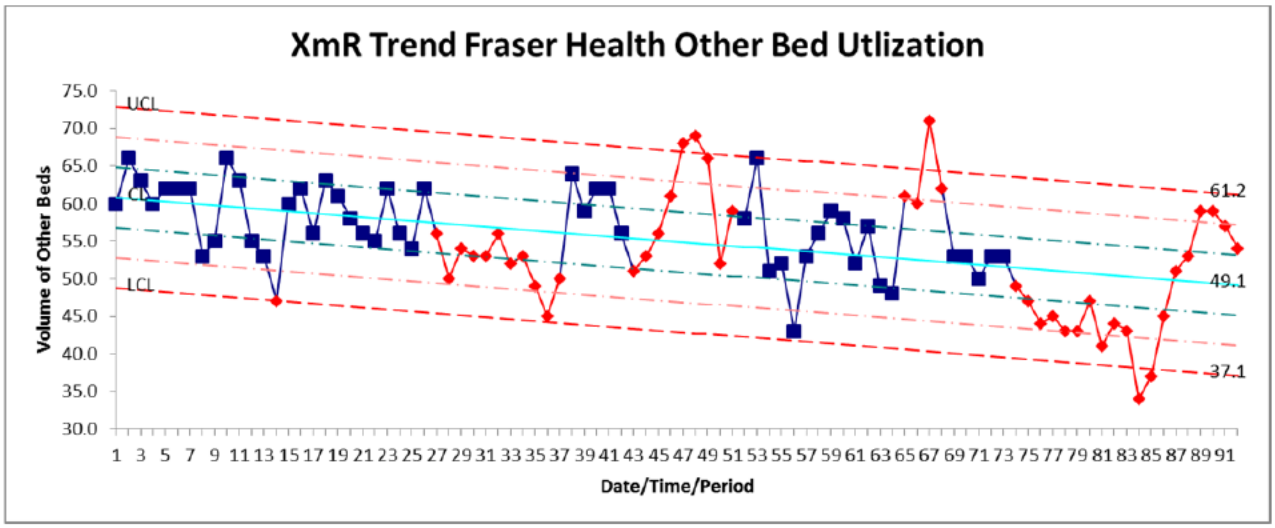
Mobile: 778-968-0396

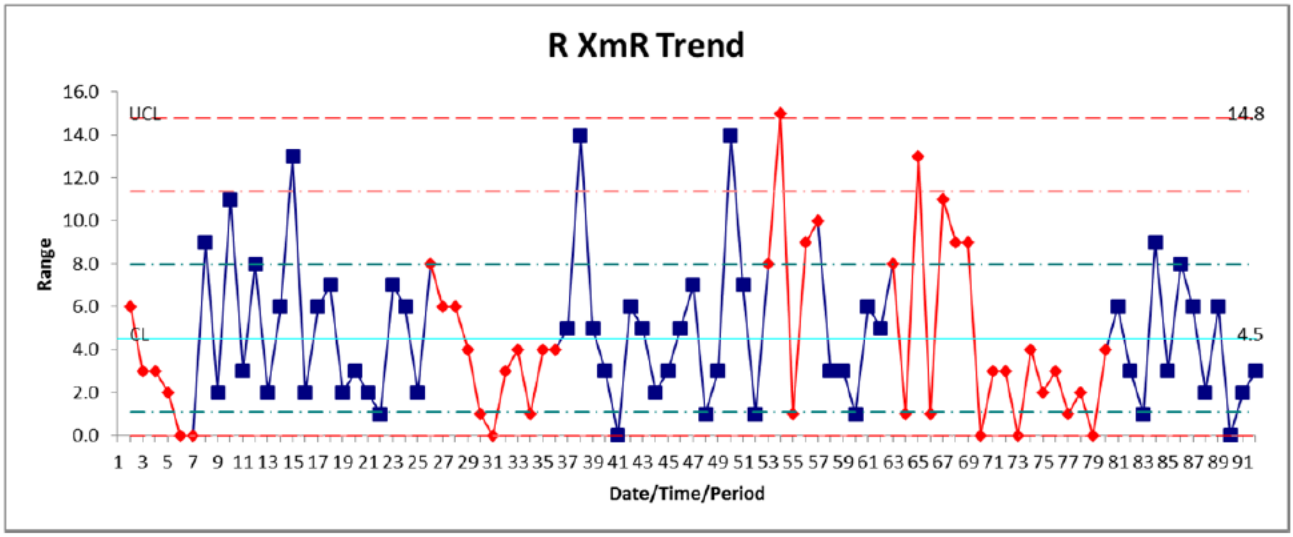
Kevin.hare@fraserhealth.ca

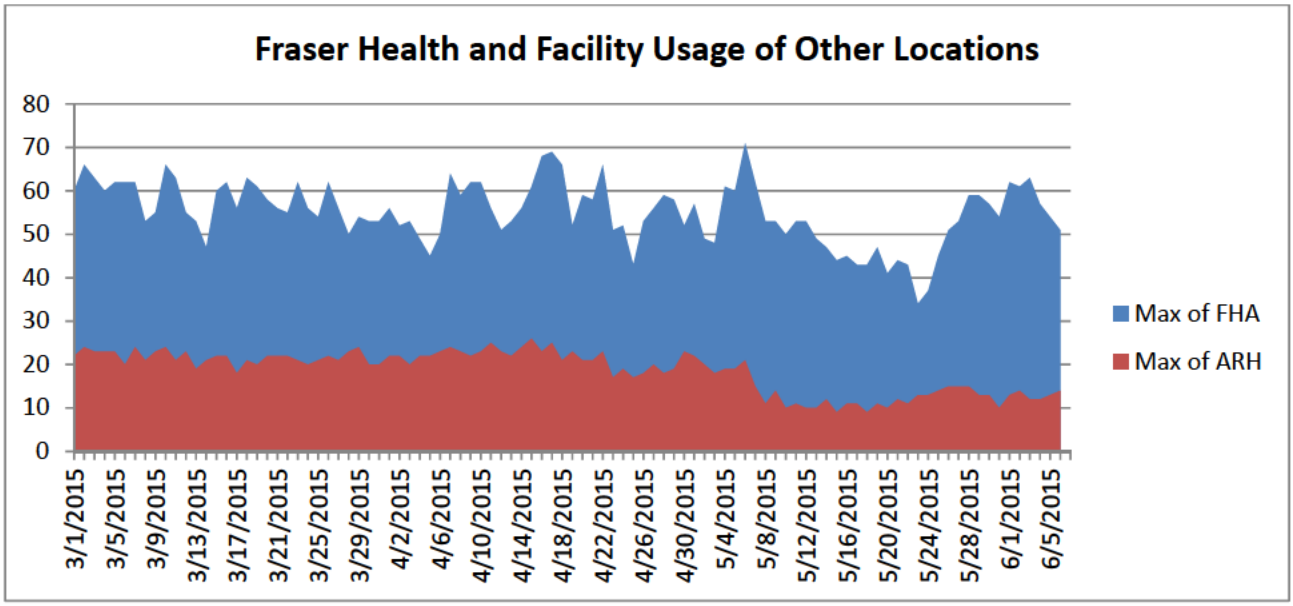
# Review of Fraser Health Other Bed Utilization

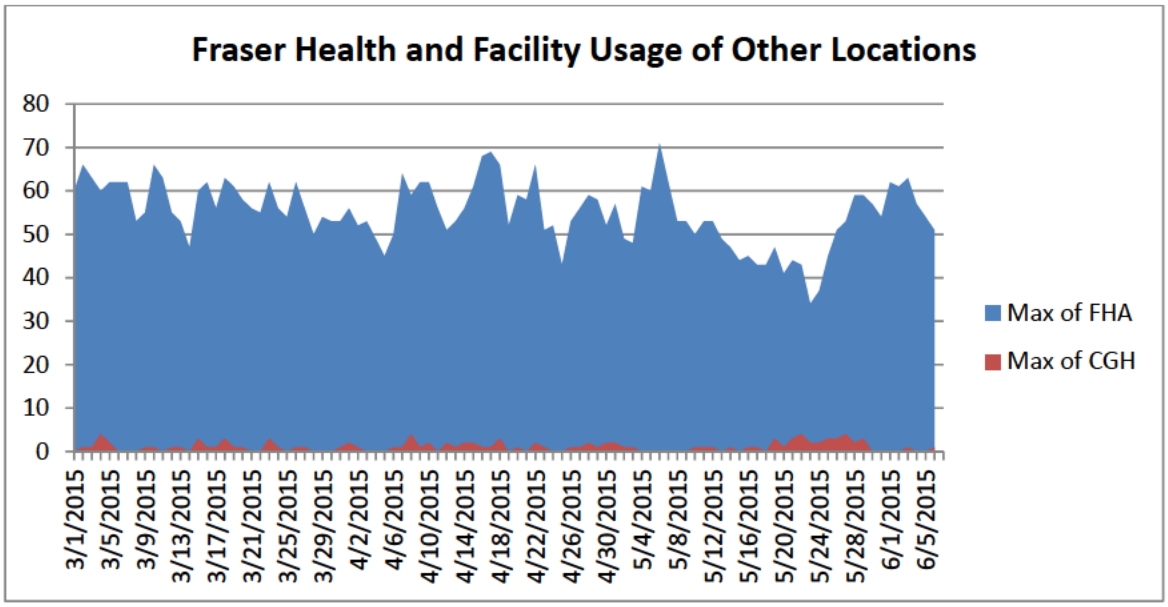
| | Other Bed utilization* | Other Bed Utilization | Other Bed Utilization | Other Bed Utilization | Mean | Median | 4 month Total |
|---|---|---|---|---|---|---|---|
| | March 2015 | April 2015 | May 2015 | June 2015 | | | |
| FH | 1798 | 1691 | 1565 | | 54 | 55 | 5054 |
| ARH | 672 | 651 | 417 | | 19 | 21 | 1740 |
| BGH | 6 | 48 | 43 | | 1 | 1 | 97 |
| CGH | 29 | 35 | 40 | | 1 | 1 | 104 |
| DH | 2 | 4 | 10 | | 0 | 0 | 16 |
| ERH | 2 | 6 | 2 | | 0 | 0 | 10 |
| FCH | 18 | 5 | 9 | | 0 | 0 | 32 |
| LMH | 98 | 93 | 87 | | 3 | 3 | 278 |
| MMH | 0 | 0 | 0 | | 0 | 0 | 0 |
| PAH | 53 | 68 | 49 | | 2 | 1 | 170 |
| RCH | 567 | 445 | 598 | | 18 | 18 | 1610 |
| RMH | 102 | 78 | 81 | | 3 | 3 | 261 |
| SMH | 249 | 258 | 229 | | 8 | 8 | 736 |

*Definition <u>Overflow – Other:</u> A location that is not defined for patient care. Example: lounge, tub room, and hallway




