Executive Limitation Monitoring Report
EL-5 Treatment of Clients
Lake of the Woods District Hospital

February 2018

Board policy is indicated in bold typeface throughout.

I hereby present my monitoring report on your Executive Limitations Policy EL-5 "**Treatment of Clients"** according to the schedule set out. I certify that the information contained in this report is true, and ***represents reasonable achievement of all aspects of the policy unless specifically stated otherwise.***

Signed_____________________________, CEO Date: February 2018

The Chief Executive Officer shall not cause or allow conditions, procedures, or decisions which are unsafe, unduly undignified, unnecessarily intrusive, that fail to provide adequate confidentiality or privacy of the person, or that otherwise jeopardize the quality of care or service to clients or potential clients, or are inconsistent with continuous quality improvement and patient-focused innovation.

CEO Interpretation (no change)

I interpret *"conditions"* to mean the physical plant, the staffing levels, schedules, functional equipment, adequate supplies, therapeutic relationships, policies and procedures to guide practice, training and organizational support systems as any of these can impact patient care.
I interpret *"procedures"* to mean procedures performed by employees of the hospital which are contained in the Procedure manuals, governed by Professional standards or Best Practice and/or contained in guidelines as these are the documents which guide our staff in carrying out specific duties.
I interpret *"decisions"* as the decisions made by hospital employees based on their assessment of each patient condition and situation and the environment.
I interpret "*unsafe"* to mean conditions within the hospital where patients would be at risk of sustaining preventable injury or illness as we cannot be held accountable for the safety of conditions outside the hospital.
I interpret *"jeopardize"* to mean put the quality of the care delivered at risk while the patient is in the care of the LWDH, as we cannot be held accountable for the quality of care when the client is no longer in our care.
I interpret *"client"* to mean people who present at the hospital or at a hospital-provided service area for treatment since we cannot be held accountable for clients who do not come to us.
I interpret *"inconsistent with"* to mean contrary to accepted hospital policy, practice and ends.
I interpret *"continuous quality improvement*" to mean continually striving to improve services, to provide the highest quality, at the best cost.
I interpret *"innovation*" to mean introducing new methods or improvements in delivery of hospital services.

Evidence

Evidence of the overall compliance with this executive limitation is provided by the cumulative evidence for the numbered policy statements below.

Further without limiting the scope of the above statement by the following list, the CEO shall not:

1. **Tolerate that a client be treated any other way than with dignity and compassion.**

CEO Interpretation (no change)

In addition to freedom from abuse as required by item 1.1 below, I interpret *"dignity"* to mean free from abuse, discrimination, harassment, intimidation or humiliation.
I interpret "*compassion*" to mean sensitivity to the beliefs, values, feelings and concerns of patients accessing our services and/or their families as the needs of the patient is the focus of our care.

Compliance will be demonstrated when

(a) The LWDH score in the annual in-house patient satisfaction survey , for the item "treated with respect" which includes the manner to which patients are treated by nurses, physicians and admitting staff, is equal to or greater than 85% (using a scale of 1-7 with 1 being unsatisfied and 7 being very satisfied). This is seen as reasonable as the NRC Picker data for the 2012 (last data available) when combining inpatient and outpatient satisfaction scores, identifies 84% compliance for large community hospitals in Ontario. As we no longer have access to NRC Picker report scores, we will continue to measure against the 2012 standard.

(b) 100% of complaints re insensitivity to dignity have been investigated and resolved within 4 weeks

Evidence: (a) **Compliant**

Year	% YES - (5-7) (Satisfied)	% MID (4) (Neutral)	% NO (1-3) (Unsatisfied)
2011	90% (n=505)	4% (n=20)	6%(n= 21)
2012	94.2%(n=375)	2.3%(n=9)	3.5%(n=14)
2013	94.0% (n=282)	2.67%(n=8)	3.3%(n=10)
2014	93.7% (n=329)	1.99%(n=7)	4.3%(n=15)
2015	94.1% (n=351)	2.68%(n=10)	3.22%(n=12)
2016	N/A	Different survey	
2017	88.78% (n-182)	7% (n – 7)	7.8%(n – 16)

b) Non- Compliant

COMPLAINTS OF INSENSITIVITY TO DIGNITY

TOPIC	2011	2012	2013	2014	2015	2016	2017
# of Complaints	2	7	4	2	2	2	8
% of Complaints resolved within 4 weeks	100%	100%	100%	100%	100%	100%	88%

Data source: Risk Monitor & Risk Feedback electronic incident reporting systems. 7/8 complaints were resolved to the complainant's satisfaction within four weeks. A missed email resulted in one not being resolved within 4 weeks. Measures in place to prevent this from happening in future. .

