GRAND RIVER HOSPITAL
MINUTES OF A PUBLIC MEETING
OF THE BOARD OF DIRECTORS
HELD ON JANUARY 24, 2012
IN THE FREEPORT BOARDROOM

PRESENT:

Bellew, G.
Bleaney, T.
Collingwood, B.
Delamere, D.
Elop, T.
Freeman, D.
Harris. B.
Hendrikse, P.
Maki, P.
Maxwell, M.
McIlwham, K.
Robertson, S.
Schlegel, J.
Sellers, L.
Sharma, A.
Singh, P
Uffelmann, D.
Weiler, B.

REGRETS:
None

STAFF:

Cavrag, K.
Cheal, B.
DeLenardo, C.
Higgs, G.
Karjaluoto, M.
Lillepold, A.
Rajaballey, J.

Recording Secretary: Karen Taylor

1.0 CALL TO ORDER

The meeting was called to order by D. Delamere at 4:00 p.m.

1.1 ACCEPTANCE OF AGENDA

The agenda was approved with the following addition:

- Board Committee and Other Reports Item 5.3: Nominating Committee

1.2 DECLARATION OF CONFLICT OF INTEREST

None.

2.0 ITEMS FOR CONSENT

2.1 BOARD MINUTES OF NOVEMBER 22, 2011

The Board minutes of November 22, 2011 were included in the Board package.

2.2 DRAFT TERMS OF REFERENCE FOR THE JOINT GRH AND GRHF MARKETING AND COMMUNICATIONS WORKING GROUP

The draft terms of reference for the joint Grand River Hospital and Grand River Hospital Foundation marketing and communications working group was included in the Board package.

2.3 ACCREDITATION UPDATE

An update was included in the Board package.

2.4 BOARD MANUAL UPDATES

The following documents were included in the Board package.

2.4.1 CODE OF CONDUCT POLICY
2.4.2 ANNUAL DIRECTOR DECLARATION AND CONSENT
2.4.3 ANNUAL COMMITTEE MEMBER DELARATION AND CONSENT
2.4.4 CONFIDENTIALITY POLICY
2.4.5 DIRECTOR DECLARATION
2.4.6 GENERAL PRINCIPLES REGARDING CONFLICT OF INTEREST
2.4.7 CONFLICT OF INTEREST POLICY
2.4.8 MEETING ATTENDANCE POLICY
2.4.9 BOARD SUCCESSION PLANNING POLICY

MOTION:
IT WAS MOVED BY G, BELLEW AND SECONDED BY K. MCILWHAM THAT THE BOARD OF DIRECTORS APPROVE THE ITEMS FOR CONSENT. CARRIED.

3.0 BOARD EDUCATION

None.

4.0 QUALITY REPORT

4.1 A DAY IN THE EMERGENCY DEPARTMENT AS REPORTED BY DR. SAHSI/ PATIENT STORY

Dr. Sahsi's presentation focused on the role of the emergency department (ED), outlined the ED process and flow, and detailed ED challenges. A copy of the presentation is attached to these minutes (Attachment 1).

Topics addressed during the question and answer period included improving communication with ED patients and their family members, ways to make the wait to be seen a more pleasant experience, current risks to ED patient quality, reducing the number of individuals left without being seen. It was suggested that the issues identified in the presentation also apply to the other 8 hospitals within the Waterloo Wellington Local Health Integration Network (WWLHIN) and that individuals at the WWLHIN might find the presentation informative.

ACTION ITEM: D. Delamere will make inquires to determine if there is interest for the presentation to be made to the WWLHIN.

5.0 BOARD COMMITTEE & OTHER REPORTS

5.1 COMMUNITY ENGAGEMENT SURVEY

A copy of the summary report results and the consultants' report of findings from the second wave of the community engagement survey were included in the Board package. Communication steps and strategic responses to the public release of the survey information were outlined.

