# Giving the Hospital Back

# To the Staff and the Community

Report of the Supervisor

Hôtel-Dieu Grace Hospital

J. Kenneth Deane

Submitted to

The Honourable Deb Matthews

Minister of Health and Long-Term Care

July 3, 2012

# Final Report

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# Introduction and Executive Summary

On January 5th, 2011 I was appointed Supervisor of The Religious Hospitallers of Hotel Dieu of St. Joseph of the Diocese of London (the "Hôtel-Dieu Grace" or "Hospital") by Order in Council. As Supervisor, I assumed all of the powers of the Board, its officers and its members in accordance with the Public Hospitals Act. The Order in Council and my terms of reference are attached in Schedule 1.

My terms of reference included developing and implementing the necessary governance, organizational, operational and cultural changes to address the issues identified in the July 2010 Report of the provincially appointed Investigators of the Surgical Pathology Issues at the Hospital and from the external review of cardiology. Namely that there were:

> "long-standing unproductive relationships that were characterized by an alarming lack of respect and trust between the medical leaders, senior management and the Board of Directors".

My appointment followed a difficult period for the Hospital as it publicly dealt with a number of issues that included: a tragic murder/suicide; medical errors, and pathology mistakes that resulted in an investigation into surgery and pathology; an external review of cardiology; fraud in the finance department; termination of a vice president and a related $6.3 million dollar lawsuit against the Hospital and specific staff; ministry announcement that it will appoint a provincial Supervisor; removal of the Board Chair by the sponsoring organization; and a subsequent resignation of a Board member.

Upon my arrival at the Hospital it was quite clear that the lack of trust and respect amongst the Hospital's key leaders and the culture that the above environment created at the Hospital was primarily the result of a lack of clearly defined roles relating to corporate accountability. In my view, the lack of clearly defined, understood and accepted responsibilities resulted in the Board, management and Medical Advisory Committee becoming embroiled in unnecessary yet frequent conflict. The constant conflict in turn resulted in the inability of the hospital leadership to govern and manage the Hospital in today's complex and challenging environment. To develop a deeper understanding of the issues and opportunities in the Hospital I met with a wide range of individuals and groups, participated in a number of meetings, observed interactions and behaviours, and reviewed the Hospital's performance.

The Board was comprised of qualified and competent individuals; however, it did not appear that the Board functioned as a team or operated in a decision-making environment that was conducive to effective decision making. The second edition of the 'Guide to Good Governance' published by the Governance Centre of Excellence and the Ontario Hospital Association states that a board needs to create a culture of good governance. This culture is one that "exhibits constructive behaviour based on a shared set of values, beliefs and norms that support good governance". Developing this culture requires the understanding that "governance is a team activity among individuals with diverse experiences, skills, and styles. Hence, the culture needs to support open, constructive dialogue, the airing of differences while respecting the opinions of others, a search for consensus, and a focus on what is best for the corporation" [1]. However, this culture of good governance was lacking at Hotel-Dieu Grace. The Ontario hospital industry has moved towards recruiting directors based on their respective skills and experiences; however, the industry has not kept up with leading private sector practices in respect of conducting peer evaluations and, where appropriate, removing non-performing directors whose impact on board performance should not be understated.

[1] Governance Centre of Excellence and Ontario Hospital Association, *Guide to Good Governance*, 2nd edition, 2011

The broad reserve powers of the Corporate Members created confusion as to the Chief Executive Officer's role, responsibilities and accountabilities to the Board. Notwithstanding this confusion it does not change the responsibility of the Chief Executive Officer to establish the tone for senior management and develop a high performing team. This did not happen at Hotel-Dieu Grace as senior management was a team in name only and did not function effectively. It was a collection of individuals who at best worked at cross purposes, and at worst overtly worked against one another. The conflicts among senior managers and an apparent tolerance for unprofessional behaviour undermined senior management's credibility and authority. In addition, it profoundly and negatively affected the whole management team and management culture. As a result, there was lack of alignment, lack of trust, inadequate and ineffective communication, and fear of reprisal for speaking up. Senior management appeared distracted by too many concurrent initiatives and seemed unable to make strategic or operational changes despite a readily apparent need to do so.

The Medical Advisory Committee did not appear to fully understand its role and responsibilities, or the role and responsibilities of the Board. Furthermore, the Medical Advisory Committee did not appear to understand its responsibility and ability to oversee the performance of the professional staff. It also appeared that the Medical Advisory Committee neither viewed itself nor was it viewed by others as a key player in the overall leadership and direction of the Hospital.

In my view, the faith sponsored culture instilled at the Hospital by the Catholic Sponsor and the Salvation Army was and is beneficial to the delivery of quality of care at the Hospital. It was the leadership culture that was the problem and despite previous internal and external observations being made, there was no evidence that repairing culture had been identified as a priority. Leadership either ignored or failed to effectively deal with the cultural problems and this impaired the ability to address its recent multitude of challenges in a productive and supportive manner. The Hospital lacked a cohesive, comprehensive, and integrated cultural strategy. Although there are cultural issues and cultural 'hot spots' within the organization, there is no evidence the issues are systemic.

Notwithstanding the fact that most of the events at Hôtel-Dieu Grace could happen at any hospital, the problem was that the Hospital lacked the leadership capacity and cohesive organizational structure and culture to effectively address the problems. At its core the Hospital had a leadership gap that was characterized by an inability to come together to deal with problems, and a lack of focus on relationships which meant that the Hospital and its leadership did not have the required internal and external support to successfully respond to challenging events. The cumulative impact of the Hospital's issues was to undermine confidence in the capacity of hospital leadership.

The following report details the work that was undertaken during my term as Supervisor in order to stabilize the Hospital; build leadership capacity and establish respectful, trusting relationships among the leadership team; and initiate a process aimed at restoring public and staff trust and confidence in the organization.

My approach was based on the following hypothesis:

- Public trust follows public perception
- Public perception follows hospital performance
- Hospital performance follows strong leadership, healthy organizational culture, and effective hospital and clinical operations.

Therefore, we needed to set the tone at the top, build from the inside, and focus on the following three key results areas:

1. Renewing and building sustainable leadership capacity,
    a. Governance structure
    b. Directors
    c. Management
    d. Medical Leadership
2. Revitalizing culture and engagement, and
3. Improving hospital and clinical operations.

As a result of these changes, I believe that the hospital's ability to respond to challenging events has already been strengthened. This is illustrated by the way in which the advisory board, senior management, and medical leaders responded in a cohesive, coordinated and supportive manner to a recent unfortunate event.

I appreciate the level of cooperation and support over the past eighteen months from people throughout the organization. Individually and in groups people have provided feedback, offered suggestions, and identified opportunities for improvement. The openness and responsiveness throughout the organziation demonstrates the broad based interest in and commitment to moving forward. I requested the Board of Directors stay on in an advisory capacity in order to ensure that I had access to the community perspective and organizational memory; obtain a measure of the Board and individuals on the Board; and avoid another major disruption and distraction.