1.1. Permit clients to be without reasonable protection from abuse.

CEO Interpretation (no change)

I interpret "*reasonable protection*" to mean measures taken to protect clients from abuse in situations where abuse could be predicted or anticipated. Such measures range from, but are not limited to, anything from removing the patient from the situation to contacting the police.

I interpret *"abuse"* to mean "mistreatment or injury or threat to mistreat or injure one individual or party by another". This limitation is further limited to those incidents which are known to have occurred and/or have been reported via verbal or written complaint as we cannot be expected to know about incidents of abuse which individuals do not report.

Compliance will be demonstrated when there are no confirmed incidents of **patient verbal or physical abuse.** (Exception: patient to patient incidents that cannot be anticipated or prevented but can be immediately managed).

Evidence: **Compliant**

INCIDENTS OF ABUSE REPORTED IN RISK MONITOR

	IN-PATIENT	OUT-PATIENT
2010	3	0
2011	0	0
2012	0	0
2014	0	0
2015	0	0
2016	2 (investigated)	0
2017	1 (investigated)	0

The one incident of abuse in 2017 was investigated, video reviewed and found to be unsubstantiated. Patient later retracted statement.

1.2. **Allow services to be delivered in a manner insensitive to patients' culture.**

CEO Interpretation – (no change)

I interpret *"insensitive"* to mean disrespectful of patient differences.

Compliance will be demonstrated when more than 80% of patients responding to Lake of the Woods District Hospital survey in the area of "respectful of my cultural needs" indicate satisfaction (using a scale of 1-7 with 1 being unsatisfied and 7 being very satisfied). This is a reasonable target as it is greater than the last available measure from community hospitals (2012).

Evidence: **Compliant**

Year	LWDH	Community Hospitals	N
2011	84%(in house survey)	79.2%	259
2012	92.3%	79	220
2013	87.6%	Not available	129
2014	87.5%	Not available	119
2015	89.2%	Not available	259
2016	N/A – Different Survey		
2017	82%	Not available	90

Some of the ways LWDH respects cultural needs are:

- Cultural needs are identified by the multidisciplinary team and incorporated in the patient's plan of care
- Utilize the local Multicultural Association for interpreter/cultural support when needed

- FT Aboriginal coordination supports inpatient and outpatient services
- Smudging room available
- Ongoing staff education re: Cultural sensitivity

2. Elicit information for which there is no clear necessity.

CEO Interpretation- no change

I interpret *"information"* to mean any information about a client.
I interpret *"clear necessity"* to mean required to deliver holistic patient care to the client.

Compliance will be demonstrated when

a) Assessment tools have been reviewed to ensure that information being collected is necessary to plan care and revised based on this review within the past 2 years as per our hospital policy on review and revision of policies and procedures.

b) Meditech access is monitored, all potential breaches are investigated and appropriate actions taken.

Evidence: **Compliant**

a) All Client assessment tools (for admission) have been reviewed and revised as part of the Meditech Patient Care System electronic documentation system implementation in 2014. Ongoing revisions and improvements continue.

b) Compliant

Year	# BREACHES
2013	2
2014	4
2015	3
2016	5
2017	4 investigated – 1 resulted in verbal discipline

3. Permit treatment without informed consent.

CEO Interpretation (no change)

I interpret *"informed"* to mean providing the client with information regarding the risks and benefits of having care and the risks and benefits of not having care, as well as alternative to the care being proposed, so the client or their substitute decision maker has the information they need to make a decision.

Compliance will be demonstrated when there are no incidents of treatment being given without informed consent reported in the Risk Management system.

Evidence: **Compliant**

TREATMENT DELIVERED WITHOUT INFORMED CONSENT

Year	2011	2012	2013	2014	2015	2016	2017
# of incidents reported	0	0	0	0	0	0	0

4. **Operate without maintaining standards that meet the requirements for accreditation by Accreditation Canada.**

CEO Interpretation (no change)

I interpret "accreditation" to mean a 3 year accreditation with Accreditation Canada with or without recommendations.

Compliance will be demonstrated when the LWDH is accredited by Accreditation Canada.