R XmR Trend
UCL
14.8
CL
4.5
Range
Date/Time/Period


Fraser Health and Facility Usage of Other Locations
Max of FHA
Max of ARH


Fraser Health and Facility Usage of Other Locations
80
70
60
50
40
30
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10
0
3/1/2015
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3/9/2015
3/13/2015
3/17/2015
3/21/2015
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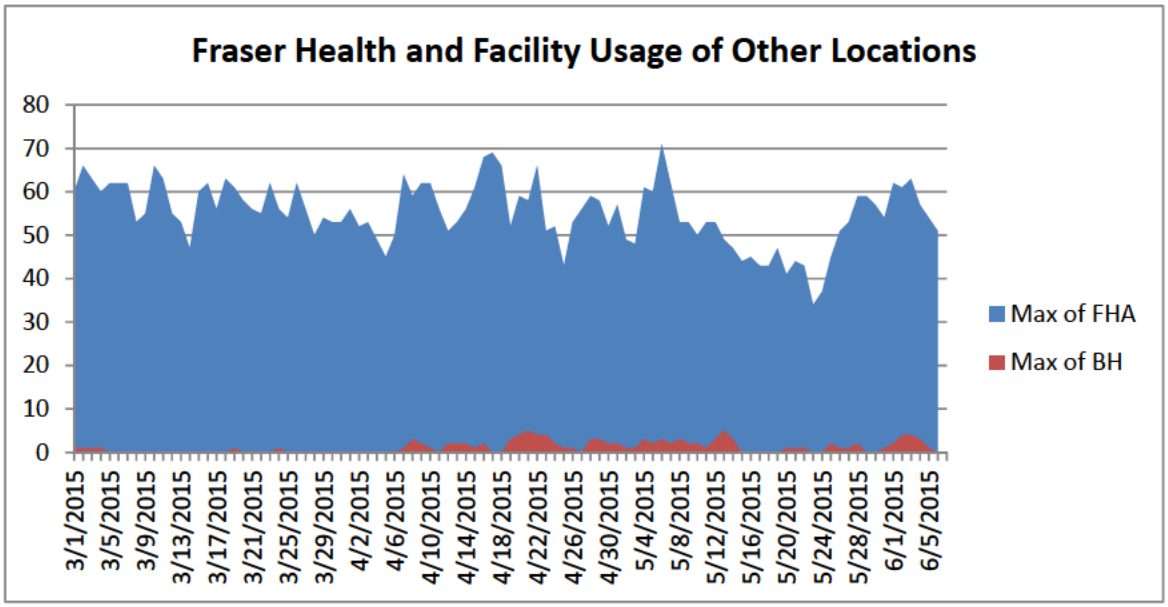
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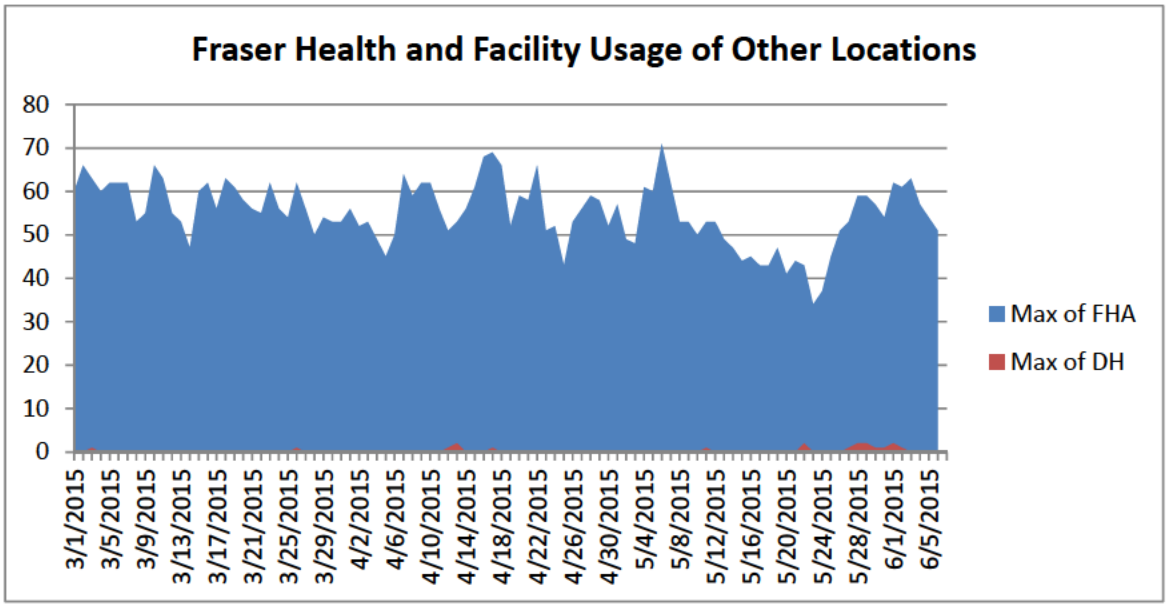
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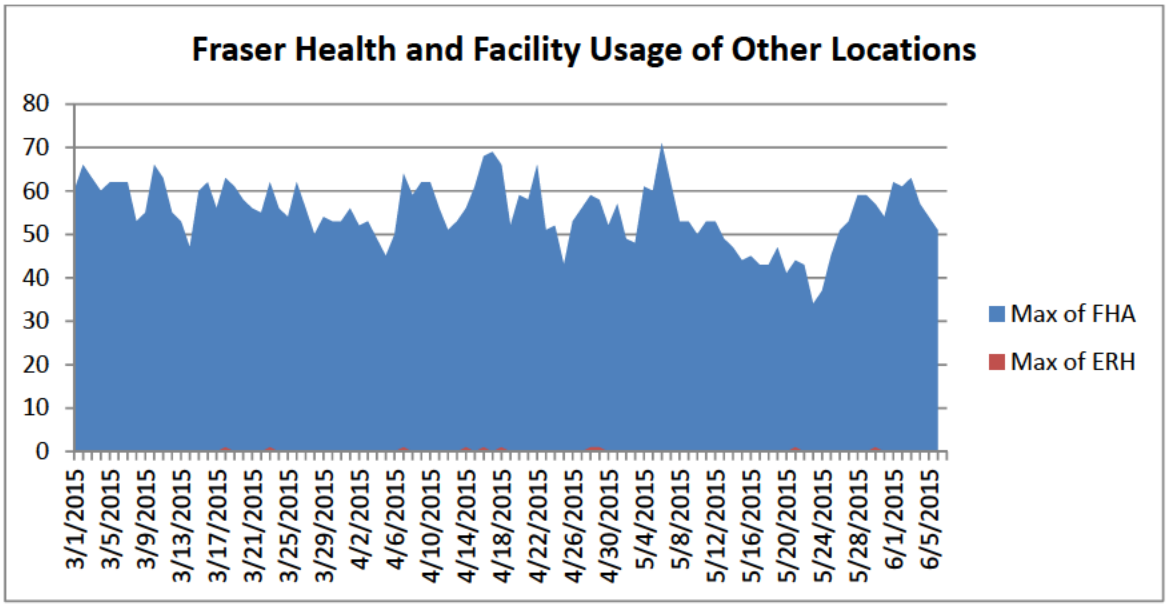
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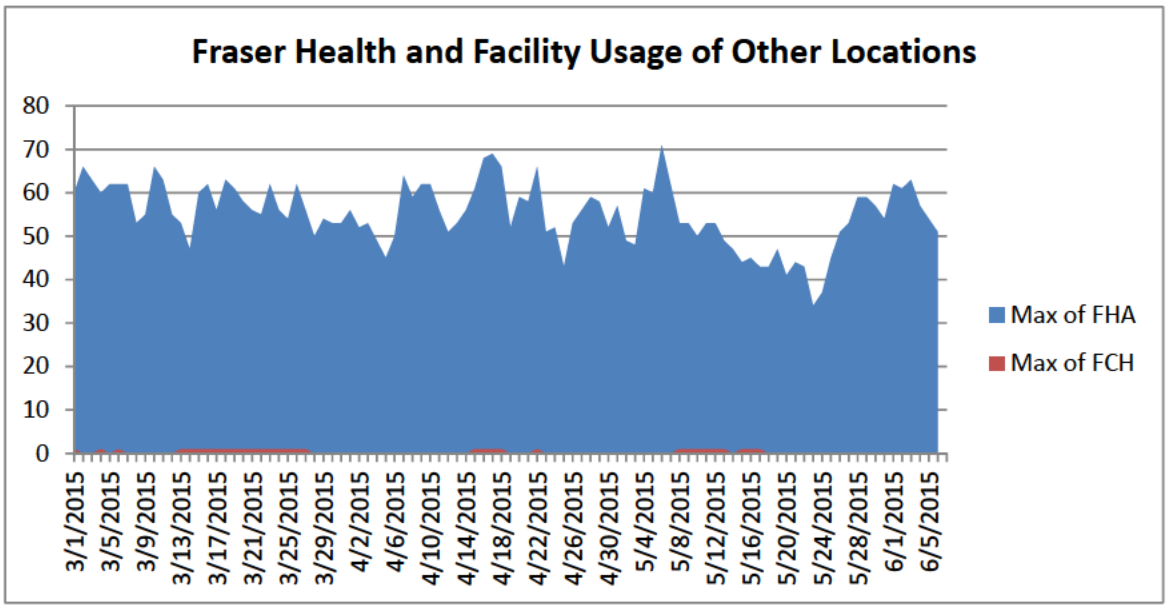
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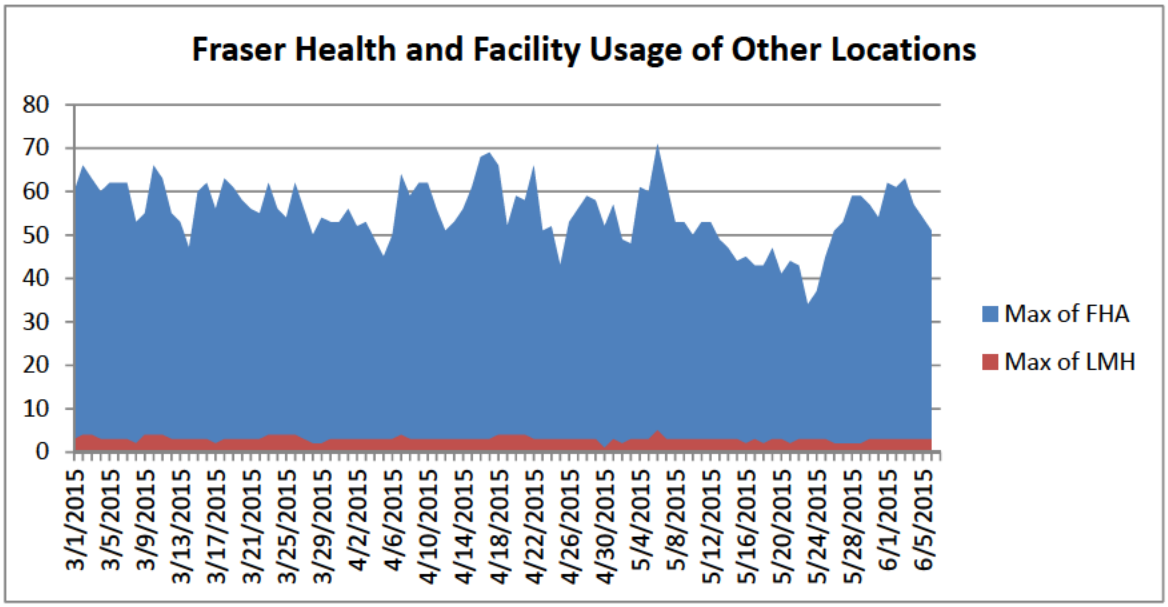
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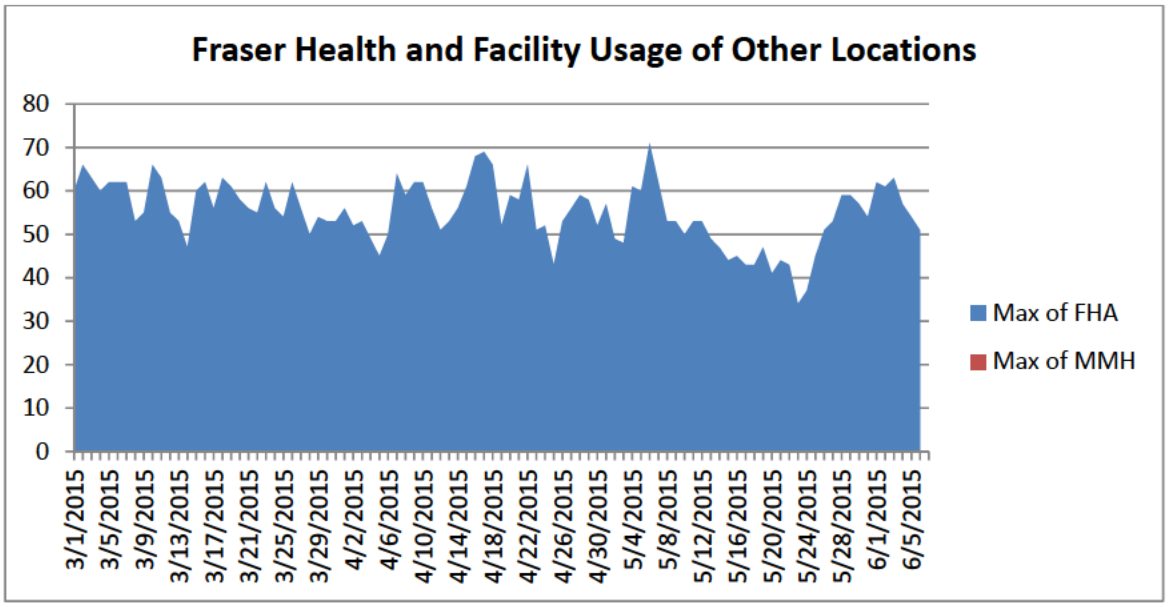
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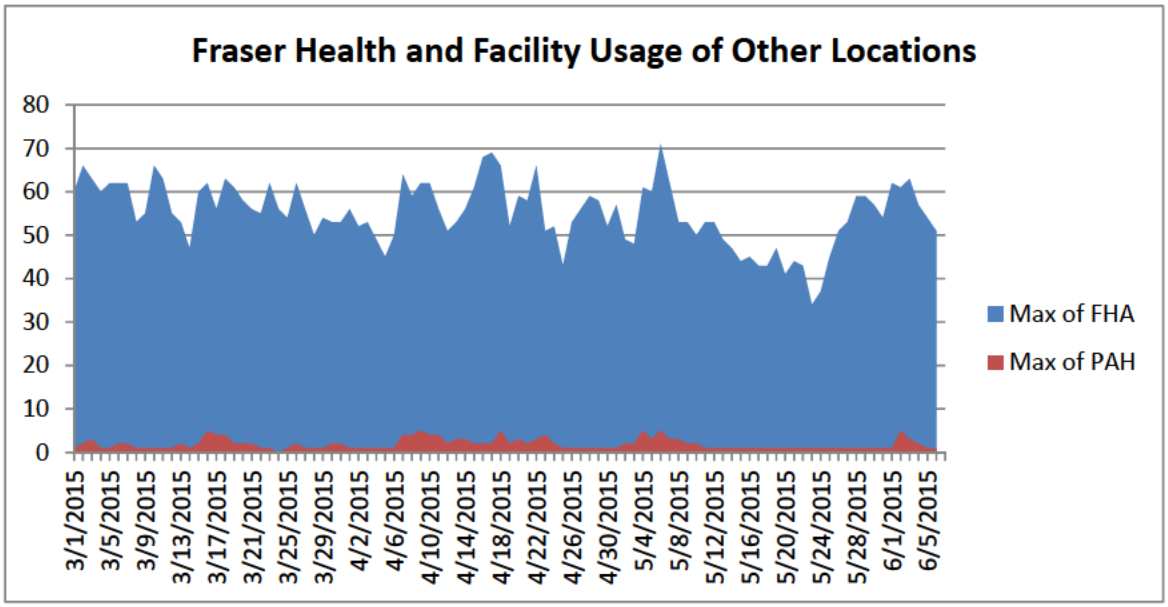
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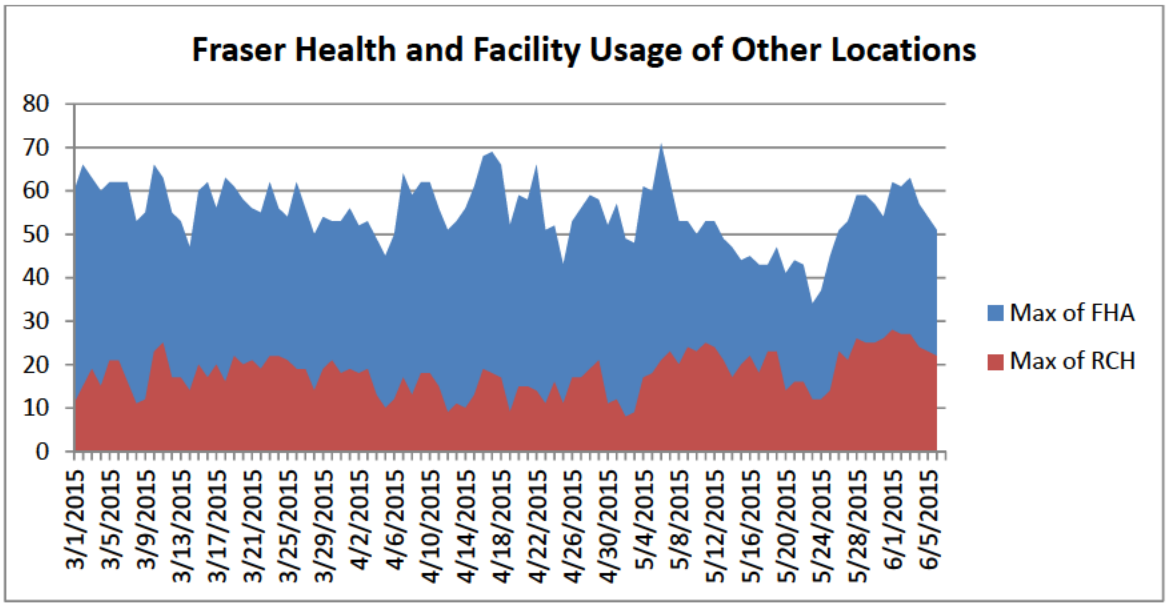
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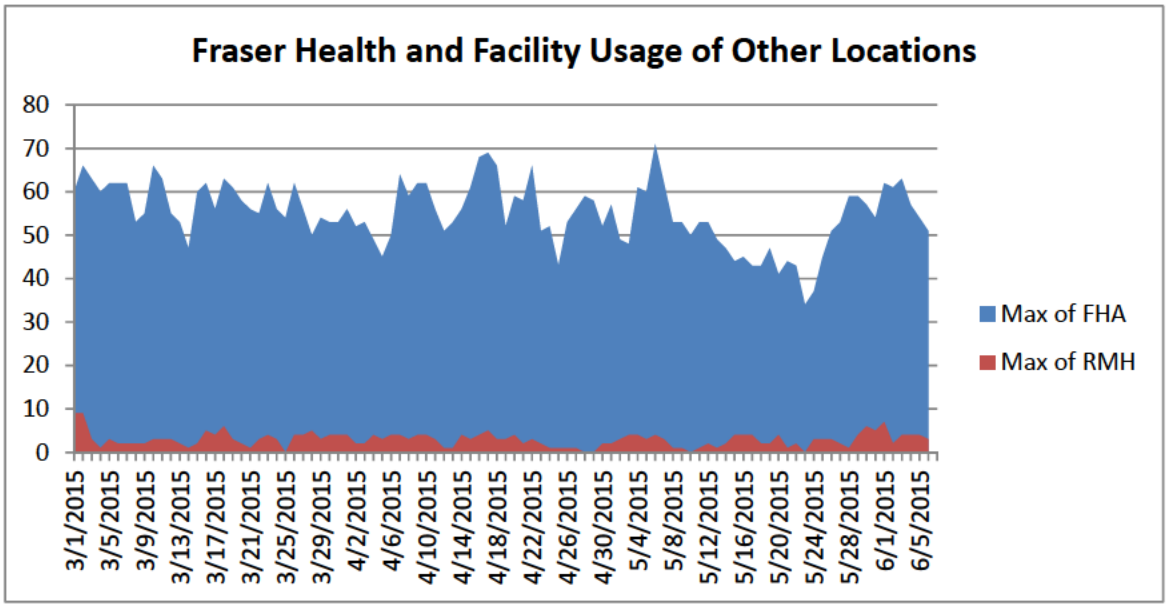
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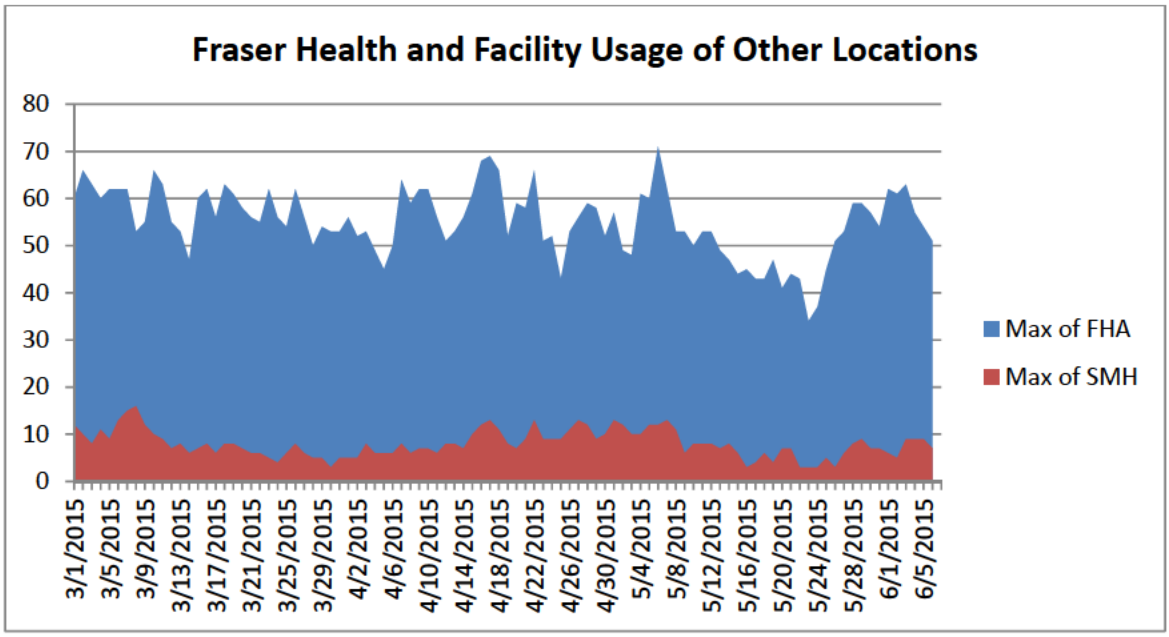
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**From:** Marchbank, Michael
**To:** Liggett, Brenda
**Subject:** Fwd: Priority Strategies
**Date:** Friday, February 27, 2015 4:15:49 PM
**Attachments:** Actions to decrease patients awaiting inpatient beds- Feb 19 DRAFT.doc
ATT00001.htm