J. Kenneth Deane

# Background

**The Catholic Mission**

Hôtel-Dieu Grace Hospital is a Catholic faith-based hospital and as such it is sponsored. Originally HDGH was sponsored by the Religious Hospitallers of St Joseph; however, in 2006 the congregation transferred sponsorship to 'Catholic Health International' (CHI). This sponsorship is incorporated under civil law and is established as a "public juridic person" under canon law. The sponsorship refers to the Catholic identity of heath institutions that is granted by the Catholic Church and how its operations conform to the founders' Mission and Values. As the sponsor, Catholic Health International is directly accountable to the Vatican for ensuring these institutions, in their operations and spirit, adequately reflect the indicators of Catholic identity. The role of the institution's board, as well as complying with the legal and moral requirements of health care provision in Ontario, is to ensure the institution fulfills the Catholic philosophy, mission and values within the operations and governance of the institution. Hôtel-Dieu Grace's corporate structure differs from public hospitals in that the Members of the corporation are the board of Catholic Health International.

**The Investigator's Report**[2]

The terms of reference for review and a summary on the status of the Investigator's recommendations are attached in Schedule 2. In my report, I want to highlight the Investigator's comments that were of particular relevance to my terms of reference:

> "Respectful, trusting relationships between medical and hospital leadership and members of the Board of Directors are essential for a safe, high quality, well-functioning hospital. Over the course of its review, the team heard about long-standing unproductive relationships at Hôtel-Dieu Grace that were characterized by an alarming lack of respect between medical leaders, senior management and the Board of Directors. The team also heard many stories about how poor relationships between leaders at various levels of the organization have resulted in the development of an unhealthy culture that is, at times, characterised by distrust and disrespect. Generally, medical and hospital leadership do not feel well supported by each other. Some physician leaders feel they are excluded from decision making, and that hospital leadership is inclined to make unilateral decisions about issues impacting on medical staff without consulting them. The team recognized that Hôtel-Dieu Grace had significant turnover in its senior leadership over the last 10 years. Although there have been recent attempts to improve relationships with some success, the team believes that Hôtel-Dieu Grace needs to put significant efforts into fostering better relationships. This will be critical for advancing a hospital-wide quality improvement agenda."

[2] Report of the Investigators of Surgical and Pathology Issues at Three Essex County Hospitals: Hôtel-Dieu Grace Hospital, Leamington District Memorial Hospital and Windsor Regional Hospital dated July, 2010

**Cardiology Review**[3]

The cultural issues were further illustrated in the external review of cardiology commissioned by the Hospital in 2010. The reviewers concluded that:

> "The members of the review team have never seen a working and relational environment this concerning in any other health care institution. The conflict began as a discussion between individuals over use of hospital resources; these issues arise frequently in every hospital and physician group. They are normally resolved by discussion, negotiation, and compromise. Successful resolution depends on several factors: impartial and effective leadership, professional respect, appropriate processes, transparency and flexibility, genuine effort to understand other points of view, ability to see long term benefits through short-term compromise, and separation of personal priorities from corporate responsibilities. All of these were lacking to an astonishing degree."

The reviewers expressed concern about: (a) the current functionality of the Medical Advisory Committee in its role as an advisory body to the Board on matters concerning the quality of medical practice, and (b) perceived confusion in the roles and responsibilities of the Board, senior administration, and the medical leadership of the Hospital.

**Additional Cultural Concerns**

In 2010, the management of the Intensive Care Unit requested a coaching team. The conditions leading to this request included: increasing acuity and patient census combined with instability in upper and middle management; a lack of physician leadership and a consistent core physician group that led to nurses holding ICU together on a day-to-day basis; continuing changes that stressed the ICU given there was no stable foundation; and staff dissatisfaction that reflected low unit morale. The coaching team received 142 complaints/problems from staff. The unit was described as having lost its team focus – trust at all levels was absent, patient care focus was failing, and staff were leaving for areas with lesser acuity and better work life.

Issues were also identified back in 2008 when the Hospital engaged a third party to conduct a SWOT/Risk analysis with key internal/external stakeholders, two over-arching themes emerged from this research. The first theme was one of inconsistency in how the Hospital delivers service in a number of areas. For example, customer service, patient-centered care, communication by care-providers to patients and families, cleanliness of the institution, compassion/care and efficiency of procedures were all perceived as being delivered in an inconsistent manner. The second theme was that while the Hospital appeared to have enough high tech, it did not have enough high touch. The Hospital generally received high marks for technology, the 'Lean' process, leading edge medical treatment, and formal communications vehicles. However, it fell short on the delivery of high touch patient-centered care, and the atmosphere in the Hospital. It does not appear that the Hospital was able to effectively execute a sustainable plan to address these themes.

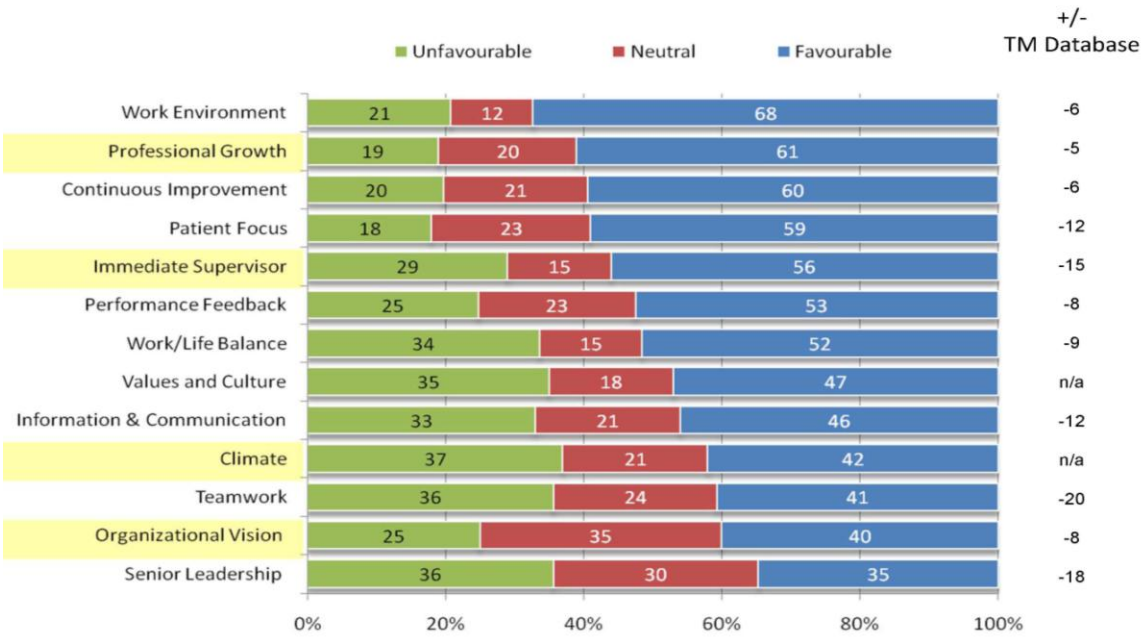
In January 2011, I received a letter from the Ontario Nurses Association in which it was stated that: "a culture of negativity permeates the workplace; there is a lack of respect and communication from hospital management for the RN's; a high volume and increasing number of Professional Responsibility Workload Concern Forms are not being addressed by hospital management; a high volume of grievances and arbitrations – labour relations issues are left too long and fester with complications that are unnecessary".

