Summary

Date: January 27, 2026
Time: 12:00–1:00 PM
Location: KGH Room 1434, Centennial Building

Attendees

Leader: Jaymi Chernoff (Chief Operating Officer, Clinical Operations); (Dr. Azzam excused - attended to a cesarean section)

Facilitators / Wellness Officers: Dr. Ben Wierstra and Dr. Deema Jassi
Guests: Lindsay Taberner, Kelly Ann Campbell , Taaryn Miller, NP, Jenn Bishop, NP, Dr. Jack Loken, Dr. Marius Aucamp, Dr. Cara Wall, Dr. Ainsley McCaskill, Dr. Stephan Mostowy, Dr. Darryl Wile, Dr. Fred Dyck, Dr. Steyn Naude, Dr. Janno de Wet, Dr. Maurice Blitz, Dr. Sylvia Thiessen, Dr. Lukas Brand
Recorder: Sarika de Wet

All attendees participated in dialogue.

Leader & Facilitators debriefed after the meeting.

Methods

a. Advertisement

- Posters and email invitations distributed via KGH medical staff email lists
- Invitations shared on WhatsApp (KGH Wellness Community group)
- Personal invitations and messages
- Paper posters placed throughout the hospital

b. Selection of Leader / Guest

Jaymi Chernoff (Chief Operating Officer, Clinical Operations)

c. Record Keeping

- Electronic minutes maintained
- AI minute-taker used with permission
- Written notes recorded

d. Information Sharing

- Summary information to be shared with attending groups

e. Follow-up on Action Items

- As outlined below
- *Items in Blue Font indicate Pending Action Items. These actions are under the direct management of another IHA leader. The Wellness Officer will have the responsibility to find the leader under whose portfolio this matter falls and will follow-up, either by inviting the responsible leader to lead a Brown Bag Lunch, or via another communication channel.*

f. Feedback from Attendees

- Informal feedback received via hallway conversations and text messages.

Summary of Pebbles & Asks

1.) Neuroscience/Neurology

1.1) Ownership / coordination of neurosciences

- **Pebble**: “Who owns neurosciences regionally?” — perception: “everybody and no one,” leading to stalled progress.

- **Ask**: Could regional owner(s) be assigned, as well as a coordinated pathway/queue for neuroscience proposals and decisions.

- **Action item**: *Jaymi to dig deeper into the complexities of Dr Wile’s experience and is encouraging continued engagement from neuroscience leadership, as there is renewed emphasis on this work provincially.*

1.2) Clear decisioning (definitive yes/no) re: neuroscience proposals

- **Pebble**: Requests receive unclear or no responses; clinicians want definitive “no” or “yes” to

move forward.

- **Ask**: Can executive decisions (or a clear status) on major proposals be communicated to the initiator? Can a decision-maker path for each outstanding neurosciences/funding proposal be shared?

- **Action item**: *see above*

1.3) Chain of communication & political advocacy

- **Pebble**: Question about how/when frontline clinicians should contact elected officials and whom to contact internally (operational dyad, division head, medical director).

- **Ask**: Provide guidance on communication/advocacy pathways (including when to involve operations/medical affairs) and promote use of operational dyads for unified messaging and solutions.

- **Action item**: *Clinical operations concerns that are raised through department heads, division heads, dyad partners, chief of staff and regional leaders provide a meaningful, cohesive and unified message to elected officials*

1.4) Material support / administrative capacity for neurology programs

- **Pebble**: Local enthusiasm and fundraising exist, but material/administrative capacity and influence to convert proposals into funded service changes are lacking.

- **Ask**: How can fundraising and local resources be used to create pilot positions or increase administrative capacity without exposing IH to untenable long-term obligations?

