LENNOX AND ADDINGTON COUNTY GENERAL HOSPITAL

MINUTES
BOARD OF DIRECTORS
April 4, 2017
Airhart Conference Room

A meeting of the Board of Directors of the Lennox and Addington County General Hospital was held in the Airhart Conference Room at 6:30 p.m. on April 4, 2017.

	PRESENT:	
Board:	Allan MacGregor (Chair)	Bob Clancey
	Wayne Coveyduck	Deb Lowry
	Tracy Kent-Hillis	Judge Geoff Griffin
	Chris Seeley	Dr. Kim Morrison
	Elaine Stillwell	Dr. Mark Waldron
	Wendy Brockmeyer	
	REGRETS:	
	Peggy Rice	Bob Vrooman
	Diane Airhart	Eric Smith
	Tony Brazda	Norm Clark
	Michelle Smith	
Staff in attendance:	Nancy Manion	Sheila Mabee (Recorder)

1. **Call to Order/Opening Remarks**
   The meeting was called to order at 6:30 p.m., by Allan MacGregor.

2. **Approval of the Agenda**
   The agenda was approved as circulated.

Motion 1

Rationale: Normal Practice

Motion: The Board of Directors hereby approves the agenda of April 4, 2017.

Moved by: Geoff Griffin
Seconded by: Deb Lowry

The motion was carried.

3. **Conflict of Interest**
   The Chair inquired if any member of the Board wished to declare a conflict of interest based on items identified in the Agenda. There were no identified conflicts of interest.

4. **Minutes of Previous Meetings**
   The minutes of the previous meeting were approved as circulated.

Motion 2

Rationale: Normal Practice

Motion: The Board of Directors hereby approves the minutes of the previous meeting dated March 7, 2017.

Moved by: Allan MacGregor
Seconded by: Chris Seeley

The motion was carried.

5. Business Arising

5.1 Health Care Tomorrow

Allan MacGregor reported that the Chair/Vice Chair meeting for this month has been cancelled; the next meeting is scheduled for April 27. It was noted that the LHIN Chair position is currently being advertised seeking a successor for Donna Segal.

The Health Information System (HIS) project is currently being worked through by Deloitte. The question of costs will be an issue, as will the scope of work to be done. Dr. Morrison noted that she and Tracy had recently participated in one of the local HIS meetings with these consultants and it was apparent that they are well aware of the advancements made by our hospital with Meditech. The consultant group have made it clear that no one will be expected to "go backwards" in technology while the other hospitals catch up.

5.2 Strategic Plan

Wayne reported that the final edits have been incorporated into the 2017-2019 Strategic Plan. The final copy was emailed out to the Board for one last round of input, to which there was none. Copies of the 2017-19 Strategic Plan were circulated to the group and Wayne discussed making it available to external stakeholders (OHA, Ministry of Health, LHIN, Accreditation body).

5.3 Accreditation – Ethics

Nancy Manion reminded Board members that the Governance Accreditation Standards were distributed at last months' meeting. The focus this month will be to discuss Ethics. The group discussed the following questions:

Q What is the process for ethical issues at the hospital as they arise?
- Ethical issues are vetted through the Ethics Committee

Q Who is represented at the Ethics Committee?
- Board Directors, including the Board Chair
- Director of Quality
- Chief Nursing Officer
- Family physician
- Social Worker
- Registered Nurses
- CEO
- Two community representatives

Q We use the I.D.E.A. framework for ethical issues. What does I.D.E.A. stand for?
- I = Identify Facts
- D = Determine Ethical Principles
- E = Explore Options
- A = Acting on Recommendations

Q As a Board member, if you were to have an ethical concern who would this be reported to?
- Elaine as Chair of the Ethics Committee or anyone who is on the Ethics Committee

Q If there is an ethical issue which cannot be resolved, is there a process in place?