[3] Cardiology Review dated June 8, 2010.

At my request, the Director of Human Resources, the Manager of Occupational Health and Safety, and the Safe Workplace Advocate prepared an organizational assessment. This assessment identified the following: lack of consistent accountability for conduct that runs counter to our values; lack of a just culture; safety not a priority; perception that senior team is not working as a cohesive team and perhaps operating in an unhealthy work environment; lack of strong, consistent leadership; and too much change without adequate support, leadership or a plan to manage the change.

To assist in gaining an understanding of the Hospital's image in the community, a third party (Pollara) was engaged to survey the community. This survey was conducted between July 16th and July 27th, 2011. It included members of the community who had utilized the services in any of the three hospitals as well as a small sample of residents who had not used any hospital services in the past two years. The telephone survey of 1,200 was conducted among a representative sample of the catchment areas in Windsor and the Essex County to obtain opinions representative of the general public 18 years of age and over. The survey identified that the major gap between what people expect and what they believe about HDGH is trust that HDGH will strive to deliver highest quality of care available. Eighty-seven percent (87%) of respondents (54% strongly) believe this is the single most important element people expect from a hospital; whereas, 66% of respondents (26% strongly) feel that HDGH delivers on this attribute. In the opinion of Pollara, shifting this particular perception will be important in improving the views of quality of care at HDGH. The top factors influencing perception are personal experience and good care, service, staff, and equipment. Of note, 45% of respondents believed that administration ran the hospital efficiently.

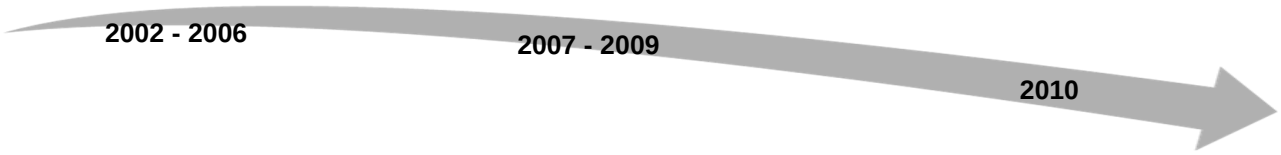
In recognition of the fact that culture is the foundation of a high performing organization, I engaged a third party (TalentMap) to conduct a cultural and staff engagement survey in May/June 2011. The survey had a staff participation rate of 38% and an overall participation rate of 33%. According to the survey, staff engagement level was 56% - 10% under the vendor's database average. The survey also covered 13 performance dimensions on all which the Hospital scored below the database average. There were six dimensions under 50% favourable: values and culture; information and communication; climate; teamwork; organizational vision; and senior leadership. Nursing scored significantly lower than all other professions across all survey dimensions.



A previous survey conducted by NRC Picker (Canada) in 2007 showed similar results. HDGH scored lower than the average for all hospitals on key indicators such as: satisfaction with the orgaization as a place to work; employee workplace experience; communication, involvement in decision making, feedback on performance; and respect and recognition.

## High Level Organizational Chronology

The following chronology is intended to identify some of the key events over the past 10 years.




**2002**
- New CEO appointed
- Ministry releases 2001 sponsored operational review report and recommendations
- Hospital has significant financial challenges due to years of successive operating deficits, and capital expenditures

**2003**
- Turnaround plan implemented
- Villa Maria nursing home closed

**2004**
- CEO leaves – Interim CEO appointed
- New CEO hired

**2005**
- Death of registered nurse Lori Dupont on hospital site
- ONA files an unsafe workplace grievance
- Ministry of Labour conducts an inspection and issues orders
- VP of Clinical Affairs appointed from within hospital
- Medical director position eliminated

**2006**
- Major re-organization of middle management
- Reporting relationship of nursing directors (middle managers) changed from vice president to CEO
- Internal report released on the death of registered nurse Lori Dupont
- Hired unit managers for every nursing unit

**2007**
- Coroners inquest into the murder
- Civil case goes to trial

**2008**
- CEO leaves – interim CEO appointed
- ONA unsafe workpace grievance settled

**2009**
- Reduced the number of unit managers due to budgetary issues
- New CEO hired

**2010**
- Medical and pathology errors identified
- Ministry of Health and Long-Term Care launches investigation into surgery and pathology
- External cardiology review
- Ministry of Health releases investigators report with 19 recommendations
- Ministry appoints facilitator to assist with implementing recommendations of surgical and pathology report
- Executive changes
  - Resignation of VP Clinical Support Services
  - Departure of VP Operations/Clincal Services; and VP Clinical Affairs
  - Departure of VP Communication / ED Foundation and subequent $6.3 million lawsuit
- Chief of Surgery leaves community
- Fraud in the finance department
- Ministry announces intent to appoint a Supervisor to run the Hospital
- Corporate sponsor removes Board Chair
- Board member resigns

## Summary of Key Activities

**January – March 2011**

- Supervisor appointed by Order in Council January 4, 2011
- Met with Board of Directors, senior management, MAC, management team, and union leadership to explain the Supervisor's role
- Requested the Board to stay on in an advisory role
- Established separate monthly meetings with middle and front line management; and established bi-monthly meetings with union leadership
- Held town hall meeting; established monthly communications forum for all management staff; established 'operations committee' to deal with operational and financial issues
- Issued 'request for quotation' for third party assistance: governance renewal; cultural and staff engagement survey; and mental health review
- Removed the President and Chief Executive Officer
- Introduced quarterly 'deep dive' operating reviews; and monthly on-off budget reviews

**April - June**

- Formed governance renewal task force; initiated review of governance structure, special Act, by-laws and Board policies; restructured board size, composition, and committee terms of reference; established community based nominating committee to recruit new Board members and community representatives on Board committees
- Issued 'request for quotation' for search assistance to replace two vice presidents; introduced '360 degree' assessments for all management staff, and talent management process for middle and front line management
- Reinstituted patient nourishments on inpatient units; eliminated $50.00 charge to process retirees post-retirement benefits; dedicated the Dr. Percy Demers Cardiac Care Centre and established a bursary in his name
- Engaged a physician executive to assist chief of staff; approved new compensation framework for medical leaders
- Conducted cultural survey
- Prepared a new management direction: "focusing on the fundamentals"
- Identified additional funding requirements to support organizational renewal and invest in the core
- Issued 'request for quotation' for a community survey - conducted telephone survey of 1,200 residents of Windsor-Essex

**July - September**

- Held discussions with CHI in respect of clarifying role of corporate sponsor and implementing necessary changes to governance structure
- Appointed advisory Board Vice Chair; approved Board committee charters
- Ministry announced operating funding of $5.0 million to support organizational renewal
- Finalized drafts of By-Law and Governance Charters

**October - December**

- Appointed new Board members and community representatives to committees
- Held orientation session for the Board, including CHI and Salvation Army representatives, senior management, and medical leadership
- Eliminated vice president, clinical support services position

**January - March 2012**

- Held second Board orientation session; held orientation sessions for committee members
- Appointed vice president clinical programs and chief nursing executive; and vice president strategic information and chief financial officer
- Introduced new organizational structure; eliminated management positions
- Initiated third party reviews: clinical services review; and peri-operative services

**April - June**

- Filed application for continuation to continue corporation as a letters patent corporation (change from Special Act Corporation)
- Approved administrative by-law, professional staff by-law, and Board policies
- Issued appointment letters to Board Chair, Vice Chair, and members
- Issued mandate letters to senior management; established senior management 'charter'
- Initiated third party review of outpatient clinics; received the draft external review of clinical services
- Application for continuation approved under the name Hotel-Dieu Grace Hospital, Windsor

# Key Results Areas

## A. Renewing and building sustainable leadership capacity

The dysfunctional leadership culture created significant issues and impaired organizational effectiveness; fostered unproductive relationships and the collateral feelings of fear and mistrust; created confusion as to who was in charge and who was responsible for what; and allowed an environment to evolve in which self-interest trumped what was in the best interest of the Hospital.

