LENNOX AND ADDINGTON COUNTY GENERAL HOSPITAL

MINUTES
BOARD OF DIRECTORS
January 6, 2015
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 January 6, 2015.

PRESENT:

Board:	Peggy Rice (Chair)	Tony Brazda
	Allan MacGregor	Robert Paul
	Cathie Vick	Bob Clancey
	Judge Geoff Griffin	Deb Lowry
	Norm Clark	Michelle Smith
	Wayne Coveyduck	Dr. Kim Morrison
	Tracy Kent-Hillis	Eric Smith
	REGRETS:	
	Elaine Stillwell	Dr. Mamdouh Andrawis
	Chris Seeley	
Staff in Attendance:	Gert Switzer	Shari Sampson
	Angela McCullough (Recorder)	

1. Call to Order/Opening Remarks

The meeting was called to order at 6:30 p.m. by Peggy Rice. Peggy welcomed Eric Smith to the LACGH Board of Directors. Eric is the appointed representative from the County of Lennox and Addington. He is also the Deputy-Reeve for Stone Mills Township.

2. Approval of the Agenda

Motion 1

Rationale: Normal Practice

Motion: The Board of Directors hereby approves the agenda of January 6, 2015.

Moved by: Allan MacGregor
Seconded by: Cathie Vick

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.

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4. Minutes of Previous Meeting

The minutes of December 2, 2014 were reviewed and no changes were noted.

Motion 2

Rationale: Normal Practice

Motion: The Board of Directors hereby approves the minutes of the previous meeting dated December 2, 2014.

Moved by: Michelle Smith
Seconded by: Norm Clark **The motion was carried.**

5. Business Arising

5.1 Sustainability

The CEOs have approved, in principle, the vision for a share service organization to support all Business Functions subject to the completion of a business case. A review of 3SO for structure and governance will be conducted.

6. Reports

6.1 Quality Committee

Deb Lowry highlighted from the Quality Committee minutes of December 16, 2014 that our ER volumes have increased which, in turn, has increased our ER Wait Times.

6.2 Finance Committee

Deb Lowry provided the following highlights from the Finance Committee meeting held on December 19, 2014.

6.2.1 - Board, CEO and Senior Management Expenses

The Finance Committee reviewed the Board, CEO and Management November 2014 expenses which totalled $5,342.98 and the revised expenses for September 2014 which totalled $798.94. The Finance Committee recommends to the Board that the following expenses be approved.

Motion 3

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 November expenses which totalled $5,342.98 and the revised expenses for September which totalled $798.94 as recommended by the Finance Committee:

November 2014

Name	Meals	Hospitality	Accommodation	Vehicle Rental/Own Used Mileage	Incidentals (Parking, tolls, etc.)	Fares	Total
Wayne Coveyduck	$22.81		$531.35	$211.90	$50.49		**$816.55**
Peggy Rice	$118.83		$1029.70			$214.99	**$1363.52**
Deb Lowry	$59.08		$798.50	$150.58		$142.66	**$1150.82**
Elaine Stillwell	$72.81		$809.44			$100.87	**$983.12**
Shari Sampson	$7.63		$809.43	$34.26	$21.64	$120.39	**$993.35**
Gert Switzer	$12.71			$19.27	$3.64		**$35.62**
TOTAL	**$293.87**		**$3978.42**	**$416.01**	**$75.77**	**$578.91**	**$5342.98**

Revised for September 2014

Name	Meals	Hospitality	Accommodation	Vehicle Rental/Own Used Mileage	Incidentals (Parking, tolls, etc.)	Fares	Total
Wayne Coveyduck				$183.95			**$183.95**
Nancy Manion				$4.96			**$4.96**
Shari Sampson	$28.35			$36.07	$4.05		**$68.47**
Gert Switzer	$42.48		$290.80	$208.28			**$541.56**
TOTAL	**$70.83**		**$290.80**	**$433.26**	**$4.05**		**$798.94**

Moved by: Norm Clark
Seconded by: Michelle Smith

The motion was carried.

