Summary

Date: February 12, 2026
Time: 12:00–1:00 PM
Location: KGH IHSC 61420

Attendees

Leader: Dr. Maurice Blitz (Senior Medical Director, Kelowna Acute) and Lindsay Taberner (Executive Director, KGH, Clinical Operations South, COK)

Facilitators / Wellness Officers: Dr. Deema Jassi
Guests: Dr. Jack Loken, Dr. Cara Wall, Dr. Ainsley McCaskill, Dr. Janno de Wet, Dr. Carolyne McLellan, Dr. Ryan Knebel, Dr. Dwight Ferris, Dr. Ann Marie McKenna
Recorder: Sarika de Wet .

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

Dr. Maurice Blitz (Senior Medical Director, Kelowna Acute) and Lindsay Taberner (Executive

Director, KGH, Clinical Operations South, COK)

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.*
- *Items in Green Font are under the management and portfolio of today's leaders*

f. Feedback from Attendees

- Informal feedback received via hallway conversations and text messages.

g. Miscellaneous

***** Considerable time was spent recognizing and appreciating the hard work both Maurice and Lindsay have put into our site, advocacy for our medical and clinical staff and patient care.

Summary of Pebbles & Asks

1) Workplace Civility

Pebble: Workplace civility / "be nice to each other" initiative / inclusivity (extend civility to every person). "***Can we focus on patient-centered care - together, the doctors and the nurses"***

Ask: Pilot a low-effort staff campaign to increase civility (compliment drives, recognition of small wins) led by MSA/wellness committee/supported by leadership

Action item: KGH Wellness Committee to continue community and camaraderie building efforts

2) Non-physician staff appreciation

Pebble: Under-recognition of non-physician staff (housekeeping, dietary, etc.)

Ask: Intentionally include and recognize non-clinical staff in recognition efforts (e.g. of past efforts, holiday lunches, thank-you communications).

Action item: Re-establish recognition distribution plan to include housekeeping/dietary/other supports. ***Assignee:*** MSA/Wellness & site operational leads

3) Safety concerns, managing expectations and improving healthcare literacy

Pebble: Recognition that medical Staff physical safety is challenged by three factors:
a. Demented/delirious elderly
b. Mental Health/Addictions
c. Patients and families whose experience does not match their expectations (decreased health care literacy)

Ask: 1. Create consistent, patient-facing messaging (verbal and written) that sets realistic expectations about realistic care expectations and why (system limits), plus staff guidance on how to communicate.

Action item: Draft standardized “welcome/expectations” messaging for emergent and inpatient flow (pamphlet/poster/emerge sign and/or QR) for review by site communications and clinical leads. ***Assignee:*** Site operations/communications with clinical input

Ask. 2. Multi-pronged approach: staff safety protocols, training for de-escalation, clearer escalation pathways, and messaging that differentiates scenarios (hostile vs medical delirium vs addiction-related).

Action item: Compile current safety protocols and training gaps; propose a prioritized set of interventions (e.g., targeted training, liaison resources, security/behavioral health pathways) and owners. ***Assignee***: Site safety lead/Access & Flow + clinical stakeholders (ED leadership, psychiatry. Deema has reached out to Brent Weiss, Drs of BC Regional Advocate as well as the MSSW to start conversations. We have all of these resources in place for included and contracted IH employees. Developing something physician specific is a great idea.

Ask 3. Provide senior patients with daily activity/stimulus similar to the programs they receive at LTC. Ensure TV is an option.

Action item: Produce and circulate a short list of available entertainment/resource options and how patients access them (Wi-Fi, iPad loan process). ***Assignee***: Site operations/patient experience. Devices exist; communications about services recommended. Lindsay will resend the memo related to the devices and information about the patient devices.