Addressing this required a broad based approach of ensuring the right people in the right positions; establishing clear delineation of roles, responsibilities, and expectations; implementing appropriate accountability mechanisms and management processes and systems; and developing and communicating a new management direction.

### Governance

It was clear that in order to optimize the effectiveness of the Board it was necessary to rebuild the basics of good governance. Therefore, I initiated a governance renewal process that focused on (a) the role and responsibilities of the Corporate Member, (b) the role and functions of the Board, (c) board structures and processes, (d) board size, composition, and recruitment, (e) duties and obligations of individual directors, (f) term of appointment, orientation and evaluation, (g) effective board – management relationships. The following actions were taken:

- Initiated a process to review and update the Special Act, the administrative by-law and the professional staff by-law with the assistance of Osler, Hoskin & Harcourt LLP.
- Filed application for continuation to continue corporation as a letters patent corporation (change from Special Act Corporation). This has been approved and the new corporate name is Hotel-Dieu Grace Hospital, Windsor.
- Engaged a third party to interview all Board members to assess interest, motivation, and skill mix, and to identify 'fit' with renewed governance expectations
- Appointed a governance renewal advisory task force chaired by Ms. Carol Derbyshire (Chair, Advisory Board) to develop a comprehensive set of governance polices, to vet proposed changes to the administrative by-law, and to support the renewal process. The administrative by-law was benchmarked against the OHA/OMA 2011 by-law, the by-laws of a number of Ontario hospitals including the recently approved by-laws approved by the following hospitals' Supervisors: The Scarborough Hospital (2008), Stevenson Memorial Hospital (2008), Kingston General Hospital (2009), Quinte Healthcare (2010), and Cambridge Memorial Hospital (2010). In addition, the Board policies were benchmarked against the OHA Guide for Good Governance, National Policy 58-201[4], the Canadian Coalition for Good Governance[5] and the TD Bank's online corporate governance charters[6]. The new by-law clearly outlines the roles, responsibilities and duties of the Board, administration, and its medical staff leaders.
- Conducted a review of best practices amongst Catholic sponsored hospitals in the province of Ontario, including the by-laws of five hospital corporations (Religious Hospitallers of St. Joseph of the Hotel Dieu of Kingston; St. Joseph's Health Centre, London; St. Joseph's Health Services Association of Chatham,

4 http://www.osc.gov.on.ca/documents/en/Securities-Category5/rule_20050415_58-201_gov-practices_2.pdf
5 http://www.ccgg.ca/
6 http://www.td.com/about-tdbfg/corporate-governance/charters-and-related-reference-material/charters.jsp

Incorporated; St. Joseph's Health Centre, Toronto; and St. Michael's Hospital, Toronto) to develop a corporate structure through the filing of the Application for Continuation and the by-law to ensure that the Hospital's Corporate Members retain appropriate reserve powers to ensure that the Catholic Mission, Philosophy and Values of the Hospital are respected and integrated into the operations of the Hospital, and that the Sponsor is able to fulfill its canonical responsibilities; yet shift some of the previous reserve powers from the Corporate Members to the Board including the power to approve the strategic plan, operating budget and capital plan and terminate the Chief Executive Officer.

- Set the size of the Board at twelve community directors, two ex-officio directors with one representing Catholic Health International and one representing the Salvation Army, and four ex-officio directors as determined per legislation.
- Appointed a 'blue ribbon' community based nominating committee to recruit new Board members. This committee was made up of four prominent community leaders: Maureen Greff (Chair), Patrick Ducharme, Don Rodzik, and Laurie Shalhoub. Carol Derbyshire (Chair of the Advisory Committee) and I served on the committee as well. Advertisements ran in the local media over a four-week period. This was the first time the Hospital conducted an open process for recruitment of volunteer Board members. Over forty highly-qualified people applied. The committee reviewed all applications and interviewed sixteen candidates. Reference checks were conducted for all individuals considered for the Board appointment or community representation on Board committees. Five individuals were appointed to the Board and seven individuals were appointed to committees.
- Following the recommendation of the governance renewal advisory task force and discussions with CHI, approved a new administrative by-law with the objective of (a) supporting the Sponsor's canonical responsibilities, (b) supporting the involvement of the Salvation Army given the Alliance Agreement, and (c) providing the Board with adequate authority and independence to fulfill its governance responsibilities. The new by-law gives authority to the Board for appointing the Chief Executive Officer and the sponsor confirming the appointment; the Board evaluates the Chief Executive Officer and has the authority to terminate; and the Board is now responsible for approving the strategic plan, operating budget, and capital plan.
- Approved the professional staff by-law recommended by the Medical Advisory Committee – greater commonality and consistency with the by-law at Windsor Regional Hospital.
- Conducted two orientation sessions for the Board. The first session included the senior management team and Medical Advisory Committee and focused on the current state of hospital board governance in Ontario and the performance governance obligations as impacted by legislation. The second orientation session held in January 2012 was for the Board members only. This session allowed them the opportunity to work together on common issues and further the process of taking ownership for their own future performance, as well as create a new culture and explore avenues in preparation to build a new strategic direction for Hôtel-Dieu Grace Hospital.
- Conducted orientation sessions for Board committee chairs and committee members. These sessions focused on healthcare in the province and region; relationship with the Local Health Integration Network (accountability agreement); HDGH profile, performance metrics, and the alliance agreement between the Religious Hospitallers of the Hotel Dieu of St. Joseph of the Diocese of London and the Governing Council of the Salvation Army in Canada. Meetings of all advisory board committees began in February 2012.

- Appointed Ms. Carol Derbyshire as Board Chair for a two year term ending at the 2014 annual meeting. Carol brings to this position a solid understanding of governance; values based leadership style with the ability to inspire, motivate, and work collaboratively; and a deep commitment to patients, staff, and the Hospital's mission.
- Appointed Ms. Shari Cunningham as Vice Chair for a two year term ending in 2014 at which time she will become Board Chair for a two year period. Similar to Carol, Shari understands governance and will provide strong and inclusive leadership to the Board.
- The reconstituted Board has six returning community Board members, and six new community Board members selected through the community recruitment process.