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As discussed. The PCC # was reduced by a further S.13(1)

Sent from my iPhone

Begin forwarded message:

**From:** "Irwin, Tracy" <Tracy.Irwin@fraserhealth.ca>
**Date:** February 19, 2015 at 4:41:45 PM PST
**To:** "Hart, Colleen" <Colleen.Hart@fraserhealth.ca>, "Dixon, Lois" <Lois.Dixon@fraserhealth.ca>, "Giglio, Vivian" <Vivian.Giglio@fraserhealth.ca>, "Letwin, Shallen Dr." <Shallen.Letwin@fraserhealth.ca>, "Marchbank, Michael" <Michael.Marchbank@fraserhealth.ca>
**Subject: RE: Priority Strategies**

Hi all -
I am attaching an updated draft of the Priority Strategies document.

Changes of note:
* Finance has now provided costing information. Finance costing estimates replace the order-of-magnitude estimates provided by operational leaders, which were used in previous drafts.
* Expanded PCC Coverage has been scaled back. Priority is being given to adding coverage on units that have no regular weekday coverage, and no weekends (days).

Thanks
Tracy

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**From:** Irwin, Tracy
**Sent:** Wednesday, February 18, 2015 3:53 PM
**To:** Irwin, Tracy; Hart, Colleen; Dixon, Lois; Giglio, Vivian; Letwin, Shallen Dr.; Marchbank, Michael
**Subject:** RE: Priority Strategies

I am attaching the next draft of the Priority Strategies document.

Changes of note:
* Investment costs and bed equivalent strategies are summarized in the first section S.13(1)

S.13(1)

* Following discussions on the first draft, some additional resources have been included . Most significant is the increased investment in expanded PCC coverage. Shallen has proposed that the Clinical VPs may further discuss a phased approach to these positions.

* Finance is working on more accurate costing which will be incorporated into the draft when available (likely tomorrow). In the meantime, order of magnitude estimates have been provided.

Thanks

Tracy

**Tracy Irwin**
Executive Director,
Access & Capacity Optimization
Chilliwack General Hospital and Community
**Fraser Health Corporate Office**
Suite 400 - Central City Tower
13450 - 102nd Avenue, Surrey, BC V3T 0H1
Cell – (604) 897-0372

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**From:** Irwin, Tracy
**Sent:** February 16, 2015 4:29 PM
**To:** Hart, Colleen; Dixon, Lois; Giglio, Vivian; Letwin, Shallen Dr.; Marchbank, Michael
**Subject:** Priority Strategies

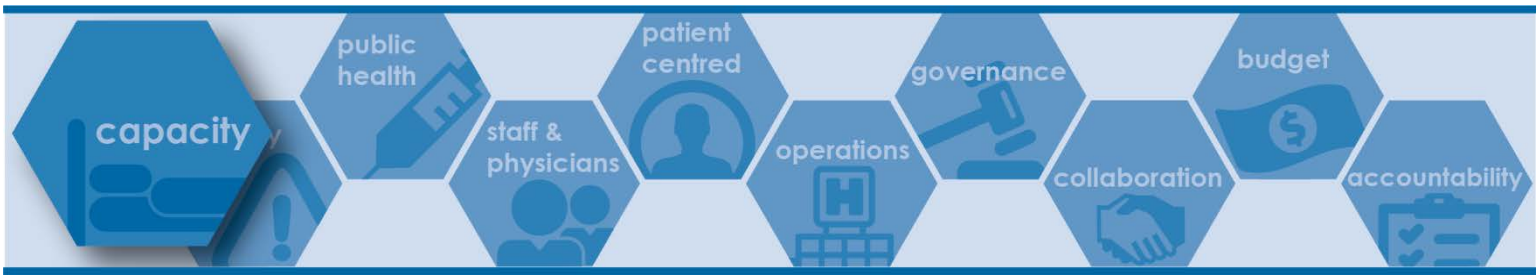
Hi all,
As discussed last Wednesday, I am attaching a draft document "Actions to Reduce Number of Patients Awaiting Inpatient Bed Placement".
This identifies priority strategies to reduce the use of hallway spaces, patient lounges, etc. as well as admitted patients in ER. The wording above is drawn from our Report Card indicator.

Thanks to all for contributing to the document:

- The ED group for participating in a discussion on Thursday to begin the draft
- Keith, Catherine, Val, and Sheila for providing content on some of the specific strategies
- Colleen, Vivian, Lois and Shallen for input on drafts and specific questions.

Please let me know if you have any questions or comments.

Thanks
Tracy




# Shaping our future: capacity

## Actions to Reduce Number of Patients Awaiting Inpatient Bed Placement

**(ER admits + "Other Locations")**

DRAFT

February 19, 2015

## Number of Patients awaiting inpatient bed placement (including Emergency Department)

When hospital occupancy exceeds available inpatient bed capacity, patients often receive care in locations not designed for inpatient care. These typically include:

- treatment spaces in Emergency Departments;
- locations in inpatient units not designed for inpatient care such as treatment rooms, tub rooms, or hallways;
- locations designed for outpatient or other services such as ambulatory care, medical imaging, or surgical daycare.

In each of these locations, care is not ideal from a patient or staff perspective. Further, maintaining high hospital occupancy (e.g., over 95%) is associated with longer lengths of stay and higher risk for errors and adverse events.

Fraser Health's report card tracks our organization's use of these spaces, and sets a target to significantly reduce their use.

This document identifies priority actions to decrease the use of "other locations" (hallways, treatment and tub rooms) for inpatient care. Each of these priorities is aligned with the Strategic and Operational Plan, and addresses needs along the patient journey:

- Preventing avoidable admissions,
- Improving quality and patient flow during acute care episodes, including better care and discharge planning on weekends,
- Increasing community supports to increase weekend hospital discharges.

| Priority | Brief Description | Expected Outcomes (* denotes report card indicator) | Investment Required |
|---|---|---|---|
| **Enhance positions in emergency department to prevent unnecessary admissions** (Page 4) | Reconfiguring and adding positions in targeted Emergency Departments, with a goal of preventing avoidable admissions and readmissions, and reducing length of stay. | Decreased ALOS*<br>Decreased admissions >75*<br>Decreased readmissions*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement*<br><br>Increased 48/6 compliance<br>Decreased site occupancy | S.13(1) |
| **Perfect Care and Discharge planning** (Page 6) | Consistent use of best practices in daily care and discharge planning. Includes:<br>• Documented, goal-oriented care plans for every patient, every day.<br>• 100% use of 48/6 for care planning, and white boards | Decreased ALOS*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement*<br><br>Increased 48/6 compliance<br>Decreased site occupancy | S.13(1) |

| Priority | Brief Description | Expected Outcomes (* denotes report card indicator) | Investment Required |
|---|---|---|---|
| | (including EDD) for communication.<br>• Active and visible manager participation in daily flow processes. | | |
| **Extended PCC Coverage (evenings / weekends) to improve flow** (Page 8) | Expanding PCC coverage to increase flow 7 days a week at targeted hospitals. Target units are medical / ACE units at sites with highest likelihood for high occupancy and patients in "other locations" | Decreased ALOS*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement*<br><br>Increased 48/6 compliance<br>Decreased site occupancy<br>Increased weekend discharges | S.13(1) |
| **On-Call Allied Health (Social Work / Occupational Therapy) to support weekend discharges** (Page 10) | Add on call allied health services to sites without weekend coverage. Target to enable imminent weekend discharges. | Decreased ALOS*<br>Decreased ALC*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement* | S.13(1) |
| **Increase weekend discharges with increased Home Health supports** (Page 12) | Expanding HH coverage to increase flow 7 days a week at targeted hospitals. | Decreased ALOS*<br>Decreased ALC*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement* | S.13(1) |
| **Improved flow to Residential Care (increase weekend discharges and reduce bed turn around time)** (Page 14) | Increase 7d/week flow to residential care facilities through:<br>• Increased availability of weekend discharge supports (e.g., PCC)<br>• Reducing bed turn around time. | Decreased ALOS*<br>Decreased ALC*<br>Long stay patients >30d* | N/A |
| **Total Investment** | | | S.13(1) |

Combined, these initiatives will reduce congestion in Fraser Health hospitals which will improve quality, reduce the number of admitted patients receiving care in Emergency Departments and eliminate the use of hallways for patient care. The benefits of these improvements will be targeted to eliminate

| Impact | Estimated bed equivalent |
|---|---|
| Prevent 1,000 Emergency Department admissions with positions to prevent unnecessary admissions and readmissions. | > 20 acute care bed equivalents across FH hospitals. |
| Decrease length of stay by adding resources to improve care and discharge planning, particularly on weekends. Resources include targeted supports for improved care and discharge planning, expanded PCC and HHL coverage, and additional allied health supports.<br><br>In a 300 bed hospital, a 0.25d LOS decrease results in a functional increase of 12 beds. Estimated "functional increase" of bed equivalents for Fraser Health hospitals based on these strategies:<br>• 3-4 bed equivalents in each regional hospital (ARH, RCH, SMH);<br>• 2-3 bed equivalents in each medium sized community hospital (BH, CGH, ERH, LMH, PAH, RMH) | 20-30 acute care bed equivalents across FH hospitals. |
| Decrease patient days waiting for Residential Care admission by decreasing residential care bed turnaround time. | 5 acute care bed equivalents across FH hospitals. |
| **Total Cost Avoidance** | 45-55 acute care bed equivalents across FH |

Evaluation of the effectiveness of each of the proposed investments is recommended at 3 months and 6 months post implementation to ensure that resources are having the intended impact.

**Enhance positions in emergency department to prevent unnecessary admissions**
EXPANSION of current strategy.

**Brief Description:**
Reconfigure and add positions in targeted Emergency Departments (EDs) with goal of preventing avoidable admissions and readmissions, as well as reducing overall LOS through early discharge planning for admitted patients in emergency. Target population is frail seniors, vulnerable populations, and patients with complex needs.

GENC and QRCM Positions in ER
Currently there are 6 sites with 7 day/week GENC and 5 day/week QRCM staffing. These positions work collaboratively to:

- divert admission of complex geriatric patients though thorough assessment and linkages to appropriate resources in the community;
- prevent readmission through community follow-up in by the QRCM.