5.2 STRATEGIC COMMUNICATIONS PLAN 2012-2015

Grand River Hospital's draft strategic communications plan was included in the Board package. The strategic communications plan is intended to support the external communications and marketing activities of GRH and further discussions are underway with the GRH Foundation to ensure the new communications plan will support the Foundation's fundraising efforts and related initiatives.

5.3 NOMINATING COMMITTEE

At the January 24 meeting of the Board a briefing note proposing an action plan for the composition of the Nominations Committee was circulated to the Board.

MOTION:
IT WAS MOVED BY P. MAKI AND SECONDED BY T. BLEANEY THAT THE GRH BOARD OF DIRECTORS APPROVE THE PLAN FOR COMPOSITION OF THE NOMINATING COMMITTEE. THE CHAIR OF THE NOMINATING COMMITTEE WILL PROCEED WITH THE WORK OF THE COMMITTEE AS SOON AS THE POSITIONS ARE FILLED.
CARRIED.

ACTION ITEM: Through the Governance Committee, a report will be provided to the Board on the progress of the Nominating Committee at the February 28, 2012 meeting of the Board.

6.0 STRATEGIC MATTERS

6.1 ED/ALC UPDATE

An update on ED and ALC performance was provided in the Board package.

6.2 STRATEGIC PLAN UPDATE

The Board package included an update on the development of the strategic plan 2012-2015 and strategic priority planning objectives.

7.0 OPERATIONAL MATTERS

None.

8.0 EXECUTIVE HIGHLIGHTS

8.1 FOUNDATION REPORT

The Foundation report was included in the package for information.

8.2 VICE PRESIDENT CLINICAL SERVICES & CHIEF NURSING OFFICER

Included in the package for information.

GRH is coming to the end of its Best Practice Spotlight Organization candidacy and it is anticipated that the hospital will be awarded the Best Practice Spotlight Organization designation at the end of April 2012.

8.3 CHIEF OF STAFF REPORT

The report from the Chief of Staff was included in the package for information.

8.4 PRESIDENT AND CEO REPORT

Included in the package for information. Additional information conveyed by M. Maxwell included a concern that provincial reductions in social service spending could result in increased use of hospital services by people living with mental illness, substance abuse and homelessness.

It is anticipated that the WWLHIN will provide GRH with hospital specific funding targets by mid-February. As a member of the Ontario Hospital Association Board, M. Maxwell will attend an upcoming event to hear the speech by the Minister of Health and Long Term Care. The speech is assumed to foreshadow the government response to the Drummond Report.

M. Maxwell has participated in a series of conversations with P. Gaskin and D. Shilton regarding the anticipated future financial pressures and how the three hospitals can work together to address them.

8.5 BOARD CHAIR REPORT

Members of the Board were reminded to complete the Board self-assessment and peer survey. Following compilation of the survey results 1 on 1 meetings will be arranged with each Board member.

Members of the Board were invited to attend the January 31, 2012 breakfast event hosted by the Greater KW Chamber of Commerce to hear Health Minister, Deb Matthews speak about the future of healthcare in Ontario.

9.0 ITEMS FOR INFORMATION

9.1 COMMITTEE MINUTES

9.1.1 MEDICAL ADVISORY COMMITTEE

Medical Advisory Committee minutes of January 10, 2012 are included in the Board package for information.

9.1.2 GOVERNANCE COMMITEE

Minutes of the January 11, 2012 meeting of NWHCC are included in the Board package for information.

9.1.3 RESOURCES COMMITTEE

Minutes of the January 10, 2012 meeting of the Resources Committee are included in the Board package for information.

9.1.3.1 FINANCIAL STATEMENTS

The financial statements as at November 30, 2011 are included in the Board package for information.

9.2 BOARD WORK PLAN

Included in the Board package for information.

9.3 BOARD EDUCATION OPPORTUNITIES

Included in the Board package for information.

9.4 FEBRUARY BOARD CALENDAR OF EVENTS

Included in the Board package for information.