I have confidence in the new Board given its strong leadership, the degree to which the returning Board members appreciate and understand the issues that led to provincial supervision, and the quality and experience of the new members. The reconstituted Board has a good understanding of the roles and responsibilities of the Board, the Chief Executive Officer, the Chief of Staff, the Chief Nursing Executive, Medical Advisory Committee, Corporate Members and governance best practices. I also believe that with (a) the approval to continue the corporation as a letters patent corporation, and (b) the approval of the new by-laws and charters the Board is supported by the right structure.

**Management**

It was necessary to implement a number of fundamental leadership changes that included:

- Restructured senior management with the termination of the President and CEO, reduction in the number of vice-presidents, and the replacement of two vice presidents. The new team has the knowledge, skill and experience required to provide strong and cohesive leadership and advance the Hospital.
- Refocused senior management on the fundamentals including day-to-day operations; connectivity with the front line; engagement with the broader management team including physician leaders; workplace safety, and relations with the collective bargaining units.
- Increased accountability for results by introducing quarterly deep-dive operating reviews with each vice president and their direct reports to discuss performance across a number of dimensions; and introducing monthly on/off budget reviews.
- Instituted $360^{o}$ reviews for all management staff and senior management conducted talent management reviews of middle and front line management.
- Developed a new management direction focused on building organizational capacity through leader development and engagement, and greater staff and physician involvement; improving the work environment through staff engagement, connectivity, and safety; improving the patient experience of care by focusing on service excellence, and operations improvement; and refocusing on our mission by pursuing an inner city strategy.
- Realigned the management structure to support the new management direction, and deal with the financial and operational challenges facing the Hospital:
  - Reduced management positions;
  - Reorganized the clinical programs and services portfolio to better align programs and services, better balance program responsibilities, and provide greater focus on quality, patient safety, patient experience of care, and capacity management;

  - Established an operations and human resources portfolio with the objective of supporting improvement in the work environment and staff safety, building leadership capacity, and strengthening the presence and impact of mission;
  - Established an information management and finance portfolio with the objective of maximizing value from our shared services organizations, strengthening performance management, and aligning planning activities.
- Increased emphasis on leadership development by offering a number of programs in 2011:
  - Leading Quality Improvement Essentials for Managers (IHI);
  - Occupational Health and Safety Management Training;
  - Contemporary Practices in Healthcare Leadership (McKinsey);
  - Essentials of Project Management;
  - 360 Degree Post Assessment Session and Assessment Coaching Session;
  - Crucial Confrontations;
  - Emotionally Intelligent Manager;
  - Self-awareness and Leadership Effectiveness (Physician Management Institute).
- Established a senior management charter that outlines how the senior management team would function as a team. Shared this mandate with staff, physicians, and volunteers. This was particularly important given the problems and issues in the past.
- Issued mandate letters to senior management that identified their key deliverables in fiscal 2013. These mandates were shared with staff, physicians and volunteers.

Senior management is aligned and unified around a four-pronged organizational renewal strategy that focuses on:

- Building organizational capacity through leader development and engagement, and greater staff and physician involvement;
- Improving the work environment through staff engagement, connectivity, and safety;
- Improving the patient experience of care by focusing on service excellence, and operations improvement;
- Refocusing mission by developing an inner city strategy.

In addition to the preceding overarching objectives each member of senior management is responsible for key deliverables contained in executive mandate letters:

Ms. Marie Campagna, Vice President, Strategic Information and Chief Financial Officer:

- Develop organizational capacity to operate within the new funding formula by identifying the necessary changes to budgeting, costing, decision support, and managerial/clinical knowledge and understanding of the funding model;
- Improve operating performance by implementing a performance monitoring and management system;
- Maximize value from our shared services organizations by implementing an effective contract management plan.

Ms. Shona Elliott, Vice President Operations and Chief Human Resources Executive:

- Improve staff safety by addressing the recommendations from the Work Well audit and strengthening disability claims management;
- Strengthen organizational stewardship by implementing an enterprise risk management system;
- Strengthen day-to-day operational management by leveraging the after-hours management team through greater integration into the management structure, improved reporting, and identifying opportunities for eliminating recurring problems.

Ms. Janice Kaffer, Vice President Clinical Programs and Chief Nursing Executive:

- Improve capacity management and patient flow by supporting bed management with real time operating information, reducing conservable bed days, increasing our capacity to predict over capacity and proactively respond, and implementing the recommendations from the peri-operative review;
- Improve the consistency and standardization of care delivery by focusing on nursing fundamentals and professional practice and creating a 'seniors friendly' environment;
- Strengthen program management by developing clear accountabilities for the administrative/medical director teams, providing appropriate educational opportunities, developing the necessary infrastructure, and establishing milestones.

Dr. Gord Vail, Chief of Staff:

- Strengthen the relationship between the Medical Advisory Committee and senior management by facilitating effective two-way communication and fostering an integrated approach to dealing with challenging patient care issues;
- Build physician understanding of the new funding model by working with the Vice President Finance and offering orientation sessions;
- Create opportunities for greater physician participation by working with the Vice President Clinical Programs in advancing program management and involving physicians in decision making.

Senior management believes that by focusing on organizational renewal and these key deliverables the Hospital will continue to advance in the provision of superior service – in a safe workplace – based on its core values – in order to make a difference in the lives of those served by the Hospital.

**Medical Leadership**

Under the strong and effective leadership of a new Chief of Staff, the Medical Advisory Committee is working well with a good understanding of their role and responsibilities. Changes implemented include:

- Established standardized contracts for chiefs, sub-section chiefs, and medical directors.
- Established new compensation structure for medical leaders that is standardized and transparent.
- Held a joint orientation session with the advisory board, medical leadership, and senior management in 2011. This orientation served to set the framework for the respective roles of each group. The intent is to continue with these joint educational retreats on a yearly basis.
- Formed a working group to revise the professional staff by-laws with the assistance of Osler, Hoskin and Harcourt LLP. The Medical Advisory Committee reviewed and benchmarked the professional staff by-law against the previously listed Supervisor approved by-laws and the OHA/OMA prototype. In addition, the draft professional staff by-law was sent to the Ontario Medical Association for consideration. Following consideration of the OMA's comments and further consultation with medical staff members, the professional staff by-law was unanimously approved by the Medical Advisory Committee for recommendation to the Supervisor.
- Initiated the development of a new physician human resources plan with the goal to create a greater alignment and clearer expectations regarding the Hospital's needs and its ability to provide services as impacted by human resources, operating capacity, funding, technology etc.
- Initiated the development and implementation of a more robust and comprehensive impact analysis process that reflected greater due diligence on the part of administration when considering an application for privileges.
- Initiated recruitment of an administrative director for medical affairs to support ongoing communications and alignment with physicians and administration within the Hospital, and to support current processes and accountability systems within the office.

- Established a budget for ongoing management training of physician leaders. A number of physician leaders participated in the Canadian Physician Management Institute executive program this past year. In addition, a program was offered in Windsor for both physicians and management staff in March 2012. The intent is to offer similar programs in Windsor annually or bi-annually.
- Established annual goals for the Medical Advisory Committee.
- Included the Hospital performance dashboard on the Medical Advisory Committee agenda to highlight operational issues.
- Involved medical leaders in capital and operating budget planning.