At medium sized sites, the GENC will also able to assist in timely care planning for complex geriatric patients who are admitted, which will decrease LOS and improve 48/6 compliance

DC2 Capacity Nurse in ER
A recent pilot of a DC2 Capacity nurse at Burnaby Hospital Emergency department has shown early success in diverting admissions as well as early initiation of care for patients admitted via the emergency department. This nurse works with the ER PCC to initiate 48/6 and medication reconciliation, and leads rounds for admitted patients.

| | |
|---|---|
| **Leads:** | Val Spurrell<br>Catherine Butler |
| **Investment Required:** | GENC and QRCM Positions in ER<br>Add GENC and QRCM to sites without these positions, (excl. MMH and FCH)<br>LMH: 1 GENC + 1 QRCM – 7.5 hrs x 7 days<br>RMH: 1 GENC + 1 QRCM – 7.5 hrs x 7 days<br>Estimate: S.13(1)<br><br>Expand QRCM to 7 days/week at sites with current 5 day/week<br>BH : QRCM – 7.5hrs x 2 days<br>RCH: QRCM – 7.5hrs x 2 days<br>SMH: QRCM – 7.5hrs x 2 days<br>PAH: QRCM – 7.5hrs x 2 days<br>ARH: QRCM – 7.5hrs x 2 days<br>CGH: QRCM – 7.5hrs x 2 days<br>Estimate: S.13(1)<br><br>DC2 Capacity Nurse in ER<br>Add DC2 Capacity Nurse in Emergency to improve care and discharge planning for admitted patients.<br>RCH: 1 DC2 – 7.5hrs x 5 days<br>ARH: 1 DC2 – 7.5hrs x 5 days |

| | |
|---|---|
| | BH: 1 DC2 – 7.5hrs x 5 days<br>SMH: 1 DC2 – 7.5hrs x 5 days<br>Estimate: S.13(1)<br><br>Total = S.13(1) |
| **Estimated Return on Investment:** | <u>GENC and QRCM Positions in ER</u><br>**Avoid approximately 1000 admissions (>20 bed equivalents)**<br><br>Extended hours of QRCM at these 6 sites and adding these positions at 4 more sites is anticipated to prevent approximately 1000 admissions (20-30 bed equivalents). This estimate is based on evaluation of existing QRCM/GENC positions in 2013/14, which indicated avoidance of nearly 1000 admissions.<br><br><u>DC2 Capacity Nurse in ER</u><br>**Decrease admission rate by 1% at target sites (6 bed equivalents)**<br><br>Very early (1 month) evaluation of this position at BH shows the site ER admission rate decrease from 14.4 % to 11%. This position will also contribute to decreased LOS based on early initiation of care and discharge planning. |
| **Indicators:** | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br>Admission rate >75<br>Site Occupancy<br>48/6 Compliance |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Complete review and evaluation of current positions in ER. | V Spurrell | Mid February 2015 |
| Pending approval, use available temporary resources to fill vacancies while completing hiring and orientation processes | Emergency leadership | March 2015 |
| Complete hiring process | " | April 2015 |
| Orient new hires | " | April 2015 |
| Partner with Emergency Department leadership to support effective use of these positions | Chris Windle | April – September 2015 |
| Review effectiveness/ evaluate | " | September 2015 |

| **Perfect daily care and discharge planning**<br>ACCELERATION of Strategic and Operational Plan strategy. | |
|---|---|
| **Brief Description:** Consistent use of best practices in daily care and discharge planning for each of our patients is the most significant leverage point for improving flow and reducing hospital occupancy. Perfect daily care and discharge planning includes:<br>• Documented, goal-oriented care plans for every patient, every day<br>• 100% use of 48/6 for care planning, and white boards (including Estimated Discharge Date) for communication<br>• Active and visible manager participation in daily flow processes | |
| **Lead:** | Tracy Irwin / Shallen Letwin<br>Site Executive Directors |
| **Investment Required:** | S.13(1) or 2 FTE temporary (1 year) supports to reinforce and sustain 48/6 implementation.<br><br>S.13(1) for PCC secondments (3-6 months per site, at each targeted site: ERH, ARH, SMH, RCH).<br><br>Plus temporary reallocation of existing resources in Access, STT, and targeted sites. |
| **Estimated ROI:** | Quantifying bed days saved through improved care and discharge planning is challenging, however, it contributes to improvements in:<br>• Length of stay<br>• Patients waiting for admission to inpatient beds<br>• Decreased site occupancy<br>• Reduced NSAE<br><br>Quantified as an example in a 300 bed hospital:<br>• Reducing LOS by 0.25 days results in a functional increase of 12 beds.<br>• Increasing the number of patients discharged by 11 a.m. from 15 percent to 30 percent adds eight functional beds<br><br>Combined with other strategies in this document (e.g., expanded PCC coverage; expanded Home Health Liaison support, etc.) these investments are expected to cumulatively contribute to bed day savings equivalent to 20-30 inpatient beds. |
| **Indicators:** | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br>Site Occupancy<br>Patients discharged before 11am |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Improve effectiveness of daily rounds at RMH; ERH; ARH; SMH; RCH | | |
| Complete project to improve daily rounds at RMH, with an outcome of developing video / tools that can be applied at other sites | Claudia Friess & Site Director | March 15 |
| Review tools developed at RMH and other tools for daily rounds to incorporate into subsequent sites. | Claudia Friess | February 2015 |
| Initiate work to improve daily rounds at ERH, ARH, SMH; RCH sites, including tailored use of tools developed at RMH. Target sites based on ALOS opportunity and current use of hallway / overflow spaces. | Claudia Friess & Site Director | February – June 2015 |
| Reinforce purpose and intention of "Meeting Free Mornings" and expectations of managers and directors on their units | Tracy Irwin | February 2015 |
| Fully adopt identified best practices – CAUTI training, 48/6, Mobilization | | |
| Continuing monthly audits of 3 best practices, including managers submitting action plans for improvement to site Executive Director | T. Irwin / V. Spurrell Site Executive Directors | Monthly |
| Initiate Roving Cart for Care Planning (based on BH example). Target sites with greatest opportunity to improve based on January audit results<br>• ARH; ERH; PAH; RCH; SMH | Sheila Finamore; Site EDs | March / April 2015 |
| Add "achieve 48/6 target" to Performance Link for all managers. | V. Giglio / S. Letwin | March / April 2015 |
| Consistently use Estimated Discharge Date (EDD) as a tool for communication and care planning | | |
| Roll out tools and supports for EDD at all sites. Presentation and discussions at HOMC and other department meetings. Add as forced function into Meditech | Spencer Lister | April 2015 |
| Full roll out of bedside white boards including their use as a communication tool at all sites. | Carol McGrandles | March 2015 |

| **Extended PCC Coverage (evenings and weekends) to improve flow**<br>EXPANSION of current strategy. | |
|---|---|
| **Brief Description:**<br>Expanding PCC coverage to increase flow 7 days a week at targeted hospitals. Target units are medical / ACE units at sites with highest likelihood for high occupancy and patients in "other locations".<br><br>PCC coverage has been extended to ensure that most medical and ACE units have minimum 7.5hrs/day coverage 7 days/week. | |
| **Lead:** | Shallen Letwin<br>Val Spurrell |
| **Investment Required:** | **Medicine and ACE Units**<br>Add PCC coverage for medicine and ACE units without regular daytime coverage 7 days/week. Excludes some smaller units.<br>Medicine Units (multiple sites): Estim S.13(1)<br>ACE Units (BH, RCH, SMH): Estimate S.13(1) |
| **Estimated ROI:** | Based on literature, positions to improve flow and reduce variation will result in incremental improvements in flow. Quantified as an example in a 300 bed hospital:<br>• Reducing LOS by 0.25 days results in a functional increase of 12 beds.<br>• Increasing the number of patients discharged by 11 a.m. from 15 percent to 30 percent adds eight functional beds<br><br>Combined with other strategies in this document (e.g., perfect care and discharge planning; expanded Home Health Liaison support, etc.) these investments are expected to cumulatively contribute to bed day savings equivalent to 20-30 inpatient beds. |
| **Indicators:** | Decrease number of patients awaiting admission to inpatient bed*<br>Increase % admissions within 10 hrs*<br>Decrease ALOS*<br>Increased number of weekend discharges on units with extended PCC coverage |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Confirm approval to move forward with expanded PCC coverage in ACE Units / Medicine Units | V. Spurrell<br>S. Letwin | February 2015 |
| Begin filling shifts with temporary staff | V. Spurrell<br>S. Letwin | March 2015 |
| Evaluate ALOS and weekend discharges on units with added coverage | Site Executive Directors | June 2015 |
| Based on evaluation results, confirm whether to move forward with permanent positions | Clinical Executive | June 2015 |

| **On-Call Allied Health (Social Work / Occupational Therapy) to support weekend discharges**<br>EXPANSION of current strategy. | |
|---|---|
| **Brief Description:**<br>Adding on-call Allied Health (Social Work / Occupational Therapy) support to sites without weekend coverage to support imminent weekend discharges.<br><br>Target social work population is primarily vulnerable adults who require housing and social support to prevent admission to hospital. Occupational Therapists may provide assessment and/or specialized equipment to support discharge home. | |
| **Lead:** | Val Spurrell |
| **Investment Required:** | S.13(1)<br><br>5.0 FTE (maximum) for on-call Social Work / Occupational Therapy in hospitals.<br><br>Given that these sites have no history of weekend coverage for these key allied health professions, it is difficult to anticipate utilization of on-call services. Close monitoring of utilization will ensure costs do not exceed available budget. |
| **Estimated ROI:** | Given the absence of these positions on weekends at most community hospitals, it is difficult to quantify the objective number of weekend discharges specific to weekend SW (or OT) services.<br><br>In combination with other supports put in place to improve patient care and discharge planning on weekends, this service will contribute to increased weekend discharges and decreased LOS. |
| **Indicators:** | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br><br>Site Occupancy<br>Increased weekend discharges |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Create on-call rotation schedule for SW (community sites without weekend coverage) using existing staff providing rotating on weekend on-call coverage | S Brolin | Feb 27 |
| Ensure pager distribution and department tracking for specific departments. | S Brolin | March 6 |
| Development of on-call criteria for SW and OT on-call usage, to target weekend discharge. | S Brolin | March 6 |
| Develop tracking tool to measure utilization of on-call usage, patient tracking and weekend discharge outcomes | S Brolin | Feb 27 |
| Communication and education plan for Site Leaders, AOC and medical / surgical units regarding availability and appropriate use of these supports | S Brolin | Feb 27 |
| Begin on-call service at selected sites | S Brolin | March 6 |
| Track and Monitor | S Brolin | March 6, ongoing |
| Preliminary evaluation of outcomes | S Brolin | September |

| **Increasing Weekend Discharges to Home Health Supports**<br>ACCELERATION of Strategic and Operational Plan strategy | |
|---|---|
| **Brief Description:**<br>Increase Home Health Liaison (HHL) supports in Fraser Health hospitals to expand weekend service capacity and enable increased weekend discharges.<br><br>Currently, Home Health provides 7 day/week services including discharge and transition supports. However, weekend resource levels are generally far lower than week days. HHLs are critical to ensuring discharges from acute care; therefore investments are targeted to this position. This work aligns with Fraser Health's "Home First" strategies. | |
| **Lead:** | Catherine Butler |
| **Investment Required:** | 11 FTE Home Health Liaisons = S.13(1)<br><br>This investment brings Fraser Health closer to the recommended ratio of 1 Home Health Liaison per 25 inpatient beds, from the current state of 1:60.<br><br>Timelines for implementation are driven significantly by time required to hire and orient new Home Health Liaisons. Casual staff will be used to increase coverage in the short term; however, the available casual pool is already highly utilized to meet current demand.<br><br>Success of this strategy requires adequate support from PCCs to identify and expedite potential patient discharges through the weekend. This supports our "Home First" and "Home is Best" initiatives. |
| **Estimated ROI:** | In combination with other proposed supports to increase weekend flow, these positions will contribute to decreasing length of stay.<br><br>Based on literature, positions to improve flow and reduce variation will result in incremental improvements in flow. Quantified as an example in a 300 bed hospital:<br>• Reducing LOS by 0.25 days results in a functional increase of 12 beds.<br>• Increasing the number of patients discharged by 11 a.m. from 15 percent to 30 percent adds eight functional beds |
| **Indicators:**<br>*Link to Report Card indicators*<br><br>*May include other measures of success* | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br>Site Occupancy<br>Increased weekend discharges |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Confirm support for this strategy | Executive Team | February 2015 |
| Convert all possible casual positions into permanent HHL roles. | | March –April 2015 |
| Recruit and Hire new HHL staff for 1 year term pending evaluation results. | | March – May 2015 |
| Orient and train new HHL staff (4 months training process) | | September 2015 |
| Evaluate effectiveness of additional positions (measure against site based discharge targets). | | December 2015, March 2016 |

| **Decreasing delays in admissions to residential care facilities from acute care**<br>NEW strategy | |
|---|---|
| **Brief Description:**<br>Decreasing residential care bed turn around time will improve patient flow to residential care facilities and reduce the number of days that patients wait in acute care beds for residential care admission . An opportunity exists to decrease bed turnaround time from its current duration of 4.9 days. | |
| **Lead:** | Keith McBain<br>Tracy Irwin |
| **Investment Required:** | Temporary reallocation of internal resources (e.g, STT, HBA) is recommended to support review of existing processes, identification of opportunities, and implementation of improved processes. |
| **Estimated ROI:** | <u>Reduce residential care bed turnaround time</u><br>Decreasing residential bed turnaround time to 4.0 days from its current duration of 4.9 days, will save acute care bed days equivalent to 5 beds. |
| **Indicators:** | Average Length of Stay (ALOS)*<br>Alternative level of care days*<br>Residential care bed turn around time |

* Indicator from FH public report card

**Next Steps:**

| Action | Lead | Timeframe |
|---|---|---|
| Confirm internal resources and small working group to review process for residential care bed turnaround time. | Keith McBain / Claudia Friess | February 2015 |
| Review and identify opportunities for improvement with current process for transitioning acute care patients to residential care beds to reduce bed turn around time from current 4.9 days. | Claudia Friess / Dee Chatha | March 2015 |
| Identify process improvements and begin implementing changes, in partnership with both contracted and owned/operated residential care facilities. | Claudia Friess / Dee Chatha | May/June 2015 |

**From:** Nuraney, Naseem
**To:** Marchbank, Michael; Letwin, Shallen Dr.; Giglio, Vivian
**Subject:** Fraser Health hospitals battle overcrowding, shortage of beds
**Date:** Wednesday, June 10, 2015 10:34:53 PM

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http://www.vancouversun.com/touch/story.html?id=11126090&utm_source=twitterfeed&utm_medium=twitter

**From:** Middleton, Rebecca
**Subject:** News Scan - June 11, 2015
**Date:** Thursday, June 11, 2015 9:25:12 AM

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**Fraser Health**

Vancouver Sun - Fraser Health hospitals battle overcrowding, shortage of beds **(Fraser Health, Emergency)**
http://www.vancouversun.com/health/Fraser+Health+hospitals+battle+overcrowding+shortage+beds/11126090/story.html

Vancouver 24hrs - Fraser Health behind on wait times **(Fraser Health, Emergency)**
http://vancouver.24hrs.ca/2015/06/10/fraser-health-behind-on-wait-times

News 1130 - ER congestion on the rise in the Fraser Health Authority **(Fraser Health, Emergency)**
http://www.news1130.com/2015/06/10/er-congestion-on-the-rise-in-the-fraser-health-authority/

CTV News Vancouver - More patients getting hallway healthcare in Fraser Valley: report **(Fraser Health, Emergency)**
http://bc.ctvnews.ca/more-patients-getting-hallway-healthcare-in-fraser-valley-report-1.2416793

Maple Ridge Pitt Meadows Times - Fraser Health chops down Maple Ridge trees **(Fraser Health, Ridge Meadows Hospital, Parking)**
http://www.mrtimes.com/news/fraser-health-chops-down-maple-ridge-trees-1.1965036

Surrey Now - REID: Help Surrey's homeless in the heat **(Fraser Health mentioned)**
http://www.thenownewspaper.com/opinion/reid-help-surrey-s-homeless-in-the-heat-1.1964437

Delta Optimist - Pillow Pals at it again! **(Delta Hospital, Jim Pattison Outpatient Care and Surgery Centre)**
http://www.delta-optimist.com/living/pillow-pals-at-it-again-1.1964107

Powell River Peak - Survey ranks community on health **(Fraser Health mentioned)**
http://www.prpeak.com/articles/2015/06/10/news/doc55778c9fcb23c137654360.txt

Langley Advance - Langley Faces and Places: How poppies improve health in Langley **(Langley Memorial Hospital Foundation)**
http://www.langleyadvance.com/community/langley-faces-and-places-june-11-2015-1.1965098

New Westminster News Leader - Overnight stays to create 'private hospitals': NDP **(Fraser Health, Surgery mentioned)**
http://www.newwestnewsleader.com/news/overnight-stays-to-create-private-hospitals-ndp-1.1965070

Abbotsford News – Letter: Hospitals not so bad **(Abbotsford Regional Hospital)**
http://www.abbynews.com/opinion/letters/306833471.html

**Other**

News 1130 - Nursing home choice could be made easier by searchable online database
http://www.news1130.com/2015/06/10/nursing-home-choice-could-be-made-easier-by-searchable-online-database/

Vancouver Sun - Six B.C. children injured in falls from windows
http://www.vancouversun.com/news/metro/Girl+survives+fall+from+second+storey+window+Surrey/11125150/story.html

Vancouver Sun - Allowing complex surgeries at private B.C. clinics could take up to 24 months
http://www.vancouversun.com/health/Allowing+complex+surgeries+private+clinics+could+take+months/11126078/story.html

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**Fraser Health hospitals battle overcrowding, shortage of beds**

222 patients were treated in ERs, hallways or lounges in April, according to report

By Tara Carman, Vancouver Sun
June 10, 2015

Hospitals in B.C.'s largest health region are largely not making progress in easing congestion, with more than 200 patients waiting in corridors or emergency departments for treatment in April, a Fraser Health report shows.