- In the past, we have used an external consultant (Ethicist) to assist with working through a difficult case which

Q When is National Health Ethics Week?
- April 3-9, 2017

Q How does the Ethics Committee stay on top of current ethics topics, trends?
- Courses, keeping an open mind, educational opportunities (webcasts) through the regional group, annual education sessions

Q Have clients and families had input into the development of the ethical framework?
- No, at the time the new Ethical Decision-making Framework was developed, we did not have a Patient and Family Advisory Council.

Elaine shared that the Ethics Committee meets 4 times per year or at the call of the Chair. The Committee has planned an education session for May 3, which Board members are welcome to attend, RSVP to Sheila Mabee. The workshop topics will be covering *Advance Care Planning* and *Health Care Consent*, provided by The Centre for Studies in Aging and Health, Providence Care.

5.4 Board Self-Assessment Follow-up

Allan relayed his thanks for the efforts of the Board members who sent in responses for the Director Self-Assessments. Almost all were completed, which was great to see. Some suggestions that have come out of this process include:

- *Education on funding formulae*: Gert will be providing an education session at the next Board meeting; Dr. Morrison was asked to extend the invitation to the Medical Directors to attend as well. There is also an OHA webcast planned for April 7; Deb, Bob and Chris plan to attend and it is open to others who would like to join in on this session
- *Get-together for Board/Administration/Physicians*: a social was suggested for front-line physicians/Administration/Board members, perhaps a wine & cheese one evening
- *Start using a 'buddy system' for new Directors*: this would pair new to existing Board members to assist with explaining processes, acronyms, etc. Elaine offered her assistance with this.
- *Education session for the Patient's First Act*: an education session will be explored, possibly with Paul Huras invited to explain the Patient's First Act and answer any questions.

6. Reports

6.1 Quality Committee

Elaine Stillwell highlighted the following from the Quality Committee minutes of March 21, 2017 meeting:

- The Committee was provided with a very positive report on patient flow and improved wait times for admissions from the ER to the inpatient unit. This nursing-led trial was in its fourth week of an eight week trial. The number of minutes from triage to transfer the patient to the floor has decreased by half since the trial has begun and appears the numbers are being maintained – the trial was astoundingly successful and noted to be worthy of publishing.

- Elaine shared that she attended the OHA's 1 day workshop in Ottawa on *Effective Governance for Quality, Patient Safety and QCIPA Overview*. Elaine provided the following overview from this session:
  - Following the MOHLTC's review of *Quality of Care Information Protection Act* (QCIPA), a number of recommendations will be implemented and will come into effect July 1, 2017. This will mean there will be clear guidance on when to use QCIPA; critical incident review investigations will be more transparent with the patient, including them in the process; there will be a clear review process which is to be used to ensure consistency; there will be terms of reference for the Quality of Care Committee. This committee, Elaine relayed, will be rolled up into the Quality Committee
  - Elaine also shared that one of the guest speakers was Joan Dawe. One of the questions she asked was: Is your Board an "engine" or a "caboose"? (A Board should be an "engine")

6.2 Ethics Committee

Further to the Ethics Committee meeting minutes of the March 8, 2017 meeting, Elaine Stillwell reported the following:

- There has been a shift in the processes and methods of discharge planning, mainly due to the efforts of our new Social Worker, which are showing some real improvements to patient flow. The Ethics Committee discussed the Per Diem and has decided that applying a per diem rate should be deferred until the LHIN makes a decision for the region on whether a per diem rate will be applied to patients declining a first available LTC bed.
- The Medical Assistance in Dying (MAID) Task Force has completed an extensive amount of work on preparing MAID processes and a MAID policy.
- The Ethics Committee has reviewed the draft MAID Policy and is recommending approval by the Board. No concerns were noted.

Motion 3

Rationale: The Medical Assistance in Dying (MAID policy was reviewed and approved by the Ethics Committee and requires support of the Board of Directors.

Motion: The Board of Directors supports the Medical Assistance in Dying (MAID) policy No. B-27, as recommended by the Ethics Committee.