6.2.2 – Review of Investment Firm

The Board had instructed the Finance Committee to conduct a review of our current Investment Firm. The Finance Committee conducted the review and agreed to continue monitor our investment portfolio and continue with status quo.

6.2.3 – November Financial Statements & Cheque List

The Finance Committee reviewed the November Financial Statements and Cheque List totalling $2,072,515.12 and has recommended that they be approved by the Board.

Motion 4

Rationale: Normal Practice

Motion: The Board of Directors hereby approves the November Financial Statements and Cheque List which totalled $2,072,515.12 as recommended by the Finance Committee.

Moved by: Bob Clancey
Seconded by: Tony Brazda **The motion was carried.**

6.2.4 – Capital Requests

The Finance Committee has recommended to the Board approval of the allocation of $62,721.00 towards the purchase of the following:

- OR Table for the OR (Cost $31,000.00)
- Colonoscope for the OR (Cost $31,000.00)
- Exam Light for the Clinic (Cost $721.00)

Motion 5

Rationale: Normal Practice

Motion: The Board of Directors hereby approves the allocation of $62,721.00 towards the purchase of the following as recommended by the Finance Committee.

- ***OR Table for the OR (Cost $31,000.00)***
- ***Colonoscope for the OR (Cost $31,000.00)***
- ***Exam Light for the Clinic (Cost $721.00)***

Moved by: Tony Brazda
Seconded by: Bob Clancey **The motion was carried.**

6.2.5 – 2015-16 Budget Plan

The Finance Committee reviewed the proposed 2015-16 Hospital Budget Plan and has recommended to the Board of Directors that it be approved.

Motion 6

Rationale: As part of their workplan, the Finance Committee is required to conduct a review of the Hospital Budget on an annual basis and recommend a final budget to the Board of Directors for review and approval.

Motion: The Board of Directors hereby approves the 2015-16 Budget Plan as recommended by the Finance Committee.

Moved by: Tony Brazda
Seconded by: Bob Clancey

The motion was carried.

6.2.6 – 2015-16 Capital Budget Requests

The Finance Committee reviewed the proposed 2015-16 Capital Budget Requests which totalled $340,351.00 and has recommended to the Board of Directors that it be approved.

Motion 7

Rationale: As part of their workplan, the Finance Committee is required to conduct a review of the Hospital Capital Budget on an annual basis and recommend a final capital budget to the Board of Directors for review and approval.

Motion: The Board of Directors hereby approves the 2015-16 Capital Budget Requests totaling $340,351.00 as recommended by the Finance Committee.

Moved by: Deb Lowry
Seconded by: Michelle Smith

The motion was carried.

6.2.7 – Westdale Complex Kitchen Start-Up Costs

The Finance Committee reviewed a request for the purchase of items for the Westdale Complex at a cost of $19,598 and has recommended to the Board of Directors that it be approved.

Motion 8

Rationale: The kitchen at the Westdale Complex will be used for the upcoming Foundation Gala, for Hospital events and will be rented for special events. The kitchen will need to be stocked with the essentials in order to accommodate these types of events.

Motion: The Board of Directors hereby approves the Westdale Complex kitchen start-up costs of $19,598.00 as recommended by the Finance Committee.

Moved by: Cathie Vick
Seconded by: Michelle Smith

The motion was carried.

6.3 Art Décor Committee

Peggy Rice advised that the Art Décor Committee is comprised of a diverse group of people. The committee was given the opportunity to obtain ten pieces of art by Mitzi Bidner through a private collector. All ten pieces were accepted as a donation.

6.4 Ethics Committee

Peggy Rice highlighted the following from the December 10, 2014 meeting of the Ethics Committee.

The committee revised the Ethical Framework to meet standards of practice and has recommended to the Board of Directors that it be approved.

Motion 9

Rationale: In keeping with their Terms of Reference the Ethics Committee reviewed and revised the Ethical Framework and has recommended to the Board of Directors that it be approved.

Motion: The Board of Directors hereby approves the revised Ethical Framework as recommended by the Ethics Committee.