9.5 GRH BOARD 2012 MEETING SCHEDULE

Included in the Board package for information.

9.6 WWLHIN BOARD 2012 MEETING SCHEDULE

Included in the Board package for information.

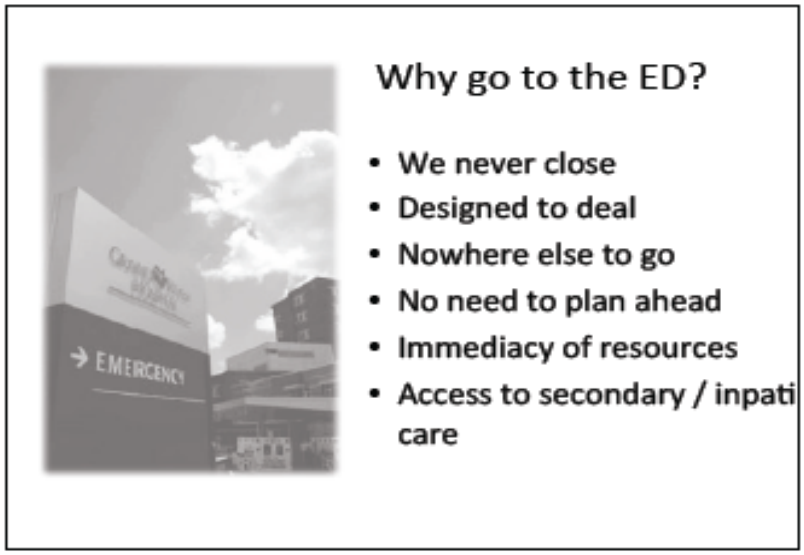
9.0 ADJOURNMENT

THERE BEING NO FURTHER BUSINESS, IT WAS MOVED BY D. FREEMAN AND SECONDED BY T. ELOP THAT THE PUBLIC PORTION OF THE MEETING BE ADJOURNED.
CARRIED.

Malcolm Maxwell,
Secretary

D'Arcy Delamere,
Chair

Attachment 1
January 24, 2012
Presentation Slides * – Dr. R. Sahsi



* Please note that the wording on several of the slides was cropped in the original document.

Objecties

- Insight into ED processes and flow
- Understand factors known to influence increased wait times and ED overcrowding
- Realize that degraded ED performance is most heavily affected *by forces outside the ED itself*

- What is the #1 cause of emergency department overcrowding?

HOSPITAL OVERCROWDING

LACK OF AVAILABLE ACUTE CARE BEDS

ED Overcrowding

- Frustratingly long waits
- Prolonged pain and suffering
- Patient dissatisfaction (violence)
- Ambulance offload delays, reduced EMS response times
- Decreased department productivity
- Cutting corners?
- Poor staff morale, retention