Moved by: Geoff Griffin
Seconded by: Deb Lowry

The motion was carried.

6.3 Medical Advisory Committee

Further to the minutes of March 9, 2017, Dr. Morrison highlighted the following:

Dr. Touzel has been spearheading a more formalized Anti-microbial Stewardship Program (ASP) with the creation of an Anti-microbial Stewardship Sub-Committee, under the umbrella of the Infection Control Committee.

The Medical Advisory Committee reviewed the re-appointment applications to the LACGH Medical Staff for the following:

- Dr. Tara Baetz - Consulting (Oncology)
- Dr. James Biagi - Consulting (Oncology)
- Dr. Christopher Booth - Consulting (Oncology)
- Dr. Jill Dudebout - Consulting (Oncology)
- Dr. Julie Francis - Consulting (Oncology)
- Dr. Richard Gregg - Consulting (Oncology)
- Dr. Nazik Hammad - Consulting (Oncology)
- Dr. Michaela Mates - Consulting (Oncology)
- Dr. Wendy Parulekar - Consulting (Oncology)
- Dr. Andrew Robinson - Consulting (Oncology)
- Dr. Anna Tomiak - Consulting (Oncology)
- Dr. Sasha Bhan - Active (Radiology)
- Dr. Jessica Biederman - Active (Radiology)
- Dr. Frank Cheeseman - Consulting (Radiology)
- Dr. Nicola Gambarotta - Active (Radiology)
- Dr. Apurva Patel - Active (Radiology)
- Dr. Annette Polanski - Active (Radiology)
- Dr. Brandy Sessford - Consulting (Radiology)
- Dr. Kenneth Sutherland - Consulting (Radiology)

No concerns were noted by the MAC; therefore, the re-appointment applications were recommended to the Board of Directors for approval. The Board reviewed the credentialing applications and no concerns were noted.

Motion 4

Rationale: Applications for the re-appointment to the Medical Staff require the review and approval of the Medical Advisory Committee and the Board of Directors.

Motion: The Board of Directors hereby approves the following re-appointment applications to the LACGH Medical Staff, as recommended by the Medical Advisory Committee:

- *Dr. Tara Baetz - Consulting (Oncology)*
- *Dr. James Biagi - Consulting (Oncology)*
- *Dr. Christopher Booth - Consulting (Oncology)*
- *Dr. Jill Dudebout - Consulting (Oncology)*
- *Dr. Julie Francis - Consulting (Oncology)*
- *Dr. Richard Gregg - Consulting (Oncology)*
- *Dr. Nazik Hammad - Consulting (Oncology)*
- *Dr. Michaela Mates - Consulting (Oncology)*
- *Dr. Wendy Parulekar - Consulting (Oncology)*
- *Dr. Andrew Robinson - Consulting (Oncology)*
- *Dr. Anna Tomiak - Consulting (Oncology)*
- *Dr. Sasha Bhan - Active (Radiology)*
- *Dr. Jessica Biederman - Active (Radiology)*
- *Dr. Frank Cheeseman - Consulting (Radiology)*
- *Dr. Nicola Gambarotta - Active (Radiology)*
- *Dr. Apurva Patel - Active (Radiology)*
- *Dr. Annette Polanski - Active (Radiology)*
- *Dr. Brandy Sessford - Consulting (Radiology)*
- *Dr. Kenneth Sutherland - Consulting (Radiology)*

Moved by: Deb Lowry
Seconded by: Bob Clancey

The motion was carried.

The Medical Advisory Committee reviewed the re-appointment application to the LACGH Medical Staff, with the noted changes, for the following:

- Dr. Mathew Downey - Active (Radiology) *change from Consulting to Active staff*
- Dr. Nadia Gammal - Consulting (Radiology) *addition of node core biopsy, U/S biopsy & FNA requested*
- Dr. Emma Robinson - Active (Radiology) *change from Consulting to Active staff*
- Dr. Binyamin (Ben) Rokach - Active (Radiology) *change from Consulting to Active staff*

No concerns were noted by the MAC; therefore, the re-appointment application with the noted changes, was recommended to the Board of Directors for approval. The Board reviewed the credentialing application and no concerns were noted.