Hospitals across the region, which extends from Burnaby east to Hope, are not meeting targets on a number of measures designed to gauge whether patients are moving between departments and being discharged in an efficient and timely manner.

The number of patients awaiting a bed while receiving care in places like hallways, lounges and emergency departments was well above the regional target of 165 or less, with 222 patients waiting for a bed in April.

Almost half of these patients were at two hospitals: Surrey Memorial and Abbotsford Regional.

Most hospitals are also missing the Fraser Health target of moving 55 per cent of admitted patients out of emergency departments within 10 hours. Only one hospital, Burnaby, hit the 55 per cent target between January and April. The hospital that fared worst on this measure, at 22 per cent, was Delta.

There are also too many patients taking up hospital beds who would be better served by home care or residential facilities, the report found. Between April and December of last year, 14.6 per cent of patients were discharged later than expected, exceeding the regional target of 10 per cent. Mission Memorial had 30 per cent of patients discharged late, with Chilliwack General and Eagle Ridge at just under 23 per cent. Two of the region's largest hospitals, Surrey Memorial and Royal Columbian, exceeded the target on this measure, at 7.3 per cent and 4.7 per cent respectively.

Hospitals across the region also have an increasing number of patients staying longer than 30 days, with 528 such patients in April, compared to a target of 455 or less.

"When patients have stayed longer than 30 days in the hospital, it is likely their care needs are better suited in a different setting, such as community, long term care, or a separate rehabilitation facility," the report said. "Keeping patients in hospitals, when they could be cared for elsewhere, is not an efficient use of our hospitals and contributes quality and safety risks."

Surrey's emergency room has been wrestling with overcrowding since it opened, despite being Canada's second-largest and B.C.'s busiest ER.

Hospital officials have pointed to several reasons for the increase in ER patients and subsequent struggles in growing waiting times, including the fact the ER has a new dedicated pediatric department (only the second such department in the province) and there's been a spike in the number of children taken there. As well, officials have said the new state-of-the-art facility has been a "draw" for people who otherwise might go to a different ER but feel that Surrey's new status might offer better care.

Meanwhile, nurses have said the hospital is understaffed, and the ER is poorly designed, which has led to slowdowns and inefficiencies in areas like admissions.

Fraser Health recently announced a $5-million investment in measures aimed at reducing congestion at its hospitals, but it will take time to see the results, said spokeswoman Tasleem Juma.

That money is being used for additional nurse clinicians, case managers and patient care coordinators to facilitate patient transitions between departments and out of hospital. Fraser Health also added 11 home health liaison positions, allowing patients to leave the hospital sooner and receive care at home.

"We recognize that progress in some areas may not be as quick as we would like, but we are confident that we are on the right track and over time will see results," said Juma.

The report card showed improvement on a number of measures, including the percentage of hip fractures completed within 48 hours (95%), staying within budget and a reduced use of overtime.

Instances of C. difficile infection were also down across the region, with two hospitals — Mission and Fraser Canyon — reporting no infections in April. The highest rates of C. difficile were at Chilliwack General and Abbotsford Regional hospitals, with rates of 10.4 and 9.5 cases per 10,000 patient days respectively. The regional target is six cases or less.

The Minister of Health was not available for comment.

The full report can be found here: http://www.fraserhealth.ca/media/report-card-may-2015_all-sites.pdf

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**Fraser Health behind on wait times**

Reporter Stefania Seccia
By Stefania Seccia, 24 hours
Wednesday, June 10, 2015 5:01:43 PDT PM

Royal Columbian Hospital in New Westminster. (File photo)

The Fraser Health Authority isn't meeting its own targets as far as wait times and patients receiving care in hallways and lounges, according to its recently released Our Health Care Report Card.

It shows patients are being moved out of the ER to a bed within 10 hours about 36% of the time — but the target is 55%.

On average, about 222 patients are getting care in emergency rooms, lounges and hallways — while the target is to have that number limited to 165.

In an emailed statement, FH said it is investing in primary and community care "but it is going to take time for this work to show up in the report card indicators."

The authority recently announced a $5-million investment to help reduce congestion, according to Tasleem Juma, said FH spokeswoman.

"At Burnaby Hospital, for example, more staff have been hired to help move patients through the system more quickly or divert them from emergency to other options when appropriate," she said.

"This has resulted in Burnaby Hospital meeting, and exceeding, the target for emergency patients admitted to hospital within 10 hours."

But NDP MLA Sue Hammell, critic for mental health and addictions, said she hears from health-care staff in the region that the situation is getting worse.

“It doesn’t matter where you are in the health-care system, the waiting times are getting longer and longer,” she said. “We’re waiting for surgeries, waiting for beds, waiting to be admitted and we are not meeting the targets.”

Hammell said as 12,000 people a year continue to move into the Surrey area alone, it’s going to have “some consequences for the hospital.”

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**ER congestion on the rise in the Fraser Health Authority**

Local
By Jill Drews
Posted Jun 10, 2015 5:21 pm PDT

BC nurses say increasing congestion is leaving more patients in hallways

Only about 35 per cent of ER patients in Fraser Health Authority admitted within 10 hours

SURREY (NEWS 1130) – The latest numbers from Fraser Health show you’re waiting even longer for help in the emergency room.

BC nurses say increasing congestion is leaving more patients waiting in hallways.

The percentage of ER patients admitted within 10 hours is down to about 35 per cent, dropping five per cent year over year.

The president of the BC Nurses Union sees Fraser Health trying to combat congestion, but says things like cuts at care homes have left people few other options.

Gayle Duteil says even recent additions aren’t making a dent in the problem. “It was a year ago this month that the new tower was opened in Surrey and we heard loud and clear that that was going to be the problem solver and that actually hasn’t happened.

She thinks more funding at care homes could help unclog the system. “At one point over the winter, there were 60 admitted patients waiting for a bed that came from residential care facilities. And they came from residential care facilities because of the absolute decimation of nursing staff.”

Fraser Health says they’re investing millions and it will take time to see that reflected in wait time reports.

The full response from Fraser Health President and CEO Michael Marchbank:

“Fraser Health posts report cards to our website so the public can track our progress and hold us accountable. We are working to reduce hospital congestion by investing in primary and community care, but it is going to take time for this work to show up in the report card indicators.

Reducing the use of hallway beds is a priority. Fraser Health recently announced a $5 million investment to help reduce congestion by preventing avoidable admissions to hospital, supporting more efficient processes so patients go home from hospital sooner, and increasing health care supports in the community, and we are already seeing success in some hospitals.

We recognize that progress in some areas may not be as quick as we would like, but we are confident that we on the right track and over time will see results.”

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**More patients getting hallway healthcare in Fraser Valley: report**

CTV Vancouver: 'Hallway healthcare' on the rise
Report shows hallway healthcare on the rise

Fraser Health has released its annual health care report, revealing more patients are being treated in hallways in region hospitals.

Published Wednesday, June 10, 2015 7:55PM PDT
Last Updated Wednesday, June 10, 2015 7:57PM PDT

Wait times in Fraser Valley hospitals are on the rise and a growing number of patients are being treated in hallways and lounges, according to the region’s latest healthcare report card.

The Fraser Health Authority report shows at any time between January and April, an average of 222 patients were being treated in hospital areas that weren’t designed for clinical care.

That's well above the target of 165 patients, and the 208 average from last year.

Mike Leenstra told CTV News he recently spent days on a gurney in the hallway at Royal Columbian Hospital because there were no beds available.

"I put up with that for four days and got out," Leenstra said. "I know there's overcrowding, what are you going to do? I was just happy that I was well looked after right away."

The FHA report also found that only 36 per cent of patients were moved from the emergency department to a hospital bed within 10 hours of being admitted. The health authority's target is 55 per cent.

Gayle Duteil of the B.C. Nurses' Union said she doesn't expect the congestion will ease up soon, as hospitals are generally busy in the summer months.

"These report cards demonstrate an ongoing failure to properly forecast in health human resources and in the population needs," Duteil said.

No one from FHA would agree to be interviewed Wednesday, but the health authority emailed a statement promising to deliver a more effective system soon.

To read the full report, click here.

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**Fraser Health chops down Maple Ridge trees**

Trees planted by the first physicians to work at the Ridge Meadows hospital are gone.

Cole Wagner / Maple Ridge-Pitt Meadows Times
June 10, 2015 03:05 PM

The green space which was sacrificed to make space for more parking at the Maple Ridge hospital included flowers and a number of mature trees, planted by the first physicians to work at the hospital. Photograph By Dr. Ken Burns

A "communication breakdown" is cited as the root error that caused Fraser Health to cut down a number of trees with significant sentimental value at the Ridge Meadows hospital, in order to make room for more parking.

The trees had been planted by the first physicians to work at the hospital when it initially opened, with the intention of providing patients with a minor green space.

But Fraser Health, the regional authority which runs Ridge Meadows hospital, saw a need for better access to handicap parking.

"There was a plan in place in terms of expanding handicap parking," said Tasleem Juma, a spokesperson with Fraser Health.

"Unfortunately, there was a breakdown in communication with the physicians," said Juma.

"We didn't know about the significant value of those trees before we cut them down," she added.

Fraser Health has now made a commitment to work with the group of physicians to secure more green space down the road, said Juma.

Linda King, a longtime resident of Maple Ridge, was visiting the hospital late last month when she noticed the trees were gone.

Now she's wondering why more wasn't done to save the trees.

"It was a beautiful shady area," said King. "Now there is nothing out there. It's a desert of asphalt."

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**REID: Help Surrey's homeless in the heat**

Amy Reid / Surrey Now
June 10, 2015 11:27 AM

Jonquil Hallgate of the Surrey Urban Mission hands out water bottles on a hot Tuesday morning. (Photo: AMY REID)

WHALLEY — Ever taken a stroll down "The Strip" in Whalley?

I have but only as a reporter.

Growing up in Whalley, behind Queen Elizabeth Secondary, I've seen the realities of the street in Surrey.

I spoke with homeless people on many occasions, often at the bus loop at Surrey Central SkyTrain where they'd congregate and ask for change.

I recall seeing prostitutes on the corner at my high school, or just down the road near Motel Hollywood on King George Boulevard.

I don't share these memories to paint the city in a bad light. But sadly, the realities of the city in my teen years are not all that different today.

Perhaps that fact fuels my passion to delve into social issues in my job as a journalist, and what drove me to become one in the first place.

So when I walked down the Whalley strip on 135A Street on Tuesday – the second time I'd ever done so – I was surprised to feel stunned at what I saw.

I was saddened.

Jonquil Hallgate of the Surrey Urban Mission had invited me to tag along as she handed out water on a particularly hot day. You see, the mission does this when it can to try to avoid street folks getting heat exhaustion. If they're able, they also hand out hats and sunscreen.

"We don't want people dying of heat stroke," she said as we made the jaunt from 108th Avenue to "The Strip," handing out a few water bottles on the way. She knew many of them by name.

"They don't have places to go to cool down. Extreme weather is both ends of the spectrum. We often just think of it as being the cold weather," she added. "But we have people who have vulnerable immune systems, we have a lot of seniors in our community that are homeless, we have lots of people with health issues, so they're at risk."

As we made it to the strip, I saw some people who had clearly not slept in days. I saw a crack pipe fall from a man's bag. Another was fixing a bike he'd "acquired" the day before. Some laid under the sparse shade that was available. Others slept. Others tweaked out.

In that moment, all I could hear were my mother's words growing up – people are people and deserve dignity, regardless of circumstance.

I don't know their stories. I don't know how they ended up there. I don't know what choices they've made or what trauma they've endured. But they're suffering today.

As a mom, I'm aware of the realities of heat exhaustion, as I've seen my son go through it. It's serious and it wouldn't take much for these folks to get, given their compromised immune systems.

Fraser Health issued a press release last week, noting heat-related illness can be as mild as thirst and dizziness or as severe as death. The health authority recommends people spend the hottest hours of the day – 11 a.m. to 2 p.m. – out of the sun. And stay hydrated, they urge – don't wait until you're thirsty to drink water.

At Christmastime, we donate – because we care. When freezing temperatures and bouts of rain ensue, we donate blankets, jackets and other essentials. But when it gets hot, what do we do?

I can honestly say I've never even thought of donating at this time year. But seeing Hallgate and her helpers hand out roughly 60 bottles of water in a matter of 15 minutes, I urge you to. It's help that's needed. While the latest regional homeless count in 2014 suggests 403 people are homeless in Surrey, it's largely recognized as an undercount. Hallgate estimates the true number is closer to 2,000.

Writing this column, I recognize there are people who don't see things my way. In fact, I have people in my life who frequently say, "Addicts are addicts, why do they get handouts?" and other things along those lines.

To each their own, I suppose. But when I hear comments like that, I think back to a famous line in Dr. Seuss' Horton Hears a Who! – "A person's a person, no matter how small."

A society is judged by how it treats its weakest and most vulnerable. Let's lead the way, Surrey.

Donations of bottled water, hats and sunscreen will be accepted at Surrey Urban Mission, located at 10776 King George Blvd.

Amy Reid is a reporter and photographer with the Now. She can be reached at amy.reid@thenownewspaper.com

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**Pillow Pals at it again!**

Delta Optimist
June 10, 2015 10:22 AM

Delta Hospital Auxiliary Pillow Pals volunteers Lesley Davis (left), Colleen Plain and Betty Davis hand over one of the 40 pillow sets to Sharon Secord (second from left), clinical nurse specialist for breast health with Fraser Health.

The auxiliary is donating the pillow sets to the Jim Pattison Outpatient Care and Surgery Centre. The Pillow Pals sew and fill more than 100 of the pillow sets every year. The pillows are designed to help women recovering from breast surgery stay comfortable.