Moved by: Tony Brazda
Seconded by: Robert Paul

The motion was carried.

The Ethics Committee is also looking into conducting case study reviews to ensure that when the time comes, the committee has the expertise in dealing with ethical issues.

6.5 Foundation

Robert Paul reported that the Christmas Tree campaign raised $29,500 this year. The plans for the Foundation Gala are proceeding well. To date, we have received over $107,000 in sponsorships.

6.6 Volunteer Services

Cathie Vick reported that the Volunteers, in conjunction with the Foundation, had a successful Book Signing in which 55 books were sold.

6.7 Medical Advisory Committee

Dr. Kim Morrison provided the following highlights from the Medical Advisory Committee held on December 18, 2014.

Based on information that was provided at the Board Retreat and using the OHA Credentialing Toolkit, the credentialing applications for appointment and reappointment to the Medical Staff have been redesigned to meet the standards of practice.

Dr. Basia Farnell requested a change in her Board approved procedural privileges which are documented in her credentialing file.

Motion 10

Rationale: Pursuant to the Medical Staff By-Laws, the MAC is required to review and make recommendations to the Board of Directors on changes to procedural privilege lists requested by the Medical Staff.

Motion: The Board of Directors hereby approves the changes in procedural privileges for Dr. Basia Farnell as recommended by the Medical Advisory Committee.

Moved by: Bob Clancey
Seconded by: Tony Brazda

The motion was carried.

6.8 Chief Executive Officer's Report

Wayne Coveyduck advised that the negotiations with KGH to bring Dialysis services to our community are ongoing. He hopes to have a signed agreement in the not so distant future..

The hospital has received the construction permits to proceed with the construction of the area at the Westdale Complex to be occupied by the SOS.

Motion 11

Rationale: Normal Practice

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

Moved by: Deb Lowry
Seconded by: Bob Clancey **The motion was carried.**

7. Other

7.1 Correspondence Received Up to December 30, 2014

There was no further correspondence.

8. New Business

8.1 Strategic Plan Review

Wayne Coveyduck and members of the Senior Management Team provided the following overview of the activities at the Hospital related to our identified Strategic Imperatives.

Quality Culture

Objective A: Developing the right culture for Quality to flourish is being achieved through a number of activities.

- In order to accelerate change and improve patient safety and quality improvement, it was important to educate frontline staff in the fundamentals of these disciplines. During the spring of 2013, we provided 16 front line staff with green belt LEAN education. In 2014, we provided additional green belt LEAN education to 12 staff members and 4 partner organizations as well as black belt LEAN education to 8 staff members and 4 external partners.
- We've increased the use of the Plan-Do-Study-Act (PDSA) cycle of improvement across the organization. Some examples of its use: review and refine the process for medication reconciliation at both admission and discharge, refine and improve the operating room medication safety process, review and improve linen cart stocking/shipping to L&A from regional laundry and the process of scheduling patients for pulmonary function testing.
- Regular quality improvement reporting to the Board through the monthly QIP update and the quarterly Balanced Scorecard. Regular quality improvement reporting to the Clinical Teams through the monthly clinical scorecards. Teams identify 3-4 indictors which are reviewed and discussed monthly. Departmental performance targets are also reviewed monthly to ensure accountability and identify when improvements need to be made.

- Results from patient surveys highlights areas that we excel in and areas that need to be improved. Results of our surveys are reviewed by the appropriate staff and improvement initiatives are identified and implemented.
- Patient feedback, both positive and negative provides us with valuable information to improve services in our hospital. All patient feedback is shared with department managers and staff involved in the patients care.
- Each Director meets with every new staff member face-to-face to explain the mission and vision of the hospital, review the strategic imperatives, review the patient declaration of values and explain the importance of quality improvement, patient safety and customer service.