The systems that have been put in place to support education of physician leaders, accountability, and a greater understanding of their role as medical leaders and as a Medical Advisory Committee in relation to the Board strengthens alignment and will optimize the effectiveness between all parties.

### B. Revitalizing culture and engagement

The evidence was compelling that the Hospital needed to explicitly focus on culture. Actions taken include:

- Formed a task group to develop an action plan to address the issues identified in the cultural survey
  - Held focus groups and planning sessions that identified the top five initiatives to support cultural change and engagement:
    - Improving the patient experience
    - Improving communications
    - Creation of a Charter of Rights for Employees, Physicians and Volunteers
    - Leadership development strategy
    - Values Clarification
  - For each of the initiatives action plans have been developed that identify: the key objectives; the impact on the workplace or patient care area; identification of the final product; resource requirements and project phases; risks; and the project timelines.
- Established two management groups with the objective of increasing engagement, vertical and horizontal communications, operational leadership, and input and recommendations to senior management by:
  - Establishing a leadership forum made up of middle and front line management, and chaired by a front line manager. As it was described to me there wasn't any encouragement for the front line and middle management to meet as a group. Forming an operations committee co-chaired by the Chief of Staff and the Vice President Clinical Programs/Chief Nursing Executive made up of administrative directors and medical directors to deal with operational and budget issues.
- Refocused the 2011 annual general meeting and the annual report by acknowledging the skill, commitment and professionalism of the front line. This acknowledgement was important given the leadership disconnect and, as well, the front line's resiliency and commitment in serving patients and the community given the public scrutiny and controversy that surrounded the Hospital. The theme for the annual report and meeting was *"Celebrating the Front Line".* The annual general meeting profiled six staff members who spoke about the Hospital, their role and commitment to patient care.
- Addressed cultural disconnects:
  - Re-instituted patient nourishments that had been eliminated from inpatient units for budget reasons;
  - Eliminated the $50.00 charge to process paperwork for post-retirement benefits; and

- Honoured the commitment made in 2003 to recognize Dr. Percy Demers by establishing the Dr. Percy Demers Cardiac Care Centre, along with a bursary in his name that will be awarded annually to a medical student who best exemplifies the attributes of collegiality, teamwork, trustworthiness and patient focus.

- Held separate monthly meetings with front line management and middle management. The purpose of these meetings was to support and strengthen connectivity, increase alignment, and overcome the fear and mistrust that had permeated the management team.
- Established bi-monthly meetings with union leadership to strengthen communication and to rebuild relationships that had deteriorated over the past few years.
- Initiated an open and transparent process with the Ontario Nurses Association to address issues identified through the professional responsibility concern report forms. The objective was to surface and, where possible, to solve issues. In the view of both management and the union this process is a marked difference from the past.

It has taken a year to start rebuilding trust within the organization and will take time to revitalize the culture. Small changes are evident and the changes to leadership are key enablers moving forward. Progress in renewing culture will reflect in higher levels of staff engagement and trust, and greater alignment of values and behaviours. Based on the literature and the experience relating to revitalizing or transforming culture it is clear that leadership is a key success factor. Leadership needs to be focused, aligned, consistent, and effective.

## C. Improving hospital and clinical operations

Based on observation and feedback from staff it was obvious that there needed to be a greater focus on operations. Actions taken include:

- Obtained increased base funding to invest in the core. This funding was earmarked for:
  - More nurses in the intensive care unit and coronary care unit to address the increased occupancy levels
  - Additional midnight coverage on inpatient units;
  - Additional after hours administrative support;
  - Additional staff in the staffing office;
  - Additional porters to reduce demand on nurses to move patients;
  - Patient enablers including blood pressure cuffs, blanket warmers, restraints, linen carts and commodes;
  - Creating a better environment through a refresh of patient units – minor room renovations, over-bed lights etc.
- Initiated the development of a 5-year plan for mental health services that included a third party review with a specific focus on physical layout; clinical processes; and risk policies, procedures, and processes for suicide assessment and prevention. The program has established a community advisory panel comprised of representatives from community health/service organizations, as well as family and consumer representatives, with the mandate to provide a forum that will support the dissemination of information to the community; consult with people on HDGH proposed directions for the mental health program; and engage our partners, consumers and families in creating and implementing strategic goals and programming.
- Identified demand management and patient flow as a priority, and initiated the development and deployment of a coordinated approach under the direction of the demand management steering committee. A variety of process improvements and initiatives are being developed and implemented including: patient flow improvement projects; bed management planning; modeling and predicting

demand; utilization management strategies; and emergency department changes such as a rapid medical unit, and a transition team to facilitate patient transfers.

- Initiated the development of an inner city strategy. The Hospital's mission reflects the rich legacy of Hôtel Dieu and the Salvation Army, both of which serviced the community with distinction. This mission is translated into the Hospital's commitment to care for the body, mind and spiritual well-being of a diverse community. Given the mission and the Hospital's unique location as an inner city hospital, it is appropriate to develop an inner city initiative that incorporates our emergency services, mental health services, and pastoral care and involves strengthening linkages with community partners. Through a relationship with Mark's Work Wearhouse the Hospital receives clothes to meet the needs of hospital patients and to supply two of our inner city partners - Street Health and the Trinity Lutheran Church.
- Identified a 'structural operating deficit' based on the cost impact of providing regional programs in neurosurgery, trauma, renal dialysis, cardiac angioplasty, and the cost impact of being the sole provider of interventional radiology in the LHIN. A contributing factor is the concentration of specialized programs and services. This is best illustrated by two different measures based on fiscal 2009/10 data. One measure is the "Acute Specialization Index" (ASI) that will be used in the new funding model (HBAM) to account for the higher costs of providing specialized services. The ASI shows the percent of a hospital's inpatient activity that is for these specialized services or programs. The HDGH ASI is 10.2%, which is the eleventh highest in Ontario, the highest among community hospitals, and even higher than some academic health science centres. A second measure is the Resource Intensity Weight that measures the relative expected cost to care for a patient. A higher RIW for a patient means that the cost of care would be expected to be higher. The average RIW per patient for HDGH is 2.21 that which is highest in the Erie St. Clair LHIN and highest among other Ontario community hospitals.
- Initiated third party reviews in response to the capacity, operational, and financial challenges facing the Hospital:
  - Peri-operative services: to identify opportunities for cost improvement and operational efficiencies, and to develop a new operating model
  - Outpatient clinics: to assess clinics as to whether they require the resources of a hospital or whether they can be provided in the community or a physician's office; and to identify those clinics that will continue to be offered in the Hospital
  - Clinical services: to identify the appropriate role for the Hospital as a regional referral centre for advanced care and as a community general hospital; to identify the range, scope, and volumes of services; and to assess organizational capacity and the adequacy of expected revenues to support the Hospital's role.

The preceding measures were intended to address a number of long standing issues, support front line staff, strengthen the hospital's presence and impact in the community, and improve operating performance. In addition the hospital has embarked upon an inclusive and systematic process to address the financial, operational, and capacity challenges it is facing.

## Provincial Investigation: Surgery and Pathology

My responsibilities as Supervisor including oversight of the progress in addressing the recommendations at Hôtel-Dieu Grace contained in the "Report of the Investigation of Surgical and Pathology Issues at the Three Essex County Hospitals". In order to objectively assess the status of implementation, an independent review was conducted to identify the level of implementation achieved on the nineteen recommendations contained in the report.