A group of six to eight volunteers makes the pillows using fabric donated by the community, as well as materials donated by Nelson's Upholstery in Ladner and International Textiles in Richmond.

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**Survey ranks community on health**

Growing problems include obesity and chronic illness

by Chris Bolster | reporter@prpeak.com
Published: Wednesday, June 10, 2015 8:45 AM PDT

People who live in Powell River have a strong sense of community belonging, but struggle with a high rate of obesity, according to a new report.

Dr. Paul Martiquet, Vancouver Coastal Health (VCH) medical health officer for rural Sunshine Coast presented the findings of the community health profile for Powell River to City of Powell River Mayor and Councillors at the June 2 committee of the whole meeting.

The highlights he presented came from the statistics gleaned from a 2013 My Health My Community report. The results of the 93-question survey of adults in Powell River were also released June 2. The project was a partnership initiative between Vancouver Coastal Health, University of BC and Fraser Health.

Martiquet said VCH recently signed a collaboration agreement with the city to recognize the work that is being done and the decisions being made to improve the health of the community.

"I think what we realize working in health is that we can't do it alone," Martiquet said. "In fact, the majority of what makes us healthy are decisions that are made every day that affect the socio-economic environment and the healthy built environment."

Employment, income levels and education have dramatic influence on what makes people healthy, the medical officer said. Then comes biology and environment.

The report provides an overview of health and wellness in Powell River that will give residents, community agencies and local governments a better understanding of the factors influencing health in their community.

"This new data is incredibly valuable because it will enable us to work upstream to prevent injuries and chronic disease through our efforts with local governments, health care planners and community stakeholders in developing health public policies," said Dr. Patricia Daly, VCH chief medical officer, in a media release announcing the results. "This will be critical for our population health and well-being, and ensuring sustainability of our health care system."

Of the 16,510 adults who live in Powell River Regional District and the City of Powell River, only 252 completed the 15-minute online health survey which was available from June 2013 to July 2014. Powell River's target was for a total of 645 completed surveys, roughly four per cent of the adult population, but only 39 per cent of that total were completed. Martiquet said that the surveyors were unable to solicit a substantial response from Tla'amin (Sliammon) Nation, so detailed information regarding that population is not available.

Across the two health authorities (VCH and Fraser Health), surveyors collected 77 per cent of their goal.

Changes to the scope of information gathered in the national census of population prompted this inquiry into the state of public health.

The survey found that over 78 per cent of respondents in Powell River said they had a strong sense of community belonging, more than 20 percentage points higher that the VCH average.

Overall general and mental health were comparable to the health authority and regional averages.

Powell River has one of the highest rates of obesity and chronic diseases such as hypertension and arthritis across the health region. Thirty-eight per cent reported they scored higher than 30 on the body mass index, putting them in the obese range.

The Upper Sunshine Coast scored high on emergency preparedness with almost 37 per cent saying they have more than three days of supplies stored.

Only slightly more than 15 per cent said that they engage in binge drinking one or more times per month, compared to Whistler which had the highest rate where almost half of the respondents said they did.

Eighty-three per cent of Powell River residents said that they had a family doctor.

While the amount of time Powell River residents spend in their cars commuting to work is some of the lowest in the health authority, Powell River is considered one of the most car-dependent communities surveyed.

Readers can see the full report online.

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**Langley Faces and Places: How poppies improve health in Langley**

Langley Advance
June 10, 2015 03:27 PM

Poppies: Royal Canadian Legion Langley Branch Joseph and Wilma McEwan presented $13,000 to the Langley Memorial Hospital Foundation representative Kate Ludlam. The funds purchased a blanket warmer for the critical care unit and a patient lift for extended care. The funds came from the sale of poppies each November. Learn more at langleyadvance.com – LMHF

How poppies improve health in Langley

The Langley branch of the Royal Canadian Legion has donated $13,000 from the proceeds of the annual Poppy Campaign to purchase two pieces of equipment for Langley Memorial Hospital.

These are a blanket warmer for the Critical Care Unit (valued at $7,500) and a sit-to-stand patient lift for Extended Care (valued at $5,500).

Each November, Poppies blossom on the lapels and collars of over half of Canada's entire population. The Poppy Campaign inspires Canadians to Remember. Every year, from the last Friday in October to Remembrance Day, The Legion conducts the Poppy Campaign. Canadians have donated money to support the services they provide and to clearly show their recognition of the debt owed to so many Canadians who gave their lives for our freedom.

Being admitted to a medical facility can be stressful for any patient. Not only are patients often faced with the uncertainty of their health and well-being, they're also forced to spend time away from the comfort of their home. To help make their treatment and recuperation as comfortable and relaxed as possible, heated blankets and linens are provided to ease stress and provide necessary medical care. Heated blankets and linens are used in numerous applications throughout the hospital and blanket warmers are found on almost every patient unit - in emergency, delivery or recovery rooms, critical care units, residential care facilities.

Medical blanket warmers are a necessary tool for increasing a patient's body temperature and decreasing blood loss. They can also result in fewer surgical site infections and shorter stays. It may seem like a trivial detail, but a warm blanket or gown can work wonders in soothing and calming a nervous patient.

Mobile Sit-to-Stand patient lifts are used in a variety of units throughout the hospital and are specially designed for people who have difficulty in standing up on their own from a seated position. They can be easily moved between different locations, rooms and users. Mobile lifts are a necessary and highly-used piece of equipment for our Residential Care facilities where patients require a varying degree of mobility assistance to carry out their daily routine. Lifts can be adapted for each raising or lifting operation to the capabilities of the individual patient and can be adjusted to accommodate patients of most sizes.

Components, such as padding, can be added for those who are sensitive to underarm or leg pressure.

They are a cost-effective solution where it is not possible to install a ceiling lift system.

About the Royal Canadian Legion: The Royal Canadian Legion is Canada's largest Veteran support and community service organization. More than 300,000 members in over 1400 Branches across Canada make a difference in the lives of Veterans and their families, provide essential services within our communities, and Remember the men and women who made the ultimate sacrifice for our Country. For more information about the Royal Canadian Legion, visit www.legion.ca.

The Langley Memorial Hospital Foundation was established in 1985, the Langley Memorial Hospital Foundation has raised more than $30 million to support Langley Memorial Hospital and the health care needs of the Langley communities.

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**Overnight stays to create 'private hospitals': NDP**

Jeff Nagel / New Westminster Newsleader
June 10, 2015 03:13 PM

Private clinics may be permitted to go beyond day surgery to multi-day patient stays. Photo Black Press file

The province may let contracted private clinics keep patients overnight for as long as three days so they can take on more complex surgeries than the day procedures they've so far been permitted to perform.

That possibility is mentioned in a health ministry discussion paper of potential surgical reforms that's gone out for stakeholder comment.

"Improved access to surgical services may include performing select surgical procedures which have length of stay up to three days, in private surgery centres using public funds," the paper says, adding the change would require amending the Hospital Act.

B.C. Health Minister Terry Lake announced an extra $10 million May 25 to perform more day surgeries this summer — some through private clinics using public funds — in order to cut wait times.

But New Westminster MLA NDP health critic Judy Darcy said letting private surgery clinics go beyond day surgery to multi-

day stays would be tantamount to turning them into full-fledged "private hospitals."

Private surgery clinics so far perform barely one per cent of government-funded procedures in B.C. when public operating rooms aren't available.

Longer patient stays would open the door to many more surgeries flowing to private facilities, Darcy said, adding critical staff may follow, further reducing capacity in public hospitals.

"Health professionals are in short supply — anaethesiologists, specialty nurses — and if we drain them out of the public system into the private system we effectively become captive to private for-profit clinics," Darcy said.

She called the proposal a "game changer" that has been quietly advanced under the guise of a short-term "band-aid" to cut waits.

"They ought to be doing the innovation and the strategic investment to use our public system to the maximum."

Fraser Health does not initially foresee hiring private clinics to supply the extra 500 surgeries it plans over the summer — it will open more of its own closed operating rooms.

But the Vancouver Island and and Vancouver Coastal health authorities have indicated they expect to make some extra use of private surgeons.

Health Minister Terry Lake was unavailable for an interview.

The ministry instead issued a statement defending extended private clinic stays as a successful method of handling more hernia surgeries in Toronto.

"This is just one option that is on the table for consideration," it said. "Not all of these will be implemented."

The policy paper indicates the main reason that about one in six hospital operating rooms are closed at any time is lack of funding, while staff shortages and lack of demand are also responsible in some cases.

The ministry says it's working to increase training for specialist nurses and support recruitment and retention of key specialists, including anaethesiologists.

Doctors of B.C. president Dr. Bill Cavers said health watchdogs are right to be wary of the potential to drain staff from the public system, but said the association believes some increased use of private surgery clinics "can be a good idea" as long as it's publicly administered and funded, and quality and safety standards are upheld.

Demand on hospitals can vary due to flu season or a backlog of patients waiting for a particular procedure, he said.

"We feel that utilizing different avenues of access to care can improve the overall efficiency of the system," Cavers said. "We have surgeons right now who can't get enough operating room time."

He said he doesn't foresee large numbers of clinics opening to the extent that they might cause problems for the public system.

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**LETTER: Hospitals not so bad**

posted Jun 10, 2015 at 2:00 PM

So often people complain about the hospital, people, food etc. when they have to go there.

I had a short overnight stay in the Abbotsford Hospital I found the nurses very caring, friendly and helpful.

The hospital is so very clean and the food was good, I had a dinner and a breakfast and they were very good and healthy. I made a joke that if I had to stay longer I wouldn't mind, comfortable bed, nurses taking care for me, and meals in bed!!

Thanks to all the staff for caring for me.

Sandra Calder

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**Nursing home choice could be made easier by searchable online database**

National
By Helen Branswell, The Canadian Press
Posted Jun 10, 2015 10:10 am PDT Last Updated Jun 10, 2015 at 9:13 pm PDT

TORONTO – Choosing a high quality nursing home for a loved one may now be a bit easier for people in some parts of Canada.

A searchable database that provides information on hospitals across the country has been expanded to include comparative

data on about 1,000 nursing homes.

The database is run by the Canadian Institute for Health Information and is located at http://www.yourhealthsystem.cihi.ca.

It currently contains data on about 57 per cent of the long-term care homes in Canada, says Brent Diverty, CIHI's vice president for programs.

These are facilities with round-the-clock nursing care. The database does not include information on assisted living homes.

Diverty says the data are drawn from assessment forms these homes complete on each of their residents once every three months.

They record information like whether the resident had fallen within the previous 30 days, or had been given anti-psychotic drugs even though he or she didn't have a diagnosis of or symptoms of psychosis (the drugs are sometimes used by nursing homes to control difficult behaviour in residents, a practice that is frowned upon).

They also note whether the individual has worsening pressure ulcers — which could indicate how good the home is at treating bedsores. They record whether residents are kept in restraints daily, whether they have improving or declining physical function, and whether they are experiencing long-term pain.

The database is set up to allow users to compare various long-term care homes based on these measures — so if one is doing a better job of pain management than others, it should be apparent. Likewise, it would be apparent if a home physically restrains patients daily more often than others.

Diverty says all facilities in Alberta, British Columbia, Ontario and the Yukon are in the database. Some facilities in Manitoba, Newfoundland and Labrador and Saskatchewan are covered, as are a handful from Nova Scotia.

That province and neighbouring New Brunswick are expected to have full coverage over time and other jurisdictions with partial coverage are expected to expand the numbers of homes they report on, Diverty says.

Quebec and Prince Edward Island homes do not gather data on residents using the same patient evaluation form as other provinces, so their facilities are not listed. Likewise there are no data from the Northwest Territories and Nunavut.

Nationally the data suggest there are a few positive trends in nursing-home care. There was a small drop in the percentage of residents who received anti-psychotic drugs without a diagnosis of psychosis. It fell to 30 per cent in 2013 from 34 per cent in 2010.

As well, the use of daily physical restraint of residents was down. It was 10 per cent of residents in 2013, down from 15 per cent in 2010. And the percentage of residents of long-term care homes in Ontario and Alberta who had long-term pain dropped during that period too.

Other measures remained stable, Diverty says.

Using the database may take some practice. The measurements that assess long-term care homes are mixed in with those that evaluate hospitals, so "it does take a little bit to get oriented," Diverty admits.

He suggests people who want to compare nursing homes in their area should start by watching a video on how to use the database. It can be found in the help menu on top of every page.

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**Six B.C. children injured in falls from windows**

Paramedics and medical experts gathered Wednesday in an effort to tell parents how to keep their kids safe

By Ian Austin, Postmedia News
June 10, 2015

METRO VANCOUVER -- Alarmed over a rash of falls from windows or balconies, paramedics and medical experts gathered Wednesday in an effort to tell parents how to keep their kids safe.

Since last Thursday, paramedics have taken six injured children who have fallen from windows or balconies to the B.C. Children's Hospital emergency department.

With more hot and dry weather in the forecast for much of the province, B.C. Emergency Health Services (BCEHS) and Children's Hospital are reminding parents and caregivers to make sure that window and balcony safety locks are in place.

"It's not even summer yet and we're already seeing a spike in pediatric emergency department visits due to window and balcony falls," said Lisa Widas, trauma program manager at Children's Hospital, where a press briefing was held.

Paramedics are first on the scene to see critical injuries, often including broken bones and facial and head trauma.

"If you look after young children or have kids visiting your home, window and door safety locks are your best friend," said BCEHS unit chief Marilyn Oberg.

"Little children move quickly and sometimes without reason or warning, so ensuring security locks are in place is a simple and effective safety measure for the warmer months."

Dr. Ash Singhal, a pediatric neurosurgeon and medical director of the Children's Hospital trauma program, said: "With temperatures rising, we often see an increase in falls from windows, and young children are particularly vulnerable to these falls.

"Many of the injuries can be quite severe, including skull fractures and brain injuries and potentially cause long-term effects for the child."

Children's Hospital says that young children are innately curious and natural climbers, and do not understand the risk of their actions.

Suggestions for parents include:

- Don't underestimate a child's mobility; children begin climbing before they can walk.
- Move household items away from windows to discourage children from climbing to peer out.
- Be aware that window screens will not prevent children from falling through; they keep bugs out, not children in.
- Install window guards on windows above the ground level, or fasten the windows, so that they cannot open more than 10 centimetres.
- Don't leave children unattended on balconies or decks, and move furniture or planters away from the edges to prevent kids from climbing up and over.

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**Allowing complex surgeries at private B.C. clinics could take up to 24 months**

College of Physicians and Surgeons of BC says many details must be worked out before such clinics an keep patients for three nights

By Pamela Fayerman, Vancouver Sun
June 10, 2015

A provincial proposal to shrink surgical waiting times by letting private surgery clinics do more complex operations could take up to two years to implement, says the registrar of the College of Physicians and Surgeons of BC.

That's because of changes to legislation that may be required to allow private facilities to keep patients for up to three nights and other changes to ensure they are more like hospitals, with security guards, full meals, a variety of health professionals, labs, imaging suites and even intensive-care units.

Currently, the College allows private facilities to do procedures requiring a maximum one-night stay.

"We applaud the minister of health for thinking outside the box to address the issue of access to care," said the registrar, Dr. Heidi Oetter, referring to the idea of expanding publicly funded access to private facilities. The proposal is in a Health Ministry discussion paper.