ED Overcrowding

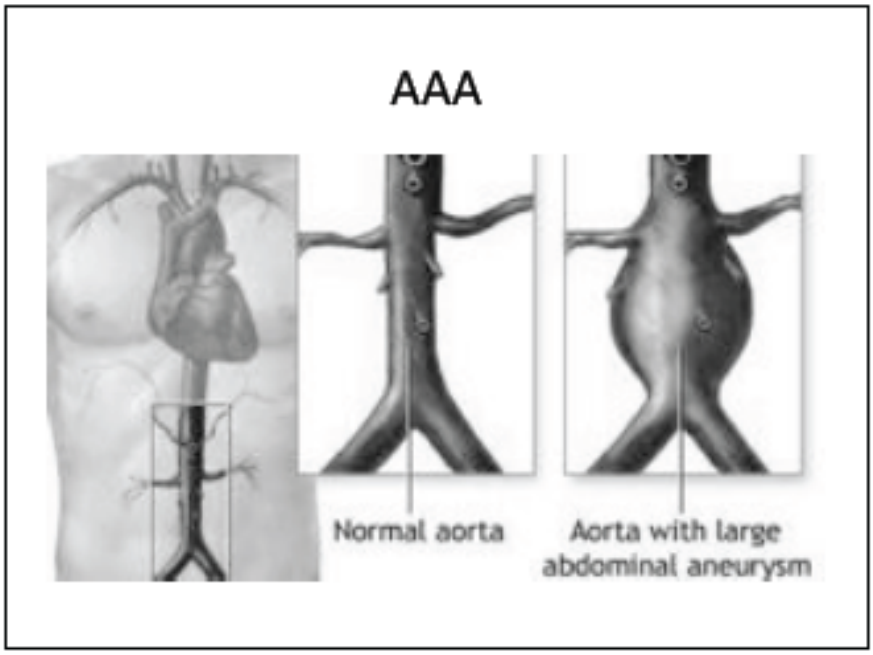
- INCREASED COSTS
- DECRESED EFFICIENCY
- MORE ADVERSE OUTCOMES

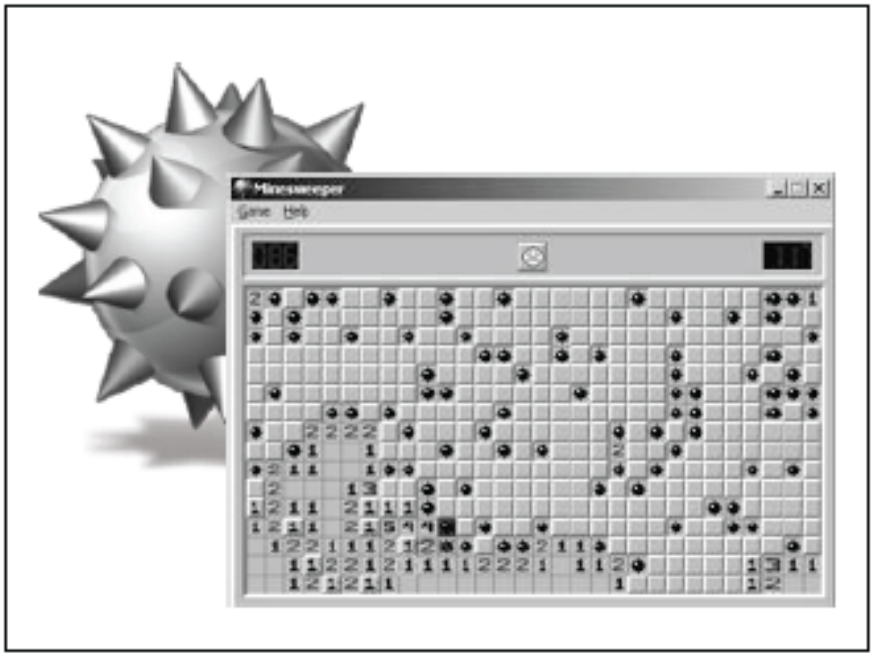
George…

- 63 year old male
- PMHx: HTN, DDD, chronic/intermittent LBP
- Meds: unsure
- Got up from chair, felt his legs give way, wound up on the floor with a pain in his lower back
- Got up with wife's assistance, but can't get comfortable
- Driven to the emergency department

DDx

- Disc-related MSK back pain
- Orthostatic/vasovagal syncope
- Vertebral fracture
- TIA "mini stroke"
- Cauda equina syndrome (!!)
- Leaking abdominal aortic aneyrusm (!!!!!!!)


AAA
Normal aorta
Aorta with large abdominal aneurysm


Minesweeper
Game Help

Canadian Triage Acuity Scale

LEVEL	Name	Time to MD	
CTAS 1	Resuscitation	Immediate (98%)	Arrest, Major Trauma, Severe Respiratory Distress
CTAS 2	Emergent	15 minutes (95%)	MI, CVA, Overdose
CTAS 3	Urgent	30 minutes (90%)	Asthma, Acute Pain, GI Bleed, Psychosis
CTAS 4	Less Urgent	60 mintutes (85%)	Headache, Laceration, Corneal FB,
CTAS 5	Non-Urgent	120 minutes (80%)	Common cold

INPUT ⇨ THROUGHPUT ⇨ OUTPUT

From: home, other primary care, within our hospital, from other facilities, etc...