Objective B – Develop and implement the right in-house process for quality improvement is being achieved by:

- Some departments have implemented visual boards to indicate to staff how their performance measures are being met. One example is the Environmental Services visual board that monitors the results of their monthly cleaning audits and the hospitals HAI (hospital acquired infection) rates. The visual boards enable staff to easily see abnormalities and provides an opportunity for the team to review and discuss their success and areas for improvement.
- The in-patient unit conducts daily bullet rounds to manage and coordinate patient care. The rounds bring all the health care professionals together who provide service to the same patient. By doing so, we are able to close the gaps within the system where patients often get lost; simplify what happens next for patients when their care changes; ensure safe transitions in settings of care and provide optimal outcomes. This multidisciplinary team consists of the hospitalist, pharmacy, nursing, physiotherapy, occupational therapy, health records, dietitian, social worker and the CCAC case manager. The team meets daily Monday to Friday and their focus is to improve patient care outcomes in a cost effective and reliable way and to plan and ensure a safe discharge to home, home care or to another healthcare facility.
- Strengthen and improve our antimicrobial stewardship program by continuous monitoring of in-patient antimicrobial use, quarterly review of antimicrobial use by the infection prevention and control committee, random antimicrobial spot audits and the review of the antimicrobial order sets. These initiatives ensure we are prescribing the right drug, at the right time, using the right dose and for the right duration. The program is a coordinated effort to monitor, manage and optimize antimicrobial use with the goal of improving patient outcomes and improving patient safety by reducing antimicrobial resistance.
- Four hospital clinical teams (Emergency, Operating Room, In-Patient and CC) meet monthly and review selected measureable indicators to ensure targets are being met and to identify performance improvement opportunities.

Objective C – Provide staff with the right tools to do their job

- Our IT department and Health records department have worked collaboratively to develop a new tool that will provide all staff and physicians with timely data to facilitate the Quality Improvement Process. This new BI tool (Business Intelligence Tool) was rolled out in January 2015. Staff are being encouraged to provide feedback on the tool so that changes/additions/deletions can be made in order to ensure they are receiving the data they need.
- In 2013 the hospital implemented the Computerized Physician Order Entry (CPOE) module which allows medical practitioners to electronically enter instructions and prescriptions for the treatment of patients. Prior to implementing this new system, three physician champions were recruited and were involved during the entire project right from building the program to trialing and piloting the module. The IT department and pharmacy department worked together for months prior to go live to ensure they had all the allergy information, ordering strings, and dose guidelines imbedded in the system. There have been numerous quality improvement and patient safety benefits achieved with the implementation of this CPOE such as a decrease in duplicate orders, decreased need for transcriptions which in turn decreased the number of transcription errors, eliminated the delay between tests/orders being prescribed to delivered, a decrease in phone calls to physicians to clarify orders (incomplete/illegible), ability to enter orders remotely, drug interaction checking, allergy checking, dose guidelines, and increased communication between health care providers.
- In 2014 the hospital implemented computerized medication reconciliation. This new patient safety initiative was a significant change to current practice and in order to be successful it needed the 'buy in' from numerous stakeholders. Physicians, Pharmacy and nurses all worked together collaboratively to implement this new process and review it on an on-going basis to identify further improvements to increase compliance.

Patient Experience

Objective A: Engage patients and families in the process of improving the overall patient experience. This is being achieved through the following processes:

- Patient satisfaction surveys are conducted on a regular basis for the Emergency Department, In-Patient units, Operating Room, Diagnostic Imaging, Cardiac Rehab and Diabetic Education. Patient feedback is used to determine how care can be improved based on the mutual experiences of the patients. The following is a list of patient surveys that have been conducted during 2013/14:
  - Emergency Department - February 2013, February 2014
  - Acute Care – December 2013, phone audits started December 2014
  - Convalescent Care – Ongoing as each patient is discharged started May 2013
  - Operating Room – April 2013, October 2014
  - Diabetic Education – Ongoing as patients are discharged
  - Cardiac Rehab – 2013, 2014
  - Diagnostic Imaging – 2013, 2014