All recommendations contained within the report have been fully addressed (Exhibit 2) with the exception of two that require capital investment. Recommendation 5 deals with the centralization of the pathologists at Windsor Regional Hospital. The hospital is currently working through the capital planning process. It should be noted that the program will retain two pathologists at HDGH. Recommendation 7 involves the implementation of digital scanning technology at all three Essex County hospitals. This will be part of a new laboratory information system.

The Essex County hospitals remain committed to implementing the remaining two recommendations as the technology is approved from implementation and as WRH proceeds with capital renovations.

## External Review of Cardiology

The external review of cardiology commissioned by the hospital in 2010 identified conflicts and cultural issues among the physicians and between staff and physicians. There was a noted lack of leadership, professional respect and processes to sustain the program and its future growth.

The recommendations relating to the factors and circumstances that gave rise to commissioning the external review have in the main been fully addressed (Exhibit 3). Recommendations relating to continuous improvement of the cardiology program are in progress (recommendations 19, 20, 21, 22) due in part to time required to recruit a sub-section chief. Now that the chief has been recruited there is both commitment and momentum to move forward and implement improvements. The recommendations relating to the regional cardiology program depend on external endorsements. One of the driving issues for a review was concern about volumes in the cardiac catheterization laboratory and specifically percutaneous coronary intervention (PCI) volumes. In fiscal 2010 there were 365 PCI procedures performed and this increased to 629 PCI procedures in fiscal 2012.

Notwithstanding the progress that has been made there is more work to be done. In my view the hospital has the capability and the program has the necessary leadership to further advance the delivery of services. My assessment is based on the appointment in March 2012 of a new subsection chief who provide the necessary leadership; the level of commitment to address the cultural issues; and the strong and consistent oversight by the medical advisory committee and senior management. On May 1, 2012 the new chief convened a meeting with staff and physicians with senior management and medical leadership present to discuss vision and moving forward. Although there are still some challenging professional relationships; efforts are being made through the medical leadership structure to mediate and resolve.

## Conclusion

This report detailed the work that was undertaken in order to stabilize the Hospital; build leadership capacity; establish respectful, trusting relationships among the leadership team; and initiate a process aimed at restoring public and staff trust and confidence in the organization.

Although progress has been made over the past eighteen months it is not possible to completely address all the issues. However, the Hospital now has the leadership capacity to effectively advance the Hospital, to revitalize culture, and to address the operational requirements. This means advancing organizational renewal, and the key deliverables identified in the executive mandate letters; moving forward with the initiatives outlined in this report such as continuing to address cultural renewal, improving the level of staff and physician engagement, and dealing with 'cultural hot spots'; continuing to strengthen relationships among the Board, administration, and medical leadership; addressing the Hospital's structural operating deficit and the implications of the new funding formula; addressing the recommendations from the external review of cardiology; and improving management processes and systems. In addition, the Hospital will need to advance the expansion of cardiac angioplasty; address the working capital deficit of $14.2 million; develop and implement a clinical services plan that supports the sustainable delivery of quality programs, and ensures continued access, quality and safety within approved funding; and forge stronger linkages with Windsor Regional Hospital in advancing the Windsor hospital system.

Now that the Hospital has received its fiscal allocation for 2012/13 it is necessary to develop an operating plan that details the measures and timeline for addressing the capacity, operational and funding challenges facing the Hospital. Hotel-Dieu Grace provides regional programs and is the sole provider in the Erie St. Clair LHIN of certain programs and services that are not funded as regional programs/services. As a result this creates financial pressures and contributes to the hospital's structural operating deficit. This issue has been identified to the LHIN and to the Ministry of Health and Long Term Care.

Development of the operating plan will take into consideration a number of factors such as:

- Effectiveness of measures to reduce overtime, sick time, orientation, and supplies expense;
- Effectiveness of measures to deal with overcapacity;
- Impact of this year's fiscal allocation and the estimated impact next year;
- Recommendations from the external reviews of peri-operative services, and outpatient clinics;
- Recommendations from the clinical services review regarding the range and scope of programs and services offered by the hospital in relation to organizational capacity and funding;
- Assessment of the likelihood of additional funding to address the structural operating deficit.

It is important to acknowledge the need to operate within the approved funding level. However, it is also important to acknowledge that although progress has been made over the past eighteen months in dealing with culture more work needs to be done over a longer period of time. The hospital will need to understand the impact on culture as it deals with its financial challenges.

Hôtel-Dieu Grace is rebuilding from within through renewed governance, management and operations, and increased engagement of our staff and physicians. The Hospital's aspiration is to support a high quality and safe patient care experience that each staff member and physician is proud of and would without reservation recommend to a loved one.

# Schedules to the Report

1. Order in Council and Terms of Reference

2. (a) Terms of Reference for Surgical and Pathology Investigation

   (b) Surgical and Pathological Investigation Status Update

3. Cardiology Report Status Update

## Schedule 1 – Order in Council and Terms of Reference

Ontario
Executive Council
Conseil exécutif

Order in Council
Décret

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit :

Whereas the Minister of Health and Long-Term Care has recommended to the Lieutenant Governor in Council that a hospital supervisor be appointed for Hotel-Dieu Grace Hospital which is a public hospital under the *Public Hospitals Act*, R.S.O. 1990, Chapter P.40, as amended;

And whereas the Minister of Health and Long-Term Care has given the board of Hotel-Dieu Grace Hospital at least 14 days notice before making such recommendation to the Lieutenant Governor in Council;

And whereas the Lieutenant Governor in Council considers it in the public interest that a hospital supervisor be appointed for Hotel-Dieu Grace Hospital;

Therefore, pursuant to subsection 9(1) of the *Public Hospitals Act*, R.S.O. 1990, Chapter P.40, as amended,

J. Kenneth Deane

is hereby appointed as a hospital supervisor for Hotel-Dieu Grace Hospital.

Recommended Deb Matthews
Minister of Health and Long-Term Care

Concurred H S Takhar
Chair of Cabinet

Approved and Ordered JAN 0 4 2011
Date

Lieutenant Governor

O.C./Décret 1/2011

1. The Supervisor will exercise all the powers of the Hôtel-Dieu Grace Hospital (hereinafter referred to as the "Hospital"), its officers and its members in governing the Hospital in accordance with the *Public Hospitals Act*, its regulations and all other applicable legislation and in exercising those powers, report to, and carry out the directions issued by the Minister within the jurisdiction of the Supervisor.
2. The Supervisor will assume the role of the Facilitator in relation to the Hospital and be accountable to the Minister, or her delegate, for the completion of the remaining facilitation and reporting tasks of that role.
3. The Supervisor will develop and implement a plan for the Hospital to adopt a team-based approach to strategic planning and hospital management that: focuses on clarifying roles for and relationships among medical leaders, senior management staff and the Board of Directors; builds governance and leadership capacity; and creates alignment throughout the organization for the delivery of high quality clinical care.
4. The Supervisor will review the composition of the Board and senior management team to create a performance plan that optimizes the effectiveness of the Board and senior management team and supports the improvement of hospital relations.
5. The Supervisor will ensure that the Hospital has the ability to implement the governance, organizational, operational, and cultural changes that are necessary to address the issues identified in the July 2010 Report of the Investigators of Surgical Pathology Issues and the external review of Cardiology.
6. The Supervisor will provide regular updates to the Deputy Minister of Health and Long-Term Care or his delegate and the Chief Executive Officer of the Erie St. Clair Local Health Integration Network.
7. The Supervisor will report to the Minister of Health and Long-Term Care as required by the Minister, including *inter alia* reporting on any plans concerning Board membership and governance prior to implementation.
8. The Supervisor will provide a written report to the Minister of Health and Long Term Care upon completion of duties.