Arrival – self, ambulance, police...

Registration

Triage

Waiting Area / Offload Delay

Availability of Appropriate Clinical Space

Assessment by RN and MD

Ordering of Investigations: Labs/ Diagnostic Imaging

Reporting of results

Treatment and Reassessment

Disposition Decision

Discharge Home

Community-Based Services

Inpatient Admission

Transfer to Another Facility

Does this patient need care immediately?

Does this patient need to be in the emergency department?

Does this patient need to be in THIS emergency department?

Can they go somewhere else?

How long can they safely wait?

INPUT

Input! Input! Increasing input!

- Population growth often outstrips resources in the ED and community
- "More load on the system"
- Volume of ED visits increases
- Increased demand for scarce inpatient resources
- Health care planning is often reactive rather than predictive

Input Myth

- *"Patients who show up to the emergency department with minor complaints gobble up resources, create the backlogs, and delay the delivery of care to the people who need it most."*

Nonsense!

- Because of triage, non-urgent complaints wait… wait… wait…
- They wait a long time, so they tend to be the population that complains the most
- Once seen, care is often simple
- Don't require tremendous resources
  (lab, pharmacy, nursing, stretchers, imaging)
- Can be directed through MT

Can we send away people who don't need to be there?

- How do you know who shouldn't be there?
- Prospective vs. retrospective
- No clear way to determine who may need aggressive care
- CTAS 4-5 still has a 4-8% admission rate
- Diversion dramatically increases risk and rate of adverse outcomes, does not meaningfully reduce wait times or cost to the system

Lack of Primary Care

- Availability of family medicine groups with on-call services can reduce deferrable visits to the ED... but...
- Orphan patients only account for ~10-12% of ED visits
- Up to 30% of patients report having already seen primary care for the same complaint
- 50% of patients access the ED for specific acute care services (*ie: suture repair, casts, diagnostic imaging studies, new concerning symptoms*) not available through family MD