- Capturing the patients experience is achieved via the hospital website, by phone, in person and through the mail. This helps us to gain an understanding of what we do well, where we have problems. We have established a process to communicate with patients and families that have concerns to help us gain an understanding of what the problem is, the impact of the problem and variances in processes. Once the problem is understood, an investigation and follow up occurs to ensure all staff involved understand the issue, improvements are implemented and the patient/family receives feedback.
- Each discharged inpatient is contacted by phone to review and discuss how they are settling in at home. The goals is to extent the inpatient experience into the home to ensure a comprehensive discharge process. It is an opportunity to a resolve any outstanding concerns the patient and family may have and to connect them with the appropriate professional within the hospital as needed. Patient and families are very thankful for the phone call. In addition this contact provides excellent information in how we can improve the discharge process
- End of Life experience – In partnership with Hospice L&A we have been able to offer end of life support for most patient dying at LACGH. The support provided is unique to each situation and extend beyond death to grief support for the surviving families. Level one and level two palliative care education has been offered at LACGH
- Patient and Family stories at end of life. We are in the process of interviewing 10 patients and families regarding their end of life experience. The purpose is to identify opportunities for improvement in end of life service at LACGH and beyond. We will be working with our local partners to carefully review the gaps and begin to design a more integrated approach to end of life care. Patient stories are a foundational step in this process.

Objective B: Improve patient and family satisfaction with reduced wait times in the Emergency Department. This is being achieved through the following processes:

- As a result of feedback from patients and families we have successfully moved elective transfusions and infusions out of the ER into a clinic setting. This provides a scheduled therapeutic environment for the patient away from the hustle and bustle of the ER.
- Wait times in the ER for low acuity patients continues to be better than the Provincial Target despite a significant increase in patient volumes. The Nurse Practitioner is working collaboratively with the Physicians to improve patient flow for lower acuity patients.

Objective C: Bring the Patient Declaration of Values to life by using the values as basic principles for the patient experience improvement efforts.

- Just in time patient experience information is being collected for the ER. Each day, 6 patients from the previous day are contacted to review their ER experience. This just in time information will guide future patient experience initiative in ER.
- Senior Friendly – The introduction of LTC at LACGH has provided a wonderful opportunity to improve patient experience specifically for seniors. A working group has been established under the leadership of Dawn Clare. Initiative include ; delirium assessment, accessibility, functional decline and hydration
- High Risk Seniors- As part of a regional initiative LACGH was the second hospital to introduce screening for seniors at risk. All patients over the age of 75 are asked 5 questions. The questions are part of an evidence based questionnaire that identifies at risk seniors. If the patient attains a threshold score they are automatically referred to home care for assessment and review in their home. A large number of seniors have been identified through this process and the necessary supports have been put in place to support them in the community
- Employee orientation- Each new employee has an opportunity to meet with the senior team. During this time the strategic plan is reviewed and their role in enhancing the patient experience is discussed. Every employee has a critical part to play in creating an excellent patient experience and we want them to understand this priority very early in their employment

Risk Management

To cope with the challenge of creating consistent and workable processes for managing operational risks, we need to adopt a "risk management culture" that emphasizes at all levels the importance of managing risk as part of each of our daily activities. The goal of creating a risk management culture is to create an environment where staff and managers instinctively look for risks and consider their impacts when making effective operational decisions.

Goal – The overall goal of Risk Management is to improve clinical, operational and financial outcomes.

Objective A: Improve clinical outcomes and mitigate the likelihood of risk affecting patients and families. The following clinical outcomes are key indicators of clinical risk:

- Patient Falls
- Infection Rates
- Medication Errors
- Patient Wait Times

The above indicators are monitored on a monthly basis at the clinical teams to identify trend and opportunities. Best practice guidelines are in place for patient falls, infection rates are monitored monthly by the ICP and reported to the IC committee, Medication errors are reviewed in the clinical setting and corporately through the medication safety working group. Patient wait times are measured in key areas

(Surgery and ER). All the indicators are within acceptable range with the exception of wait times for inpatient beds.