Motion 5

Rationale: Applications for the appointment to the Medical Staff require the review and approval of the Medical Advisory Committee and the Board of Directors.

Motion: The Board of Directors hereby approves the following re-appointment to the LACGH Medical Staff with the noted changes, as recommended by the Medical Advisory Committee:

- *Dr. Mathew Downey - Active (Radiology) change from Consulting to Active staff*
- *Dr. Nadia Gammal - Consulting (Radiology) addition of node core biopsy, U/S biopsy & FNA requested*
- *Dr. Emma Robinson - Active (Radiology) change from Consulting to Active staff*
- *Dr. Binyamin (Ben) Rokach - Active (Radiology) change from Consulting to Active staff*

Moved by: Allan MacGregor
Seconded by: Elaine Stillwell

The motion was carried.

The Medical Advisory Committee reviewed the appointment applications to the LACGH Medical Staff for the following:

- Dr. Jocelyn Garland - Consulting (Nephrology)
- Dr. David Holland - Consulting (Nephrology)
- Dr. M. Khaled Shamseddin - Consulting (Nephrology)
- Dr. Christine White - Consulting (Nephrology)
- Dr. Martine McKay – Locum Tenens (Family Practice)
- Dr. Andrea Donovan - Locum Tenens (Radiology)
- Dr. Justin Haba - Locum Tenens (Radiology)
- Dr. Paul O'Brien - Locum Tenens (Radiology)

No concerns were noted by the MAC; therefore, the appointment applications were recommended to the Board of Directors for approval. The Board reviewed the credentialing applications and no concerns were noted.

Motion 6

Rationale: Applications for the appointment to the Medical Staff require the review and approval of the Medical Advisory Committee and the Board of Directors.

Motion: The Board of Directors hereby approves the following appointment applications to the LACGH Medical Staff, as recommended by the Medical Advisory Committee:

- *Dr. Jocelyn Garland - Consulting (Nephrology)*
- *Dr. David Holland - Consulting (Nephrology)*
- *Dr. M. Khaled Shamseddin - Consulting (Nephrology)*
- *Dr. Christine White - Consulting (Nephrology)*
- *Dr. Martine McKay – Locum Tenens (Family Practice)*
- *Dr. Andrea Donovan - Locum Tenens (Radiology)*
- *Dr. Justin Haba - Locum Tenens (Radiology)*
- *Dr. Paul O'Brien - Locum Tenens (Radiology)*

Moved by: Deb Lowry
Seconded by: Bob Clancey

The motion was carried.

6.4 Volunteer Services
The Volunteer Services minutes from the March 28, 2017 meeting were briefly reviewed as circulated in the Board package. No concerns were noted.

6.5 Finance Committee
Deb Lowry reviewed the following from the March 28, 2017 Finance Committee meeting:

6.5.1 – Board, CEO, and Senior Management Expenses
The Finance Committee reviewed the Board, CEO, and Senior Management Expenses for February 2017 which totaled $245.02. The Finance Committee recommends to the Board, that the following expenses be approved:

Motion 7

Rationale: The Broader Public Sector Accountability Act requires that the expenses of the Board, CEO and Senior Management be reviewed and/or approved by the Board.

Motion: The Board of Directors hereby approves the following Board, CEO and Senior Management Expenses which totaled $245.02, as recommended by the Finance Committee.

February 2017

Name	Meals	Hospitality	Accommodation	Vehicle Rental/Own Used Mileage	Incidentals (Parking, tolls, etc.)	Fares	Total
Wayne Coveyduck				196.56			**196.56**
Gert Switzer	21.85			26.61			**48.46**
TOTAL	**21.85**			**223.17**			**$245.02**

Moved by: Deb Lowry
Seconded by: Bob Clancey

The motion was carried.