## Schedule 2(a) – Terms of Reference for Surgical and Pathological Investigation

Terms of Reference for Investigators for Hôtel-Dieu Grace Hospital, Leamington District Memorial Hospital, Windsor Regional Hospital (hereinafter referred to as the "Hospitals")

1. The Investigators will investigate and report on issues relating to the following matters at Hôtel-Dieu Grace Hospital (HDGH):

   a) The quality of care and treatment of patients at HDGH, analysis of any errors with particular reference to pathology results and recent reports of any surgical errors over the last two years;

   b) The processes and practices employed by HDGH to measure and improve the clinical appropriateness and quality of surgical care and the quality of pathology services;

   c) Review of surgical leadership structure, the process for previewing adverse events, the structure and culture of communication between pathologists and surgeons, and the recorded frequency of Multidisciplinary Case Conferences (MCCs) for cancer patients at HDGH;

   d) The executive and board monitoring of patient care and professional staff conduct with specific reference to whether HDGH has appropriate patient care practices and procedures to protect the safety and security of their patients.

   e) The role of HDGH's Medical Advisory Committee in fulfilling its responsibilities under the Public Hospitals Act.

2. Based on the findings relating to the issues set out in paragraph 1 for HDGH, the Investigators will determine whether similar or other issues should be reviewed at Leamington District Memorial Hospital and Windsor Regional Hospital.

3. The Investigators will investigate and report on issues relating to shared pathology services at the Hospitals.

4. The Investigators will review the status of recommendations from all relevant previous studies, strategies and reports regarding medical care quality, surgical services and pathology services at the Hospitals.

5. The Investigators will provide specific systemic recommendations to promote accountability among hospital boards for the quality of the pathology processes and surgical care (beyond the role of Medical Advisory Committee).

6. The Investigators will make recommendations and identify next steps for the Hospitals and the LHIN to respond to issues identified in the Investigation.

7. The Investigators will actively liaise with: the CEO of the Erie St. Clair Local Health Integration Network, the Boards, CEOs and senior clinical staff of the hospitals, the former CEO of Windsor Regional Hospital, and other relevant stakeholders, including Cancer Care Ontario.

8. The Investigators may seek external resources as appropriate to assist in completing their mandate.

9. The Investigators will provide regular updates to the Deputy Minister, Ministry of Health and Long-Term Care and/or Assistant Deputy Minister, Health System Accountability and Performance Division.

10. The Investigators will report to the Minister of Health and Long-Term Care as required. The Investigators will provide a written report to the Minister of Health and Long-Term Care upon completion of Duties no later than June 30, 2010.

**Schedule 2(b) - Surgical and Pathological Investigation Status Update**

| | HDGH Specific | Status |
|---|---|---|
| **1** | Pathology reporting processes be reviewed and there be a new standard report format, policies and processes for obtaining and recording a 2nd opinion | **Completed** |
| **2** | Pathologists participate in continuing professional development | **Completed** |
| **3** | Undertake a clinical competency assessment of Dr. Williams | **Completed** |
| **4** | Adopt a quality assurance program for pathology including peer assessments | **Completed** |
| **5** | Pathologist to be centralized on one site - WRH | **Planning process underway** at WRH to accommodate |
| **6** | Hospitals improve the process of preparing cytological specimens using liquid-based cytology systems | **Completed** |
| **7** | Digital scanning technology be implemented to facilitate second opinion consultations | **Partially completed.** Digital scanning technology requires an investment in an LIS system. Until this system is acquired multi-headed scopes are used at WRH and HDGH for 2nd opinions. |
| **8** | Collaboration b/w hospitals and LHSC be enhanced | **Completed** |
| **9** | HDGH reconsider position to restrict Dr. Heartwell's privileges | **Completed** |
| **10** | Dr. Heartwell participate in quality and continuing professional development | **Completed** |
| **11** | Medical leaders, senior management staff and Board develop supportive relationships / communications | **Completed** |
| **12** | HDGH support ongoing leadership training for Board, senior management and medical leaders | **Completed** |
| **13** | Medical staff be educated on HDGH's sentinel event policy and processes for reporting errors and near misses | **Completed** |
| **14** | Hospitals collaborate to advance patient quality and safety | **Completed** |
| **15** | Surgeon attendance at MCCs and work towards the development of joint MCCs | **Completed** |
| **16** | Hospitals review the roles and responsibilities of medical leadership positions | **Completed** |

## Schedule 3 - Cardiology Report Status Update

| | HDGH Specific | Status |
|---|---|---|
| 1. | Recruit physician leader | **Completed** |
| 2. | Create effective reporting structure | **Completed** |
| 3. | Create effective reporting structure | **Completed** |
| 4. | Assign VP to regional cardiac care program | **Completed** |
| 5. | Physician leader and program director to work closely with VP | **Completed** |
| 6. | Establish goals for quality improvement and monitoring of corporate quality and safety indicators | **Completed** |
| 7. | Establish standardized contracts - accountability agreements and performance expectations | **Completed. Will be implemented as contracts are renewed** |
| 8. | MAC to expand membership - physician leaders of key programs | **Completed** |
| 9. | MAC to focus on quality and patient care | **Completed** |
| 10. | MAC to form an executive | **Completed** |
| 11. | MAC to approve a physician human resources plan | **In progress** |
| 12. | MAC to develop a recruitment and selection process | **Completed** |
| 13. | MAC to implement a disruptive behaviour policy | **Completed** |
| 14. | Hold a retreat to review roles and responsibilities - Board, MAC, and senior management | **Completed** |
| 15. | Recruit additional clinicians | **Partially completed. Depends on availability of resources and personnel, and designation as a regional centre.** |
| 16. | Review call models and enhance subspecialty coverage | **Completed** |
| 17. | Review cardiology call models | **Completed** |
| 18. | Cath lab time allocation: 18 hours per interventionalist and 24 hours for invasive cardiologists | **Partially completed. Depends on availability of resources and personnel, and designation as a regional centre.** |
| 19. | Review and amend rules and regulations and standards of care | **In progress** |
| 20. | Establish mechanisms to focus on quality of care and patient outcomes | **In progress** |
| 21. | Establish clinical service teams | **In progress** |
| 22. | Establish sub-committees - quality, utilization, finance, research | **In progress** |
| 23. | Define reporting structures - MAC, senior management, board, and LHIN | **Completed** |
| 24. | Improve communications and conflict resolution mechanisms | **Completed** |