- **Action item**: *Improving the quality of communication channels between funders, foundation, operational leaders and physician leaders will lead to aligned efforts to create sustainable change*

5) Nurse Practitioners

5.1) Recruitment (TRU Fair feedback) and NP workforce integration

- **Pebble**: Concerns that the IH presence at a recent provincial NP recruitment event was not productive (ripped paper example)

- **Ask**: Clarify what the NP recruitment event was for, and what our ask as a region was and if that presentation aligns with our capacity and structure.

- **Action item**: *Ensure representation at recruitment events aligns with the site/regional priorities, capacity and infrastructure. Jaymi to do some digging into the event vs No action item was assigned?*

5.2) Nurse practitioner (NP) funding, role design, and union/term risk

- **Pebble**: NPs would like to join acute care clinical services and feel there is insufficient onboarding, training, opportunities or resources to join an acute care service in a meaningful way.

- **Ask**: Can clinical services at KGH/IHA expand to include NP support positions in multiple divisions? Can NP job postings include onboarding and education supports for acute care positions.

- **Action item**: *This is a complex provincial issue, and there are few health authorities that have integrated NPs into acute care effectively. At IHA there is work being done, and it requires collaboration with physician leads, operations, unions and contracts for example. No action item was assigned.*

6) Public-facing metrics and transparency

- **Pebble**: There is a request to provide public facing metrics (wait times, admissions/bed assignment). This way, our patients and us can see how we are doing compared to other sites, and resources can be allocated based on these values.

- **Ask**: Public-facing metrics and alignment with resource-allocation plans

- **Action item:** *There is some work on this being done an it is widely recognized and accepted that many health care systems do share their metrics with the public, including but not limited to average length of stay, time from admission to bed, readmission rate, patient satisfaction, volume etc. There was no action item assigned but a reassurance that these discussions are underway.*

7) Capital planning / Cottonwood expansion / Bed capacity

- **Pebble**: Uncertainty over capital projects, Cottonwoods is being planned for 2 floors when there is city zoning permission for 6 floors, why did this happen? When are will information about the 6E potential expansion be made available?

- **Ask**: Clarify capital project status, phasing, expected bed/capacity impact, and linkage to rehab/service reallocation plans. Identify ways to re-scope or split projects to stay within approvable thresholds/budgets.

- **Action Item:** *There are complex reasons allocation of resources needs to be within the IHA acute site vs IHA LTC site, these are listed in the Hospital Act. There are also ceilings on capital funding requests that limit the ability to build more than a certain amount at a time. In order to provide some type of expansion, the lower financial/capital asks are preferred as they are more likely to be approved and completed within a certain amount of time. No official action item was assigned.*

8) Maintain clinician engagement and transparent prioritization

- **Pebble**: Clinicians get enthusiastic but disengage when feedback is slow or absent (risk of losing passionate contributors).

- **Ask**: Can we keep stakeholders/proposal initiators informed (accepted / deferred / next-cycle) with clear reasons and timelines so effort is not wasted? Can IH create an engagement/status list for high-value clinician proposals (accepted / deferred / reason / next review date) and communicate it regularly?

- **Action item**: *Jaymi acknowledged that the "who" to ask is not always clear and work can be done on increasing awareness of the roles and responsibilities within the medicine and operations portfolios. No action item was assigned.*

Update / December Brown Bag Lunch

Item: Anesthesia Records Management

Pebble: Anesthesia records are removed from charts during admission and may not be returned (for 7+ days), creating information gaps

Ask: Engage the Medical Records administrators and request that they retain anesthesia records in charts until discharge; photocopy and keep a physical copy in the chart at all times

Action Item: Robyn has started an investigation and action is underway

Follow-up:

- *Anesthesia record issue: Anesthetic Records are always available in paper charts at Heath Records for non-analyzed charts.*
- *Chart assembly and processing post discharge now takes approximately 14-17 days (improved from 24-29 days).*
- *If a patient is representing during the two week period following discharge, the charts are available on demand from Health Records and the Anesthetic Records are still in that paper chart which would allow the medical staff to view the documents in paper form.*
- *No other action items due to the complexity of scanning records to ensure patient safety, information security, and legal integrity*