6.5.2 – February Financial Statement and Cheque List
The Finance Committee reviewed the February 2017 Financial Statements and Cheque List which totaled $2,206,371.57. No concerns were noted by the Finance Committee or the Board.

Motion 8

Rationale: Normal Practice.

Motion: The Board of Directors hereby approves the February 2017 Financial Statements and February 2017 Cheque List totaling $2,206,371.57, as recommended by the Finance Committee.

Moved by: Chris Seeley
Seconded by: Elaine Stillwell

The motion was carried.

6.5.3 – Capital Equipment Requests
The Finance Committee reviewed a request for the allocation of $3,043 towards the purchase of: OR Supply Cart ($2,345); Various Departments, wheelchairs ($698) shipping on previously approved chairs. No concerns were noted by the Finance Committee or the Board.

Motion 9

Rationale: The Board of Directors is required to review and approve capital requests.

Motion: The Board of Directors hereby approves the following capital requests totaling $3,043, as recommended by the Finance Committee:

- *OR, supply cart ($2,345);*
- *Various, wheelchairs ($698) shipping on previously approved chairs.*

Moved by: Chris Seeley
Seconded by: Elaine Stillwell

The motion was carried.

6.6 Chief Executive Officer's Report
Further to the written report provided in the Board package, Wayne Coveyduck shared the following:

HDIRS has sent a request requiring immediate attention and sign back for a Diagnostic Imaging Peer Review program. Turnaround times were tight with our Chief Radiologist, Dr. Polanski, away at the time. Dr. Polanski was looking into another vendor to conduct peer reviews through, however this HDIRS opportunity was quite reasonable in comparison and she was agreeable to it. Wayne requested Board support to proceed with the initial investment and annual fee. No concerns were noted.

Motion 10

Rationale: The Board of Directors is required to review and approve capital requests.

Motion: The Board of Directors hereby approves the following HDIRS Diagnostic Imaging Peer Review Program capital requests:

- *Initial capital cost of $15,716);*
- *Annual cost of $3,206.*

Moved by: Elaine Stillwell
Seconded by: Chris Seeley

The motion was carried.

Wayne noted that the CT Business Case presentation to SECHEF went well. A tremendous amount of work and preparation went into the business case and presentation. It is expected that our request will go before the LHIN Board at their regular April meeting.

Attention was drawn to the Hay Report which was flagged in Wayne's administration report. The Hay Report was not part of the list of items that Dr. Reznick proposed to SECHEF as future area items for us to work on. Reference to the items supported at the CEOs December 2016 SECHEF meeting is accurate, except for the inclusion of the Hay Report item. Paul Huras stated that he included the Hay Report item because it was important to our future efforts for the region.

Motion 11

Rationale: Normal Practice

Motion: The Board of Directors hereby accepts the reports from the Quality Committee, Ethics Committee, Medical Advisory Committee, Volunteer Services, Finance Committee and the CEO.

Moved by: Deb Lowry
Seconded by: Chris Seeley

The motion was carried.

7. **Correspondence Received up to March 27, 2017**
There was no additional correspondence to report.

8. **New Business**
8.1 Quality Improvement Plan 2016/17
Nancy provided a presentation detailing the annual indicators which form the 2016/17 Quality Improvement Plan:

Hand Hygiene: we have seen a decrease in hand hygiene, mainly due to new auditors. This has been attributed to less visibility and is likely more realistic numbers. Lowering the target rate from 95% for the upcoming year is being considered.

Hospital Acquired Infections: before the end of March there were 0 bloodstream C.diff cases reported. It was noted that if the summer months are not being audited, it should be annotated so as not to skew the averages.

Patient Satisfaction: the CVC, ER and in-patient units were sent surveys. Overall, 96% of patients would recommend our Hospital to family and friends.