Evidence: **Compliant**

LWDH achieved four year "Accreditation with Commendation" in October 2015. Follow up with Accreditation Canada is ongoing to address outstanding Require Organizational Practice compliance criteria. A report was submitted March 29/16 re Suicide Risk Assessment as per accreditation report requirements.

Additional compliance information was sent by the March 29, 2017 deadline on Medication Management Standards (evaluation/audit of antimicrobial stewardship, separation of look-alike/sound alike/high alert medications, formalized Pharmacy on-call process, Mental Health Standard (response to safety concerns), Perioperative Medication standard (medication storage/security).

May 4, 2017 we received a letter from Accreditation Canada advising and congratulating us on meeting all the follow-up requirements.

5. **Operate without an appeal process for those who believe they have not been accorded a reasonable interpretation of their rights under this policy.**

CEO Interpretation (no change)

I interpret "*appeal process*" to mean a process through which a patient can bring a concern or complaint to a person at an administrative level either verbally or in writing. We cannot be expected to be aware of or be accountable for complaints which are not brought to us.
I interpret "*reasonable interpretation*" to mean the viewpoint of the client

Compliance will be demonstrated when all complaints recorded in the Risk Monitor system are investigated and resolved within 4 weeks

Evidence: **Compliant**

- There is a Board Policy on an appeals process in place (GP-16) – last revised Dec. 06/07 and last reviewed by the Board in March 2016. Due for review again in 2018.
- This policy is available to the public on the external LWDH web site
- There is an administration complaint policy and guideline in Policy Tech. Policy last revised 09/2014. Guideline last revised 03/2017.
- ECFAA (2010) required publicly posted Patient Relations process be available and is posted on external LWDH website with a link to the policy.

	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017 to date**
Compliments	12	20	11	14	10	17	3
Complaints	6	19	15	21	20	37	29
Complaints Resolved	6	19	15	21	20	37	29
Complaints Unresolved	0	0	0	0	0	0	0

Data Source: Risk Feedback electronic complaints/compliments program.

6. Operate in a way that does not ensure that patient safety is an organizational priority and goal of all involved in the patient's care

CEO Interpretation (no change)

I interpret "*patient safety"* to mean protection of patients from preventable injury or harm as the hospital has a responsibility to protect our patients from harm while in our care.
I interpret *"organizational priority"* to mean of primary importance to all levels of the organization and identified in policy, as patient safety is everyone's responsibility.

Compliance will be demonstrated when the LWDH has completely implemented all Accreditation Canada Required Organizational Practices (ROP's). Compliance with these practices indicates comprehensive patient safety practices are in place.

Evidence: **Compliant**

Evidence of compliance with all major and minor Required Organizational practice criteria will be submitted to Accreditation Canada as per reporting requirements.

6.1 Permit the organization to be without a culture of safety.

CEO Interpretation (no change)

I interpret *"culture of safety*" to mean a belief throughout the organization that risk mitigation for the safety of patients, family members, and visitors is a priority and the prevention and management of risk is the responsibility of each and every employee in an environment that is free from blame and retribution. A culture of safety is supported by policies and procedures intended to assist staff in reducing and managing risk.

Compliance will be met when there are no medication incidents or falls which result in an injury that will result in need to extend treatment or that result in Permanent Harm/ Damage or Death of the Patient. (As per Risk Monitor severity of injury definitions = severity level 3 or 4).

Evidence: **Compliant**

Incidents:

	2011	2012	2013	2014	2015	2016	2017
# of medication incidents resulting in a need to extend treatment or that resulted in Permanent Harm/ Damage or Death	0	0	0	0	0	0	0
# of falls resulting in a need to extend treatment or that resulted in Permanent Harm/ Damage or Death	0	5	0	2	0	0	1

Medication incidents are reviewed at the department level and also at the committee level by the Patient Care committee, the Professional Advisory Committee, the Quality/Patient Safety/Risk Management committee and the Pharmacy & Therapeutics Committee. A quarterly report of all medication incidents is distributed at the front line staff level. Severity level 3 or 4 level incidents would also be reported to the Board Quality Committee.

Although, falls prevention is not included in the 2016-17 Quality Improvement Plan, the Board Quality Committee continues to receive reports on the incidence & severity of patient falls.

When they occur, these incidents are reported to the Board through both the Quality Committee and VP Patient Care or Chief of Staff Reports. Each event is investigated through the Quality of Care Review process and recommendations made as a result to prevent further incidents. **There was one outpatient fall in 2017 considered level 3 resulting in a fracture.** Fall unwitnessed. Patient is a poor historian, so unclear as to whether fall occurred in hospital or out of hospital.