Five overcapacity beds were opened in Dec 2013 and all five beds have been fully utilized since May 2014. Inpatient capacity is consistently at 116%. Recently we have resorted to inpatients having to be cared for in the hallway. The need for overcapacity has been a direct result of the number of patients waiting for nursing homes. In January 2015, the number of patients waiting for LTC beds peaked at 70% of our active beds, leaving 7 beds available for acute patients. As a result, admitted patients have to wait longer periods of time in ER before being transferred to the inpatient unit.

Objective B: Build a strong operational reputation within our community by creating a customer-service mentality throughout our Hospital and compete for the patients' business.

- Strive to exceed stakeholder expectations.
- Close the gap between internal realities and stakeholder perceptions.

Determining the ever changing customer service needs has always been a challenge. Basic customer service skills are reviewed with all employees at the time of hire. We have even gone as far as scripting employees in key areas of the hospital where customer service interactions may be challenging. Customer expectations are ever changing particularly in the Emergency Department. We are continually challenged to meet the expectation of an instant society. We are becoming used to having everything quicker and faster as a society. There are a number of non-health care companies that have been successful in meeting customer expectations. The business approach to service delivery is currently being actively explored.

We have redesigned a number of processes using the LEAN approach to process improvement. The goal is to eliminate multiple steps and streamline the process. However, the best way to manage expectations is often at the time of interaction. This requires coaching and skill development with our employees. This has been identified by staff as an area where they would appreciate additional education. How we best meet their identified needs is currently being explored

Staff Safety

Our first and foremost duty as an employer is to protect our staff. It is our goal to ensure no one gets hurt at work and we take this responsibility very seriously.

Objective A: We have maintained a comprehensive Health and Safety Management System which promotes internal responsibility of all personnel.

Safety Group:

We participate in safety group annually to enhance our safety services through collaboration with external agencies in the development and maintenance of a H & S Management System. This includes an internal audit annually of the policies and procedures. This year we underwent a WSIB Safety Group Audit on May 22, 2014. The audit covered the 2013 safety management system. We achieved the only score of 100% and received a letter of recognition from the Executive Director, Henrietta

Van Hulle from the Health & Community Care, Public Services Health & Safety Association.

Workplace injuries:
In April 2014, we achieved 18 months with no lost time injuries. From April to December, we have had two lost time injuries – 1 burn with 3 lost time days and 1 patient action resulting in 3 lost days. Claims with 5 days or less of lost time are claim Type 1 and do not have any reserve costs; reserve costs begin with the 6th day of lost time. We make every effort to offer safe and early return to work to all employees. As a result of our record, our NEER Performance Index on September 30, 2014 was 0.53 resulting in a rebate of $7,247.55.

Workplace violence annual risk review:
In December of 2014, the JOHSC completed our annual workplace violence risk review. There were six reports of workplace violence and harassment concerns investigated in 2014 (this is down by greater than 50% from the previous year). There were no Type 1 (external person unrelated to the hospital) incidents reported. Four incidents reported were Type 2 (client to worker). Prevention strategy: The hospital continues to offer education to support staff in learning techniques to deescalate and manage aggressive behaviours ("Gentle Persuasive Approach"). One Type 3 (worker to worker) incident was reported which was investigated with insufficient evidence to suggest violence or intent. One Type 4 (personal relationship) concern was reported. The hospital supported the worker by developing a safety plan and offered resources for domestic violence.

Worklife Experience
Objective A: The Board approved $435,357 in capital expenditures for this year. Annually staff is asked to submit recommendations for capital.

Objective B: Year-to-date, we have invested $52,438 in staff training excluding mileage where applicable. (This does not include replacement costs for staff and payment for attending education).

To support a learning environment we introduced the Continuing Education Loan Program and we are pleased to support five staff members in 2014/15. The following education programs are being supported: Advanced Wound Care Program, the Ontario Healthcare Housekeepers Association Environmental Services Course, the Central Service Association of Ontario (CSAQ) Medical Device Reprocessing (MDR) Techniques Course, Laboratory Quality Management and the National Payroll Association Course.