Reduce Unnecessary Time Spent in Acute Care: new patient flow approach to discharge planning for ALC patients to more appropriate setting. The Home First philosophy education has been refreshed with staff and physicians. Health Links has joined the multidisciplinary team rounds. An interface for CCAC has been completed to notify about patients in the ER to assist with admission avoidance.

CVC Falls Rates: less than 10% is the target. The percentage can be skewed some months due to the low monthly numbers which significantly impact the data. Falls assessment on admission is completed for every CVC resident. Residents are provided with non-slip socks. Hourly rounding was introduced and residents have a falls assessment completed post-fall by the OT.

CVC Pressure Ulcers – Tracy Kent-Hillis is currently working on recalculations for this indicator. It should be less than 3% for most months which makes more sense.

CVC Elderly Mobility Scale: an average of 86.5% of residents had improved mobility at discharge (target = 85%)

Medication Reconciliation at Admission: the target is 90% and is monitored monthly by the COS. Discussions occur with physicians, as needed. Rates have been steadily improving and are approaching 100%.

Medication Reconciliation at Discharge: rates have improved significantly over last year with the 100% target reached 35% of the time.

Other Achievements: regional participation in the COPD working group; zero critical medication errors on CVC; antipsychotic use on CVC at 0%; 100% of residents have weekly weights performed; 100% of residents have nutrition assessment completed by the dietician on admission.

Challenges: MOH generally 3-4 quarters behind in data which makes it difficult to measure improvement outcomes; staff turnover impacts consistency in maintaining quality initiatives; change fatigue; small numbers have a significant impact on data.

Summary:

Indicator	*Quality Improvement Initiative*	*Target Met*
Efficiency	Implement Cognitive Assessment Tool (CAM) to screen for delirium.	Implemented
Patient Centered	Post-discharge phone calls to answer patient's questions, clarify discharge instructions to assist with transition in care	Implemented
Resident Centered	All Residents with have elderly mobility scale scores completed with a goal of improved mobility (>10) at discharge.	Completed

Access	85% of residents with improved elderly mobility scale score from admission to discharge.	Target Met

Motion 12

Rationale: The Excellent Care for All Act, 2010 (ECFAA) requires that the compensation of the President & CEO and other executives be linked to the achievement of performance improvement targets laid out in the Performance Improvement Plan which forms part of the Quality Improvement Plan.

Motion: The Board of Directors hereby approves the release of the 3% of the compensation for the pay at risk component of the 2016/17 Quality Improvement Plan for:

President & CEO/Long Term Care Administrator
Chief of Medical Staff
Chief Nursing Officer/Director of Care
Chief Financial Officer
Director of Quality, Support Services and Operational Efficiencies

Moved by: Geoff Griffin
Seconded by: Elaine Stillwell

The motion was carried.

8.2 Board Assessment
Allan MacGregor requested that the Board Directors complete the OHA Board Assessment. Sheila Mabee will send the link to Board members to complete. Responses will be collated and returned to Tony Brazda as Chair of the Governance Committee to follow up.

9. Closed Session
At 8:15 p.m., the Board moved into closed session.

Motion 13

Rationale: Normal Practice

Motion: The Board of Directors hereby moves into closed session.

Moved by: Deb Lowry
Seconded by: Geoff Griffin

The motion was carried.

At 8:31 p.m., the Board rose from closed session.

Motion 14
Rationale: Normal Practice
Motion: The Board of Directors hereby rises from closed session.
Moved by: Geoff Griffin Seconded by: Deb Lowry
The motion was carried.

10. Next Meeting

The next regular meeting of the Board is scheduled for May 2, 2017 at 6:30 p.m. in the Airhart Conference Room. Gert will be providing an education session on Funding at 6:00 p.m. Dr. Morrison will invite the Medical Directors to attend this session.

11. Adjournment

The meeting was adjourned at 8:34 p.m.

Motion 15
Rationale: Normal Practice
Motion: The Board of Directors hereby adjourns their meeting at 8:34 p.m. on April 4, 2017.
Moved by: Bob Clancey Seconded by: Deb Lowry
The motion was carried.