A LWDH Falls Prevention Committee continues to meet regularly to review falls and implement fall prevention strategies, including falls risk assessments in both inpatient and outpatient departments.

6.2 Operate without measures to prevent and contain Hospital acquired infections.

CEO Interpretation (no change)

I Interpret "*safe measures"* to mean processes which protect patients from harm *as a result of a hospital acquired infection.*
I interpret *"Hospital acquired infections"* to mean infections which the patient develops while in hospital which they did not have when they were admitted to hospital.
Compliance will be demonstrated when we are within the Ministry standard which requires that MRSA and VRE bacteremia rates are less than five times higher than the provincial average and with a case count more than one (2 or more) or there has not been an increase of all three patient safety indicators (CDI, MRSA, VRE) within the reporting period.
Compliance will further be demonstrated when Central Line Infections, Ventilator Acquired Pneumonia rates, Surgical Site Infection (SSI) Prevention, Surgical Safety Checklist and Hand Hygiene compliance are better than the provincial average.

Evidence: **Compliant**

Currently hospitals in Ontario are required to publicly report Nosocomial infections for CDI monthly, and for MRSA and VRE quarterly.

Definition: Clostridium difficile infection (CDI): Clostridium difficile is a bacteria in the intestines. It is found normally in healthy and ill people alike.

definition: Methicillin-resistant Staphylococcus aureus (MRSA): The term MRSA or methicillin resistant Staphylococcus aureus is used to describe those examples of this organism that are resistant to commonly used antibiotics. Methicillin was an antibiotic used many years ago to treat patients with Staphylococcus aureus infections. It is now no longer used except as a means of identifying this particular type of antibiotic resistance.

definition: Vancomycin Resistant Enterococci (VRE): Enteroccocci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Vancomycin is an antibiotic that is often used to treat infections caused by enterococci. In some instances, enterococci have become resistant to this drug and thus are called vancomycin-resistant enterococci (VRE).

definition: Ventilator Associated Pneumonia (VAP): A pneumonia that occurs in patients in the Intensive Care Unit requiring mechanical ventilation for greater than 48 hours.

definition: Central Line Infection (CLI) A blood stream infection is considered to be associated with a central line if the line was in use during the 48 hour period before the development of the infection.

definition: Surgical Site Infection Prevention (SSI): The goal is to ensure that one of the most important steps in preventing SSIs is being done and that is ensuring that antibiotics are administered at a certain time just before knee joint replacement surgery. Studies have shown that antibiotic administration just before a joint replacement is a good way to reduce the chance of infection.

definition: Surgical Safety Checklist: A surgical safety checklist is a patient safety communication tool that is used by our team of operating room professionals (nurses, surgeons, anesthesiologists, and others) to discuss important details about each surgical case. In many ways, the surgical checklist is similar to an airline pilot's checklist used just before take-off.

CLOSTRIDIUM DIFFICILE

	Provincial Average Rate	# OF NEW CASES OF C-DIFFICILE	C-DIFFICILE RATES (per 1000 patient days)
2016 JANUARY	0.25	0	0.00
FEBRUARY	0.25	0	0
MARCH	0.26	0	0
APRIL	0.22	0	0
MAY	0.25	0	0
JUNE	0.20	0	0
JULY	0.23	0	0
AUGUST	0.22	0	0
SEPTEMBER	0.23	<5	0.65
OCTOBER	0.24	0	0
NOVEMBER	0.24	0	0
DECEMBER	0.24	0	0
2017 JANUARY	0.24	0	0/1413 = 0%
FEBRUARY	0.24	0	0/1427 = 0%
MARCH	0.24	0	0/1375 = 0%
APRIL	0.22	0	0/1240 = 0%
MAY	0.22	0	0/1537 = 0%
JUNE	0.22	0	0/1444 = 0%
JULY	0.21	0	0/1371 = 0%
AUGUST	0.21	0	0/1358 = 0%
SEPTEMBER	0.21	1	1/1372 = 0.73%
OCTOBER	0.20	1	1/1775 = 0.56%
NOVEMBER	0.20	0	0/1621 = 0%
DECEMBER	0.20	0	0/1556 = 0%

METHACILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

	Provincial Average Rate	# OF NEW CASES OF MRSA	MRSA RATES (per 1000 patient days)
2014- Jan-Mar	0.02	0	0
Apr-June	0.02	0	0
July-Sept	0.024	0	0
Oct-Dec	0.023	0	0
2015- Jan-Mar	0.028	<5	0.204
Apr-June	0.020	0	0
July-Sept	0.015	0	0
Oct- Dec	0.019	0	0
2016- Jan-Mar	0.019	0	0
Apr-June	0.016	0	0
July-Sept	0.035	0	0
Oct - Dec	0.035	0	0
2017 January	0.027	0	0/1459 = 0%
February	0.027	0	0/1463 = 0%
March	0.027	0	0/1416 = 0%
April	0.031	0	0/1270 = 0%
May	0.031	0	0/1563 = 0%
June	0.031	0	0/1563 = 0%

July	0.032	0	0/1422 = 0%
August	0.032	0	0/1410=0%
September	0.032	0	0/1393=0%
October	0.031	0	0/1782=0%
November	0.031	1	1/1662=0.60%
December	0.031	1	1/1577=0.63%

VANCOMYCIN RESISTANCE ENTEROCOCCI

	Provincial Average Rate	**# OF NEW CASES OF VRE**	**VRE RATES (per 1000 patient days)**
2014- Jan-March	0.01	0	0
Apr-June	0.005	0	0
July-Sept	0.003	0	0
Oct-Dec	0.008	0	0
2015- Jan-Mar	0.006	0	0
Apr-June	0.007	0	0
July-Sept	0.0004	0	0
Oct-Dec	0.0005	0	0
2016 Jan-Mar	0.008	0	0
Apr-June	0.007	0	0
July-Sept	0.035	0	0
Oct-Dec	0.035	0	0
2017 January	0.027	0	0/1459 = 0%
February	0.027	0	0/1463 = 0%
March	0.027	0	0/1416 = 0%
April	0.031	0	0/1270 = 0%
May	0.031	0	0/1563 = 0%
June	0.031	0	0/1563 = 0%
July	0.032	0	0/1422 = 0%
August	0.032	0	0/1410 = 0%
September	0.032	0	0/1393 = 0%
October	0.031	0	0/1782 = 0%
November	0.031	0	0/1662 = 0%
December	0.031	0	0/1577 = 0%

VENTILATOR ACQUIRED PNEUMONIA

	Provincial Average Rate	**# OF NEW CASES OF VAP**	**VAP RATES (per 1000 patient days)**
2014-Jan-Mar	1.01	0	0
Apr-June	0.89	0	0
July-Sept	0.76	0	0
Oct-Dec	0.76	0	0
2015- Jan-Mar	0.55	0	0
Apr-June	0.92	0	0
July-Sept	1.09	0	0
Oct-Dec	0.72	0	0
2016 Jan-Mar	n/a	0	0
April - June	.51	0	0
July - Sept	not reported	0	0
Oct-Dec	not reported	0	0
2017 Jan-Mar	not reported	0	0
Apr-June	not reported	0	0
July - Sept	not reported	0	0

Oct - Dec	not reported	0	0

CENTRAL LINE INFECTIONS

	Provincial Average Rate	# OF NEW CASES OF CLI	CLI RATES (per 1000 patient days)
2014- Jan-Mar	0.37	0	0
Apr-June	0.48	0	0
July-Sept	0.58	0	0
Oct-Dec	0.42	0	0
2015- Jan-Mar	0.18	0	0
Apr-June	0.32	0	0
July-Sept	0.27	0	0
Oct-Dec	0.34	0	0
2016 Jan-Mar	n/a	0	0
April - June	0.33	0	0
July - Sept	not reported	0	0
Oct - Dec	not reported	0	0
2017 Jan-Mar	not reported	0	0
April-June	not reported	0	0
July - Sept	not reported	0	0
Oct - Dec	not reported	0	0

HAND HYGIENE COMPLIANCE

	Provincial Average Rate		LWDH Average Rate	
	Before Patient Contact	After Patient Contact	Before Patient Contact	After Patient Contact
2009-10	65.74%	78.61%	49%	61%
2010-11	72.14%	83.27%	88%	94%
2011-12	80.52%	88.23%	85.66%	93.35%
2012-13	85.6%	91.22%	89%	94%
2013-14	86.24%	91.2%	88.1%	95.3%
2014-15	87.5%	91.6%	95.8%	99.5%
2015-16	87.81%	91.44%	89%	94%
2016-17	87.32%	91.23%	87.66%	93.17%
2017-18	not reported	not reported	90.14	95.39