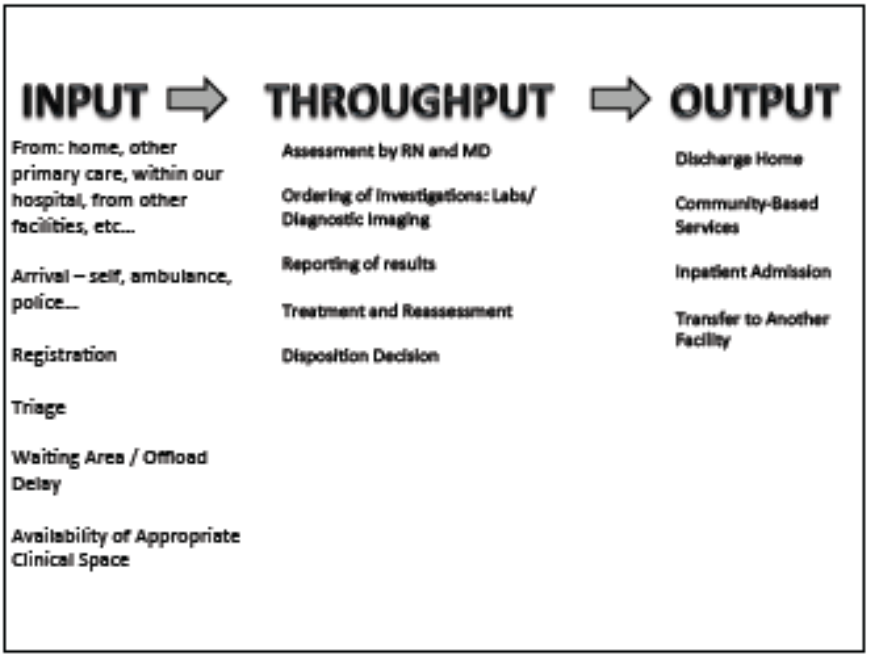
Community Care Matters

- Management of chronic disease states
  - Community-based secondary prevention of complications from the disease
  - Follow-up from inpatient discharges
  - Keep people healthier, longer
  - Reduce need for emergency and inpatient care
- Mental Health and Addictions
- Geriatrics/Aging at Home

Appropriate Facility?

- Are they at the right hospital?
- Rationalization of resources
- Walk-in vs Ambulance
- Access to specialists
- Need for transfer for admission can cause output delays

- Coordinated public education?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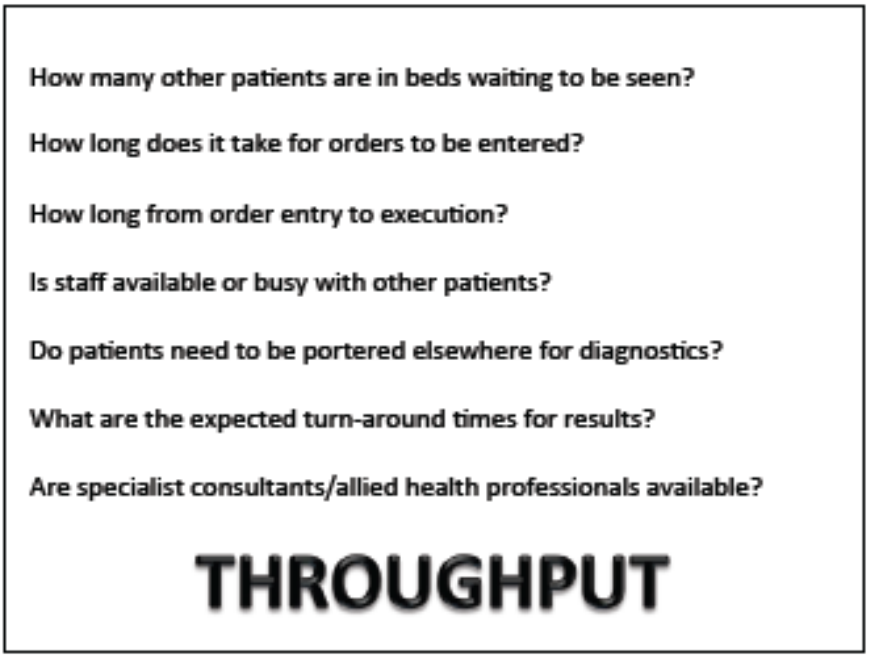

How many other patients are in beds waiting to be seen?
How long does it take for orders to be entered?
How long from order entry to execution?
Is staff available or busy with other patients?
Do patients need to be portered elsewhere for diagnostics?
What are the expected turn-around times for results?
Are specialist consultants/allied health professionals available?
THROUGHPUT

More complicated patients…

- Older population with more chronic disease, exacerbations of which require ED or inpatient care
- Medical/pharma allowing longer lifespans for these people
- Patients present with multiple comorbid condtiions → much harder to detect or exclude serious occult diseases → needs more time and resources