4) Spiritual Care - highly valued service

4.1) Reporting alignment

Pebble: Spiritual care reporting alignment and resourcing (role overloaded; high demand)

Ask: Re-examine reporting alignment (Access & Flow vs Allied Health),and increase capacity/resources (FTE or supports/volunteer training) so spiritual care can meet demand (ICU and site-wide).

Action item: Direct discussions between site operations lead and spiritual care practitioner regarding challenges, gaps and opportunities. ***Assignee:*** Site operations (Lindsay) to pursue a deeper understanding. Discussions are occurring with SCP regarding workload and priority setting, but there is no current action to realign him or add additional resources at this time.

4.2) Workload and Resourcing

Pebble: High spiritual care workload in ICU and across site (single clinician stretched)

Ask: Quantify demand (ICU % time, consult numbers) and evaluate options: additional hire, protected time, volunteer training, or regional centralized model.

Action item: Discussions are occurring with SCP regarding workload and priority setting, but there is no current action to realign him or add additional resources at this time.

5) Wellness and fitness

Pebble: Wellness physical resources — gym/fitness & basketball hoop idea

Ask: Explore low-cost, low-space physical wellness options (e.g., outdoor basketball hoop or repurposed area) driven by the wellness committee.

Action item: Identify potential locations, safety/operational implications, and costs; bring a feasibility proposal to site operations.
Assignee: MSA Wellness Committee to work with COS and site operations to discuss possibilities

6) Reverse bed-spacing pilot

Pebble: Current care model involves acute patients being treated in ER C1 and hallways, whereas patients who are stable and close to discharge are in rooms on a ward. This results in increasing delirium at the beginning of a stay and longer length of stay and likely poorer outcomes.

Ask: Reverse bed-spacing / “reverse bed flow” to reduce length of stay and free acute beds. Example from St. Mike’s was discussed.
Consider a targeted pilot to tag near-discharge stable patients for placement in designated spaces (e.g., an alcove/unit) to expedite flow while protecting delirium-prone patients.

Action item: Review eligibility criteria, handover processes, and staffing implications; propose a pilot with inclusion/exclusion criteria and outcome measures (LOS, re-admissions, delirium

rates). ***Assignee***: Lindsay + Access & Flow/Bed management team with clinical leads (medicine/surgery).Lindsay met with the C1 / ED leaders. The goal currently is to keep C1 with patients who are anticipated a short admission time and those with more complex needs and anticipated longer length of stay are assigned inpatient beds as they become available. It is not always possible, but we are trying to maintain this configuration. This aligns with the reverse bed spacing idea to ensure shorter length of time in C1. We will continue to review patients in C1 maintaining shorter LOS patients in C1 and longer LOS patients moving to inpatient beds. We also currently move shorter LOS patients into hallways on units prior to discharge. This keeps them with the same unit and care team which has been shown to reduce adverse events and overall LOS by reducing transitions in care.

7) Community paramedicine

Pebble: Community paramedicine / field diagnostics to avoid unnecessary ED transfers

Ask: Explore expanded community paramedicine models (field ECG, bloodwork, remote docs) and local trials to manage frail-at-home patients and avoid ED arrivals.

Action item: Identify existing paramedic pilots (cardiac/field lytics) and evaluate extension to frail-at-home pathways; consult with Brent Hobbs and community partners to scope pilot. ***Assignee:*** CODFP collaboration, Cara working on this. Access & Flow/Paramedic program leads + ED clinical leads. Some trials exist (cardiac); suggested further exploration.

8) Long-term care (LTCH) transfers and OPAT / hospital-at-home opportunities

Pebble: Data on long-term care (LTCH) transfers and OPAT / hospital-at-home opportunities

Ask: Quantify LTCH-to-ED transfers, review reasons (e.g., need for IV antibiotics), and pilot OPAT/hospital-at-home expansions or LTCH supports to reduce transfers.

Action item: Continue work with Regional Integrated Services, CODFP-ER, CODFP-Hospitalist sub committees and the Hospital at Home team and Home Health programs to review options to support IV antibiotics in LTC.