SURGICAL SITE INFECTION PREVENTION

	Provincial Average Rate	% of TKR patients who received pre operative Antibiotics within the accepted time frame
2014- Jan-Mar	97.73	100%
Apr-June	97.86	100%
July-Sept	97.29	50%
Oct-Dec	96.17	100.00%
2015- Jan-Mar	97.78	81.25%
Apr-June	98.09	87.50%
July-Sept	97.82	Not required to report
Oct-Dec	97.88	80.0%
2016 Jan-Mar	98.08	100%
Apr-June	98.42	95.83%
July-Sept	not reported	100%
Oct-Dec	not reported	93.75%
2017 January	not reported	100%

February	not reported	75%
March	not reported	n/a
April	not reported	71.43%
May	not reported	n/a
June	not reported	87.5%
July	not reported	n/a
August	not reported	n/a
September	not reported	100%
October	not reported	100%
November	not reported	n/a
December	not reported	n/a

COMPLIANCE WITH SURGICAL CHECKLIST

	Provincial Average Rate	**% Surgeries where the Surgical Checklist was done in its entirety pre operatively**
2014- Jan-June	99.52%	100%
July-Dec	99.23%	99.64%
2015- Jan-June	99.39%	100.0%
July-Dec	99.28%	100%
2016 Jan - June	99.53%	99.83%
July-Dec	Not available	100%
2017 Jan-June	Not available	100%
July - Dec	Not available	99.92%

6.3 Operate with staffing levels that pose a threat to client safety.

CEO Interpretation (no change)

I interpret "*staffing levels*" to mean staffing levels determined based on patient census and acuity.
I interpret "*threat*" to mean jeopardizing or potentially jeopardizing the health status of the client as patient safety is an organizational priority

Compliance will be achieved when no "Professional Responsibility- Workload Reports" are left unresolved resulting in an external review. If there is no evidence that efforts are made to resolve improper work assignments, it might indicate that the organization is not motivated to maintain staffing levels that support patient safety.

Evidence: **Compliant**

When a staff member feels that the workload is beyond the staff's ability to provide safe patient care she/he completes a "Professional Responsibility- Workload Report Form" (PR-WRF).

	2011	2012	2013	2014	2015	2016	2017
Improper work Assignment unresolved / number submitted	0/9	0/9	0/8	0/16	0/22	0/36	0/12

All improper work assignments came from ONA and were investigated by the manager and reviewed with the Union executive and solutions discussed for resolution and prevention of similar issues. Written responses were sent to the person(s) submitting the PR-WRF after discussion at the Hospital Association Committee Meetings.

7. **Allow clients to be without access to spiritual care.**

CEO Interpretation- revised

I interpret "*spiritual care*" to mean religious beliefs or belief in a spiritual creator regardless of religious affiliation or religious denomination.

Compliance will be demonstrated when 80% (considered reasonable) of patients who respond to this survey question indicate that they felt that their spiritual needs were respected in our organization

Evidence: **Compliant**

An onsite spiritual retreat room is available to all patients 24/7/365 but is not monitored to determine use. An onsite spiritual coordinator is available to assist patients or to coordinate visits by their own spiritual advisor. The Cultural Care Coordinator assists and provides spiritual care to First Nations patients upon request or referral. Currently, we do not collect data on the number of patient consults/contacts made by the Chaplain.

	2012 (n=170)		**2013 (n= 95)**		**2014 (n = 123)**		**2015 (n= 110)**		**2016**	**2017 (n – 84) S=Satisfied N= Neutral U= Unsatisfied**		
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**		**S**	**N**	**U**
Staff were sensitive to my spiritual needs	88.2%	5.3%	82.11%	10.53%	84.5%	9.8%	72.7%	9.1%	N/A Different survey	78.6%	9.52%	11.9%

In the 2017 Patient Experience Survey, Satisfied and Neutral responses exceed the 80% target.

Some of the ways LWDH provides access and respects spiritual care needs are:

- During the admitting process, all patients are asked a question re: religion and religious affiliation.
- LWDH has a Spiritual Care Coordinator who is provided with a list of patients with a religious affiliation. She endeavours to visit those patients or connects them with representation from their specific religious community.
- The Spiritual Care Coordinator participates in multidisciplinary round and routinely visits patients requesting spiritual care.
- Aboriginal Coordinator facilitates Elder visits, Smudging and any other Traditional/Spiritual requests.
- Spiritual care is built into the patient's plan of care.
- Recent renovation to the Multi-faith Chapel located on the 3rd floor.