In an interview, Oetter said expanding the types of surgeries the province pays for at private clinics is not easy to sort out quickly.

"There's a role for the private facility sector. But this requires an extensive review," said Oetter, adding it could take from 18 to 24 months. The government has set up a Surgical Services Secretariat that will, among other things, work with the College on changes to laws and procedures to enable longer stays in private facilities, if that direction is chosen.

While private facilities like the Cambie Surgery Centre and the Centric Health Surgical Centre (formerly False Creek Surgical Centre) consider themselves hospitals, the College makes a distinction and Oetter said private facilities are inspected and accredited for one-night stays only.

"We think of them as private facilities, not hospitals. When you think of hospitals, you think of 24-hour staff, security guards, meals and so on," she said.

There are nearly 80,000 adults and children waiting for surgery in B.C. hospitals and median waiting times have not changed in several years despite reforms. According to the policy paper, 90 per cent of elective surgery patients got their surgery within 40 weeks in 2013/14, while the rest waited longer.

In 2013/14, 5,503 publicly funded operations were performed in private facilities, down from the 7,839 cases performed in private clinics the year before. Another 541,886 scheduled (elective) operations were done in B.C. public hospitals. There are about a dozen private surgery centres in B.C. offering a range of operations, general anesthetics and overnight stays.

About 50,000 people pay for their procedures themselves each year in private facilities.

Renee Hourigan, spokeswoman for Centric, declined to comment.

Dr. Brian Day, owner of the Cambie Surgery Centre, a block from Vancouver General Hospital, said it would be rather easy to accommodate patients for longer periods and to meet any new requirements.

"We're not going to hire a chef, but we already provide snacks and meals to patients. We give them menus and they choose what they want and the food is delivered. "

Cambie has five operating rooms plus a dental procedure suite and seven private post-op recovery rooms. He said whether the facility is a hospital or not is really a matter of semantics.

“Think about all the tiny community hospitals around B.C. and you can see that we are far more advanced and closest to the best hospital in B.C. Our staff are all the best you can get.”

Day said Cambie has been inspected and approved not only by the College but by the national body that audits and accredits hospitals — Accreditation Canada. Such accreditation isn’t mandatory, but College approval is required.

About 700 B.C. surgeons have privileges to work at private surgery centres. Under provincial law, any facility where surgeons work must be inspected and accredited by the College to ensure high standards of care and patient safety.

Sarah Plank, a spokeswoman for the Health Ministry, said the government is analyzing what kind of cases might be suitable for funded private surgery centres. The process is in the early stages so a timeline of up to two years is “not unreasonable,” she said.

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**From:** Letwin, Shallen Dr.
**To:** Bagri, Lakh; Cook, Jason; Doull, Kathy; Finamore, Sheila; Pardy, Petra; Veldhoen, Rhonda
**Subject:** Other-Hallway Locations
**Date:** Tuesday, July 07, 2015 3:50:00 PM

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Dear Team,

As you recall, there was significant investment put in to resources to eliminate hallway "other-non clinical" locations. I need for you to ensure you are well on your way in winding the use of these areas down, as messaging will be coming out shortly from our CEO.

I want to thank you for your continued hard work with your teams in ensuring patients are cared for in a safe and efficient manner. The Senior Leadership Team is supportive of your efforts to take a firm stand on not using these locations for care.

**Current Occupancy Metrics**
**as of: 7/7/2015 9:25:02 AM**

| Site | % Occupancy | Emergency Inpatients | Other Locations |
|---|---|---|---|
| ARH | 119.3% | 37 | 7 |
| BH | 105.7% | 23 | 1 |
| CGH | 108.1% | 16 | 2 |
| DH | 103.4% | 8 | 0 |
| ERH | 104.6% | 7 | 0 |
| FCH | 110.0% | 0 | 0 |
| LMH | 98.1% | 14 | 2 |
| MMH | 112.5% | 2 | 0 |
| MSA | 104.0% | 0 | 0 |
| PAH | 101.6% | 7 | 1 |
| QPH | 96.5% | 0 | 0 |
| RCH | 107.8% | 15 | 27 |
| RMH | 108.8% | 15 | 7 |
| SMH | 105.6% | 49 | 3 |

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**From:** Irwin, Tracy
**To:** Hart, Colleen; Dixon, Lois; Giglio, Vivian; Letwin, Shallen Dr.; Marchbank, Michael
**Subject:** RE: Priority Strategies
**Date:** Thursday, February 19, 2015 4:41:49 PM
**Attachments:** Actions to decrease patients awaiting inpatient beds- Feb 19 DRAFT.doc

Hi all -
I am attaching an updated draft of the Priority Strategies document.

Changes of note:
* Finance has now provided costing information. Finance costing estimates replace the order-of-magnitude estimates provided by operational leaders, which were used in previous drafts.
* Expanded PCC Coverage has been scaled back. Priority is being given to adding coverage on units that have no regular weekday coverage, and no weekends (days).

Thanks
Tracy

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**From:** Irwin, Tracy
**Sent:** Wednesday, February 18, 2015 3:53 PM
**To:** Irwin, Tracy; Hart, Colleen; Dixon, Lois; Giglio, Vivian; Letwin, Shallen Dr.; Marchbank, Michael
**Subject:** RE: Priority Strategies

I am attaching the next draft of the Priority Strategies document.

Changes of note:
* Investment costs and bed equivalent strategies are summarized in the first section S.13(1)

S.13(1)

* Following discussions on the first draft, some additional resources have been included . Most significant is the increased investment in expanded PCC coverage. Shallen has proposed that the Clinical VPs may further discuss a phased approach to these positions.

* Finance is working on more accurate costing which will be incorporated into the draft when available (likely tomorrow). In the meantime, order of magnitude estimates have been provided.

Thanks

Tracy

**Tracy Irwin**
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Access & Capacity Optimization
Chilliwack General Hospital and Community
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**From:** Irwin, Tracy
**Sent:** February 16, 2015 4:29 PM
**To:** Hart, Colleen; Dixon, Lois; Giglio, Vivian; Letwin, Shallen Dr.; Marchbank, Michael
**Subject:** Priority Strategies

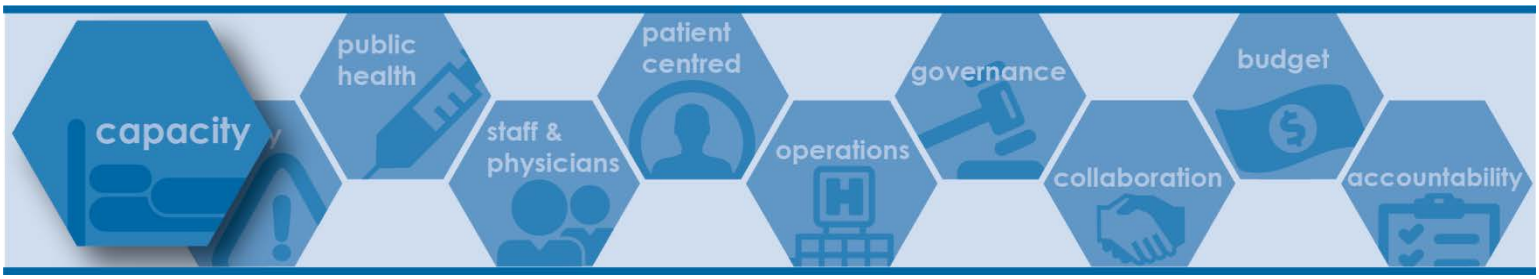
Hi all,
As discussed last Wednesday, I am attaching a draft document "Actions to Reduce Number of Patients Awaiting Inpatient Bed Placement".
This identifies priority strategies to reduce the use of hallway spaces, patient lounges, etc. as well as admitted patients in ER. The wording above is drawn from our Report Card indicator.

Thanks to all for contributing to the document:

- The ED group for participating in a discussion on Thursday to begin the draft
- Keith, Catherine, Val, and Sheila for providing content on some of the specific strategies
- Colleen, Vivian, Lois and Shallen for input on drafts and specific questions.

Please let me know if you have any questions or comments.

Thanks
Tracy




# Shaping our future: capacity

## Actions to Reduce Number of Patients Awaiting Inpatient Bed Placement

**(ER admits + "Other Locations")**

DRAFT

February 19, 2015

## Number of Patients awaiting inpatient bed placement (including Emergency Department)

When hospital occupancy exceeds available inpatient bed capacity, patients often receive care in locations not designed for inpatient care. These typically include:

- treatment spaces in Emergency Departments;
- locations in inpatient units not designed for inpatient care such as treatment rooms, tub rooms, or hallways;
- locations designed for outpatient or other services such as ambulatory care, medical imaging, or surgical daycare.

In each of these locations, care is not ideal from a patient or staff perspective. Further, maintaining high hospital occupancy (e.g., over 95%) is associated with longer lengths of stay and higher risk for errors and adverse events.

Fraser Health's report card tracks our organization's use of these spaces, and sets a target to significantly reduce their use.

This document identifies priority actions to decrease the use of "other locations" (hallways, treatment and tub rooms) for inpatient care. Each of these priorities is aligned with the Strategic and Operational Plan, and addresses needs along the patient journey:

- Preventing avoidable admissions,
- Improving quality and patient flow during acute care episodes, including better care and discharge planning on weekends,
- Increasing community supports to increase weekend hospital discharges.

| Priority | Brief Description | Expected Outcomes (* denotes report card indicator) | Investment Required |
|---|---|---|---|
| **Enhance positions in emergency department to prevent unnecessary admissions** (Page 4) | Reconfiguring and adding positions in targeted Emergency Departments, with a goal of preventing avoidable admissions and readmissions, and reducing length of stay. | Decreased ALOS*<br>Decreased admissions >75*<br>Decreased readmissions*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement*<br><br>Increased 48/6 compliance<br>Decreased site occupancy | S.13(1) |
| **Perfect Care and Discharge planning** (Page 6) | Consistent use of best practices in daily care and discharge planning. Includes:<br>• Documented, goal-oriented care plans for every patient, every day.<br>• 100% use of 48/6 for care planning, and white boards | Decreased ALOS*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement*<br><br>Increased 48/6 compliance<br>Decreased site occupancy | S.13(1) |

| Priority | Brief Description | Expected Outcomes (* denotes report card indicator) | Investment Required |
|---|---|---|---|
| | (including EDD) for communication.<br>• Active and visible manager participation in daily flow processes. | | |
| **Extended PCC Coverage (evenings / weekends) to improve flow** (Page 8) | Expanding PCC coverage to increase flow 7 days a week at targeted hospitals. Target units are medical / ACE units at sites with highest likelihood for high occupancy and patients in "other locations" | Decreased ALOS*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement*<br><br>Increased 48/6 compliance<br>Decreased site occupancy<br>Increased weekend discharges | S.13(1) |
| **On-Call Allied Health (Social Work / Occupational Therapy) to support weekend discharges** (Page 10) | Add on call allied health services to sites without weekend coverage. Target to enable imminent weekend discharges. | Decreased ALOS*<br>Decreased ALC*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement* | S.13(1) |
| **Increase weekend discharges with increased Home Health supports** (Page 12) | Expanding HH coverage to increase flow 7 days a week at targeted hospitals. | Decreased ALOS*<br>Decreased ALC*<br>Increased 10hr rule *<br>Decreased patients waiting for inpatient bed placement* | S.13(1) |
| **Improved flow to Residential Care (increase weekend discharges and reduce bed turn around time)** (Page 14) | Increase 7d/week flow to residential care facilities through:<br>• Increased availability of weekend discharge supports (e.g., PCC)<br>• Reducing bed turn around time. | Decreased ALOS*<br>Decreased ALC*<br>Long stay patients >30d* | N/A |
| **Total Investment** | | | S.13(1) |

Combined, these initiatives will reduce congestion in Fraser Health hospitals which will improve quality, reduce the number of admitted patients receiving care in Emergency Departments and eliminate the use of hallways for patient care. The benefits of these improvements will be targeted to eliminate

| Impact | Estimated bed equivalent |
|---|---|
| Prevent 1,000 Emergency Department admissions with positions to prevent unnecessary admissions and readmissions. | > 20 acute care bed equivalents across FH hospitals. |
| Decrease length of stay by adding resources to improve care and discharge planning, particularly on weekends. Resources include targeted supports for improved care and discharge planning, expanded PCC and HHL coverage, and additional allied health supports.<br><br>In a 300 bed hospital, a 0.25d LOS decrease results in a functional increase of 12 beds. Estimated "functional increase" of bed equivalents for Fraser Health hospitals based on these strategies:<br>• 3-4 bed equivalents in each regional hospital (ARH, RCH, SMH);<br>• 2-3 bed equivalents in each medium sized community hospital (BH, CGH, ERH, LMH, PAH, RMH) | 20-30 acute care bed equivalents across FH hospitals. |
| Decrease patient days waiting for Residential Care admission by decreasing residential care bed turnaround time. | 5 acute care bed equivalents across FH hospitals. |
| **Total Cost Avoidance** | 45-55 acute care bed equivalents across FH |

Evaluation of the effectiveness of each of the proposed investments is recommended at 3 months and 6 months post implementation to ensure that resources are having the intended impact.

**Enhance positions in emergency department to prevent unnecessary admissions**
EXPANSION of current strategy.

**Brief Description:**
Reconfigure and add positions in targeted Emergency Departments (EDs) with goal of preventing avoidable admissions and readmissions, as well as reducing overall LOS through early discharge planning for admitted patients in emergency. Target population is frail seniors, vulnerable populations, and patients with complex needs.

GENC and QRCM Positions in ER
Currently there are 6 sites with 7 day/week GENC and 5 day/week QRCM staffing. These positions work collaboratively to:

- divert admission of complex geriatric patients though thorough assessment and linkages to appropriate resources in the community;
- prevent readmission through community follow-up in by the QRCM.