We are in the process of investigating payroll deduction for Professional Association memberships with the various Professional Associations.

Objective C:

Organizational Recognition

We received the Silver Quality Healthcare Workplace Award from the OHA at Health Achieve and the Gold Public Health Workplace Wellness Award in 2014.

We achieved first place in the Interhospital Health Challenge for a second year in a row. The Wellness Committee organized a number of events throughout May to promote the challenge which supports healthy lifestyle initiatives. This year our hospital had 12 teams and competed against twelve other hospitals. There were a total of 501 teams entered in the challenge.

Staff Recognition

Milestones:

The Annual Awards Dinner was held at the Renaissance Event Venue on November 13, 2014 with 57 persons in attendance. Twenty-two staff members were honoured for reaching milestones ranging from 5 to 40 years of service (Nancy Carter celebrated 40 years of service as a Registered Nurse with our hospital). A total of 300 years of service to our community was celebrated with 45 members now in the 25 year club.

Commitment to Regular Attendance:

This year the number of staff achieving perfect attendance increased once again for both fulltime and part time. We had 76 employees (31.6% of staff) achieving perfect attendance (29 FT and 47 PT). The hospital provided each employee with a gift to recognize their commitment to attending work regularly.

Retirements:

Veronica Wemp, RPN, retired from our hospital after 32 years of nursing service. Veronica's memorable day was spent at the Touch of Wellness Spa with two of her colleagues.

Peter Stenzl, Electrician, celebrated his memorable day following 27 years of service at the Smugglers Glenn golf course with fellow colleague Jaison John.

Sylvia Ollsen, RN, retired after 33 years of service. She spent the morning at the spa with 2 colleagues followed by a wine tour in the county.

Wellness:

The hospital staff support local community charities through participation in Casual Fridays with donations through Payroll deduction. This year we raised $1,793.00 for the Salvation Army Food Bank.

Awareness and funds for cancer research were raised with our October breast screening promotion and the Movember competition.

We hosted Weight Watchers at work program. This 26 week program is offered through payroll deduction. The meetings are held in the workplace to make it easy for staff to attend.

On May 14, 2014 we received our annual Financial Analysis from Stevenson and Hunt for our Manulife Extended Health and Dental Care Benefits for the period of December 1, 2012 to November 30, 2013. Our plan performed favorably during the review period. We experienced a surplus in both extended health care and dental care. Our Claims Fluctuation Reserve is fully funded resulting in an available surplus. Twenty five per cent of the surplus will be directed to employee wellness.

Objective D:
Strategic communications meetings were held throughout the year lead by the CEO or delegate. All team leaders are invited to provide updates in a round table meeting and to report back information to their units in a manner which meets the needs of the staff within the unit.

The hospital implemented electronic communication screens in key areas of the hospital to enhance communications with the staff and public.

Turnover rates are incorporated into the Balanced Scorecard and are reported to the Quality Committee of the Board. Exit interviews and / or surveys are undertaken with all staff retiring or resigning from the hospital and this information is used for continuous improvement in staff work life.

We have worked with the SEIU Labour Management on our long-term care transition and mitigated any possible layoffs.

9. Closed Session

At 7:46 p.m., the Board moved into closed session.

Motion 12

Rationale: Normal Practice

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

Moved by: Michelle Smith
Seconded by: Deb Lowry **The motion was carried.**

At 8:12 p.m., the Board rose from closed session.

Motion 13

Rationale: Normal Practice

Motion: The Board of Directors hereby rises from closed session.

Moved by: Allan MacGregor
Seconded by: Judge Geoff Griffin **The motion was carried.**

10. Next Meeting

The next regular meeting of the Board is scheduled for February 3, 2015 at 6:30 p.m. in the Airhart Conference Room.

11. Adjournment

The meeting was adjourned at 8:12 p.m.

Motion 14

Rationale: Normal Practice

Motion: The Board of Directors hereby adjourns their meeting at 8:12 p.m. on January 6, 2015.

Moved by: Eric Smith
Seconded by: Allan MacGregor **The motion was carried.**