At medium sized sites, the GENC will also able to assist in timely care planning for complex geriatric patients who are admitted, which will decrease LOS and improve 48/6 compliance

DC2 Capacity Nurse in ER
A recent pilot of a DC2 Capacity nurse at Burnaby Hospital Emergency department has shown early success in diverting admissions as well as early initiation of care for patients admitted via the emergency department. This nurse works with the ER PCC to initiate 48/6 and medication reconciliation, and leads rounds for admitted patients.

| | |
|---|---|
| **Leads:** | Val Spurrell<br>Catherine Butler |
| **Investment Required:** | GENC and QRCM Positions in ER<br>Add GENC and QRCM to sites without these positions, (excl. MMH and FCH)<br>LMH: 1 GENC + 1 QRCM – 7.5 hrs x 7 days<br>RMH: 1 GENC + 1 QRCM – 7.5 hrs x 7 days<br>Estimate S.13(1)<br><br>Expand QRCM to 7 days/week at sites with current 5 day/week<br>BH : QRCM – 7.5hrs x 2 days<br>RCH: QRCM – 7.5hrs x 2 days<br>SMH: QRCM – 7.5hrs x 2 days<br>PAH: QRCM – 7.5hrs x 2 days<br>ARH: QRCM – 7.5hrs x 2 days<br>CGH: QRCM – 7.5hrs x 2 days<br>Estimate: S.13(1)<br><br>DC2 Capacity Nurse in ER<br>Add DC2 Capacity Nurse in Emergency to improve care and discharge planning for admitted patients.<br>RCH: 1 DC2 – 7.5hrs x 5 days<br>ARH: 1 DC2 – 7.5hrs x 5 days |

| | |
|---|---|
| | BH: 1 DC2 – 7.5hrs x 5 days<br>SMH: – 7.5hrs x 5 days<br>Estimate: S.13(1)<br><br>Total = S.13(1) |
| **Estimated Return on Investment:** | <u>GENC and QRCM Positions in ER</u><br>**Avoid approximately 1000 admissions (>20 bed equivalents)**<br><br>Extended hours of QRCM at these 6 sites and adding these positions at 4 more sites is anticipated to prevent approximately 1000 admissions (20-30 bed equivalents). This estimate is based on evaluation of existing QRCM/GENC positions in 2013/14, which indicated avoidance of nearly 1000 admissions.<br><br><u>DC2 Capacity Nurse in ER</u><br>**Decrease admission rate by 1% at target sites (6 bed equivalents)**<br><br>Very early (1 month) evaluation of this position at BH shows the site ER admission rate decrease from 14.4 % to 11%. This position will also contribute to decreased LOS based on early initiation of care and discharge planning. |
| **Indicators:** | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br>Admission rate >75<br>Site Occupancy<br>48/6 Compliance |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Complete review and evaluation of current positions in ER. | V Spurrell | Mid February 2015 |
| Pending approval, use available temporary resources to fill vacancies while completing hiring and orientation processes | Emergency leadership | March 2015 |
| Complete hiring process | " | April 2015 |
| Orient new hires | " | April 2015 |
| Partner with Emergency Department leadership to support effective use of these positions | Chris Windle | April – September 2015 |
| Review effectiveness/ evaluate | " | September 2015 |

| **Perfect daily care and discharge planning**<br>ACCELERATION of Strategic and Operational Plan strategy. | |
|---|---|
| **Brief Description:** Consistent use of best practices in daily care and discharge planning for each of our patients is the most significant leverage point for improving flow and reducing hospital occupancy. Perfect daily care and discharge planning includes:<br>• Documented, goal-oriented care plans for every patient, every day<br>• 100% use of 48/6 for care planning, and white boards (including Estimated Discharge Date) for communication<br>• Active and visible manager participation in daily flow processes | |
| **Lead:** | Tracy Irwin / Shallen Letwin<br>Site Executive Directors |
| **Investment Required:** | S.13(1) for 2 FTE temporary (1 year) supports to reinforce and sustain 48/6 implementation.<br><br>S.13(1) for PCC secondments (3-6 months per site, at each targeted site: ERH, ARH, SMH, RCH).<br><br>Plus temporary reallocation of existing resources in Access, STT, and targeted sites. |
| **Estimated ROI:** | Quantifying bed days saved through improved care and discharge planning is challenging, however, it contributes to improvements in:<br>• Length of stay<br>• Patients waiting for admission to inpatient beds<br>• Decreased site occupancy<br>• Reduced NSAE<br><br>Quantified as an example in a 300 bed hospital:<br>• Reducing LOS by 0.25 days results in a functional increase of 12 beds.<br>• Increasing the number of patients discharged by 11 a.m. from 15 percent to 30 percent adds eight functional beds<br><br>Combined with other strategies in this document (e.g., expanded PCC coverage; expanded Home Health Liaison support, etc.) these investments are expected to cumulatively contribute to bed day savings equivalent to 20-30 inpatient beds. |
| **Indicators:** | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br>Site Occupancy<br>Patients discharged before 11am |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Improve effectiveness of daily rounds at RMH; ERH; ARH; SMH; RCH | | |
| Complete project to improve daily rounds at RMH, with an outcome of developing video / tools that can be applied at other sites | Claudia Friess & Site Director | March 15 |
| Review tools developed at RMH and other tools for daily rounds to incorporate into subsequent sites. | Claudia Friess | February 2015 |
| Initiate work to improve daily rounds at ERH, ARH, SMH; RCH sites, including tailored use of tools developed at RMH. Target sites based on ALOS opportunity and current use of hallway / overflow spaces. | Claudia Friess & Site Director | February – June 2015 |
| Reinforce purpose and intention of "Meeting Free Mornings" and expectations of managers and directors on their units | Tracy Irwin | February 2015 |
| Fully adopt identified best practices – CAUTI training, 48/6, Mobilization | | |
| Continuing monthly audits of 3 best practices, including managers submitting action plans for improvement to site Executive Director | T. Irwin / V. Spurrell Site Executive Directors | Monthly |
| Initiate Roving Cart for Care Planning (based on BH example). Target sites with greatest opportunity to improve based on January audit results<br>• ARH; ERH; PAH; RCH; SMH | Sheila Finamore; Site EDs | March / April 2015 |
| Add "achieve 48/6 target" to Performance Link for all managers. | V. Giglio / S. Letwin | March / April 2015 |
| Consistently use Estimated Discharge Date (EDD) as a tool for communication and care planning | | |
| Roll out tools and supports for EDD at all sites. Presentation and discussions at HOMC and other department meetings. Add as forced function into Meditech | Spencer Lister | April 2015 |
| Full roll out of bedside white boards including their use as a communication tool at all sites. | Carol McGrandles | March 2015 |

| **Extended PCC Coverage (evenings and weekends) to improve flow**<br>EXPANSION of current strategy. | |
|---|---|
| **Brief Description:**<br>Expanding PCC coverage to increase flow 7 days a week at targeted hospitals. Target units are medical / ACE units at sites with highest likelihood for high occupancy and patients in "other locations".<br><br>PCC coverage has been extended to ensure that most medical and ACE units have minimum 7.5hrs/day coverage 7 days/week. | |
| **Lead:** | Shallen Letwin<br>Val Spurrell |
| **Investment Required:** | **Medicine and ACE Units**<br>Add PCC coverage for medicine and ACE units without regular daytime coverage 7 days/week. Excludes some smaller units.<br>Medicine Units (multiple sites): Estimate S.13(1)<br>ACE Units (BH, RCH, SMH): Estimate S.13(1) |
| **Estimated ROI:** | Based on literature, positions to improve flow and reduce variation will result in incremental improvements in flow. Quantified as an example in a 300 bed hospital:<br>• Reducing LOS by 0.25 days results in a functional increase of 12 beds.<br>• Increasing the number of patients discharged by 11 a.m. from 15 percent to 30 percent adds eight functional beds<br><br>Combined with other strategies in this document (e.g., perfect care and discharge planning; expanded Home Health Liaison support, etc.) these investments are expected to cumulatively contribute to bed day savings equivalent to 20-30 inpatient beds. |
| **Indicators:** | Decrease number of patients awaiting admission to inpatient bed*<br>Increase % admissions within 10 hrs*<br>Decrease ALOS*<br>Increased number of weekend discharges on units with extended PCC coverage |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Confirm approval to move forward with expanded PCC coverage in ACE Units / Medicine Units | V. Spurrell<br>S. Letwin | February 2015 |
| Begin filling shifts with temporary staff | V. Spurrell<br>S. Letwin | March 2015 |
| Evaluate ALOS and weekend discharges on units with added coverage | Site Executive Directors | June 2015 |
| Based on evaluation results, confirm whether to move forward with permanent positions | Clinical Executive | June 2015 |

| **On-Call Allied Health (Social Work / Occupational Therapy) to support weekend discharges**<br>EXPANSION of current strategy. | |
|---|---|
| **Brief Description:**<br>Adding on-call Allied Health (Social Work / Occupational Therapy) support to sites without weekend coverage to support imminent weekend discharges.<br><br>Target social work population is primarily vulnerable adults who require housing and social support to prevent admission to hospital. Occupational Therapists may provide assessment and/or specialized equipment to support discharge home. | |
| **Lead:** | Val Spurrell |
| **Investment Required:** | S.13(1)<br><br>5.0 FTE (maximum) for on-call Social Work / Occupational Therapy in hospitals.<br><br>Given that these sites have no history of weekend coverage for these key allied health professions, it is difficult to anticipate utilization of on-call services. Close monitoring of utilization will ensure costs do not exceed available budget. |
| **Estimated ROI:** | Given the absence of these positions on weekends at most community hospitals, it is difficult to quantify the objective number of weekend discharges specific to weekend SW (or OT) services.<br><br>In combination with other supports put in place to improve patient care and discharge planning on weekends, this service will contribute to increased weekend discharges and decreased LOS. |
| **Indicators:** | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br><br>Site Occupancy<br>Increased weekend discharges |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Create on-call rotation schedule for SW (community sites without weekend coverage) using existing staff providing rotating on weekend on-call coverage | S Brolin | Feb 27 |
| Ensure pager distribution and department tracking for specific departments. | S Brolin | March 6 |
| Development of on-call criteria for SW and OT on-call usage, to target weekend discharge. | S Brolin | March 6 |
| Develop tracking tool to measure utilization of on-call usage, patient tracking and weekend discharge outcomes | S Brolin | Feb 27 |
| Communication and education plan for Site Leaders, AOC and medical / surgical units regarding availability and appropriate use of these supports | S Brolin | Feb 27 |
| Begin on-call service at selected sites | S Brolin | March 6 |
| Track and Monitor | S Brolin | March 6, ongoing |
| Preliminary evaluation of outcomes | S Brolin | September |

| **Increasing Weekend Discharges to Home Health Supports**<br>ACCELERATION of Strategic and Operational Plan strategy | |
|---|---|
| **Brief Description:**<br>Increase Home Health Liaison (HHL) supports in Fraser Health hospitals to expand weekend service capacity and enable increased weekend discharges.<br><br>Currently, Home Health provides 7 day/week services including discharge and transition supports. However, weekend resource levels are generally far lower than week days. HHLs are critical to ensuring discharges from acute care; therefore investments are targeted to this position. This work aligns with Fraser Health's "Home First" strategies. | |
| **Lead:** | Catherine Butler |
| **Investment Required:** | 11 FTE Home Health Liaisons = S.13(1)<br><br>This investment brings Fraser Health closer to the recommended ratio of 1 Home Health Liaison per 25 inpatient beds, from the current state of 1:60.<br><br>Timelines for implementation are driven significantly by time required to hire and orient new Home Health Liaisons. Casual staff will be used to increase coverage in the short term; however, the available casual pool is already highly utilized to meet current demand.<br><br>Success of this strategy requires adequate support from PCCs to identify and expedite potential patient discharges through the weekend. This supports our "Home First" and "Home is Best" initiatives. |
| **Estimated ROI:** | In combination with other proposed supports to increase weekend flow, these positions will contribute to decreasing length of stay.<br><br>Based on literature, positions to improve flow and reduce variation will result in incremental improvements in flow. Quantified as an example in a 300 bed hospital:<br>• Reducing LOS by 0.25 days results in a functional increase of 12 beds.<br>• Increasing the number of patients discharged by 11 a.m. from 15 percent to 30 percent adds eight functional beds |
| **Indicators:**<br>*Link to Report Card indicators*<br><br>*May include other measures of success* | Average Length of Stay*<br>Emergency Patients Admitted to hospital within 10 hours *<br>Number of admitted patients awaiting inpatient bed*<br>Site Occupancy<br>Increased weekend discharges |

* Indicator from FH public report card

**Next Steps**

| Action | Lead | Timeframe |
|---|---|---|
| Confirm support for this strategy | Executive Team | February 2015 |
| Convert all possible casual positions into permanent HHL roles. | | March –April 2015 |
| Recruit and Hire new HHL staff for 1 year term pending evaluation results. | | March – May 2015 |
| Orient and train new HHL staff (4 months training process) | | September 2015 |
| Evaluate effectiveness of additional positions (measure against site based discharge targets). | | December 2015, March 2016 |

| **Decreasing delays in admissions to residential care facilities from acute care**<br>NEW strategy | |
|---|---|
| **Brief Description:**<br>Decreasing residential care bed turn around time will improve patient flow to residential care facilities and reduce the number of days that patients wait in acute care beds for residential care admission . An opportunity exists to decrease bed turnaround time from its current duration of 4.9 days. | |
| **Lead:** | Keith McBain<br>Tracy Irwin |
| **Investment Required:** | Temporary reallocation of internal resources (e.g, STT, HBA) is recommended to support review of existing processes, identification of opportunities, and implementation of improved processes. |
| **Estimated ROI:** | Reduce residential care bed turnaround time<br>Decreasing residential bed turnaround time to 4.0 days from its current duration of 4.9 days, will save acute care bed days equivalent to 5 beds. |
| **Indicators:** | Average Length of Stay (ALOS)*<br>Alternative level of care days*<br>Residential care bed turn around time |

* Indicator from FH public report card

**Next Steps:**

| Action | Lead | Timeframe |
|---|---|---|
| Confirm internal resources and small working group to review process for residential care bed turnaround time. | Keith McBain / Claudia Friess | February 2015 |
| Review and identify opportunities for improvement with current process for transitioning acute care patients to residential care beds to reduce bed turn around time from current 4.9 days. | Claudia Friess / Dee Chatha | March 2015 |
| Identify process improvements and begin implementing changes, in partnership with both contracted and owned/operated residential care facilities. | Claudia Friess / Dee Chatha | May/June 2015 |

**From:** Letwin, Shallen Dr.
**To:** Scheffler, Laurel
**Cc:** Irwin, Tracy
**Subject:** Re: Update for Thursday ARH-MMLH transfers
**Date:** Thursday, February 20, 2014 7:47:11 PM

Fantastic work Laurel....really nice

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**From**: Scheffler, Laurel
**Sent**: Thursday, February 20, 2014 07:25 PM
**To**: Richardson, Brook; Goudsblom, Mark; Duggan, Barbara; Herman, Linda; Irwin, Tracy; Wilkinson, Bryan
**Cc**: Deromeri, Leanne; Canning, Trena; Letwin, Shallen Dr.
**Subject**: Update for Thursday ARH-MMLH transfers

Hello everyone,
Today there have been some successes and some challenges:

- 2 patients were successfully transferred to MMH
- 1 patient that was going to transfer to MMH was actually successfully discharged home instead
- 1 repatriation to MMH is planned for tomorrow
- 2-3 patients that were planned for transfer to MMH will be going home tomorrow instead
- Challenges for today were the 4 patients/family that refused to be transferred to MMH. It would be good to have a communication plan that informs the community that in response to the congestion and hallway nursing, Fraser Health has opened further capacity at MMH to support ARH and patients could be assigned a bed at either site. Tracy, Brook and Shallen, would you be able to take this back to the executive? A first available bed policy would also be helpful to the frontline staff who are approaching this patients. I heard that there were tears, begging etc. from patient's and their families to leave them at ARH
- The Access Team along with the Medicine Outreach Nurse from MMH (Joy) in collaboration with the ARH PCC's did a lot of time consuming work to identify the appropriate patients for MMH. It would be very helpful to have a standard criteria for what kind of patient could be safe to transfer to MMH in terms of their care needs. That way the whole team are have the same understanding. I am wondering if the Medicine Program could prepare something that the Access team could use.
- Tonight the Access Team is continuing to identify patients for potential tomorrow

Thank you to everyone for the huge effort that went into the work today! Although only 2 patients actually transferred to MMH today, the teams were successful in discharging others instead of transferring which is always the preferred option.

**Laurel Scheffler**

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