Understaffing

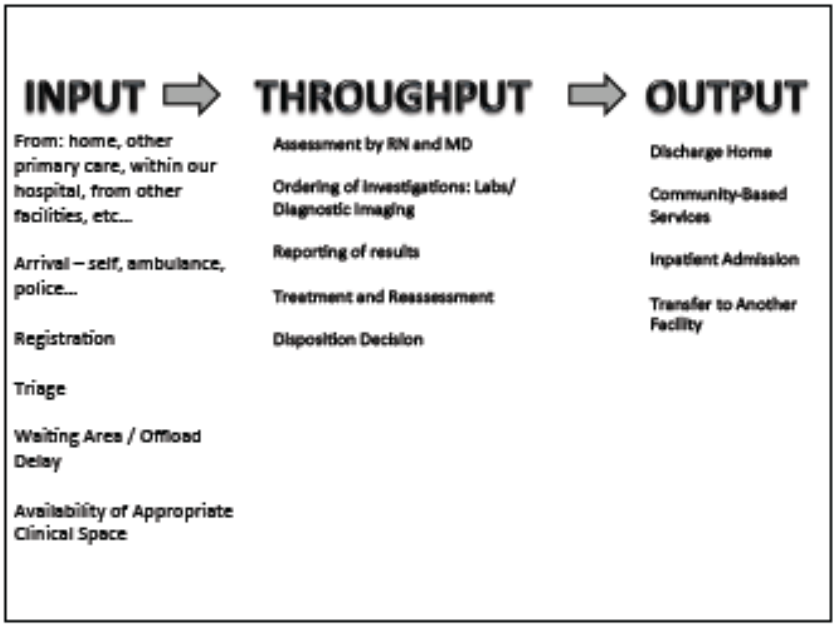
- Experienced, dedicated nursing staff are the backbone of ED care
- RN Shortages = overburdened staff, reduction in efficiency, increase in risk
- High staff turnover = many new, inexperienced nurses = less efficient
- Float/agency nurses sent from other areas of the hospital = less efficient

Understaffing

- Effective number of support staff
  - Clerical
  - Telecommunications
  - Phlebotomy
  - Respiratory Therapy
  - OT/PT
  - Portering and Housekeeping
- Underestimation of the cost of cutting corners in these areas

Fear of admitting

- Many patients with disease processes that would have mandated admission are now being treated in the ED and discharged
- More care provided in ED == more resources + greater EDLOS
- Clinical Decision Unit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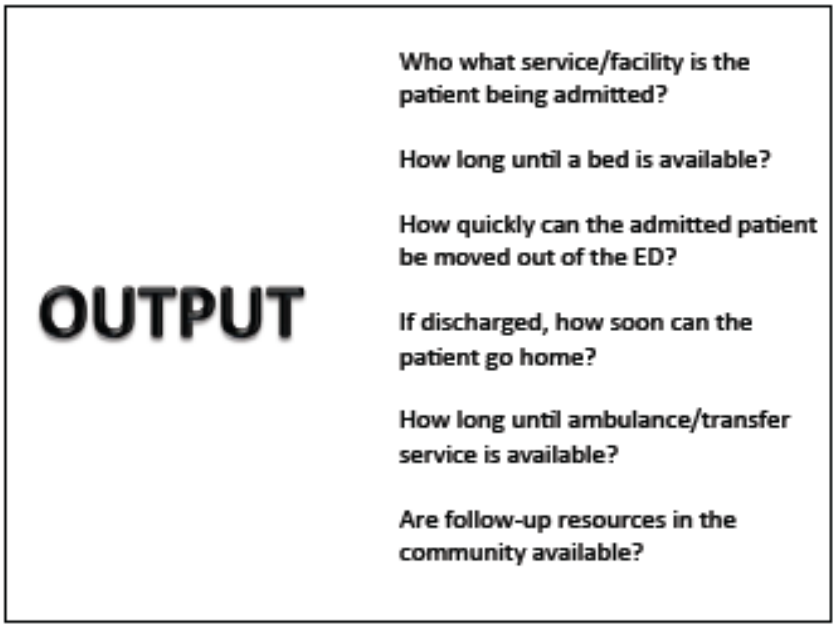

OUTPUT
Who what service/facility is the patient being admitted?
How long until a bed is available?
How quickly can the admitted patient be moved out of the ED?
If discharged, how soon can the patient go home?
How long until ambulance/transfer service is available?
Are follow-up resources in the community available?

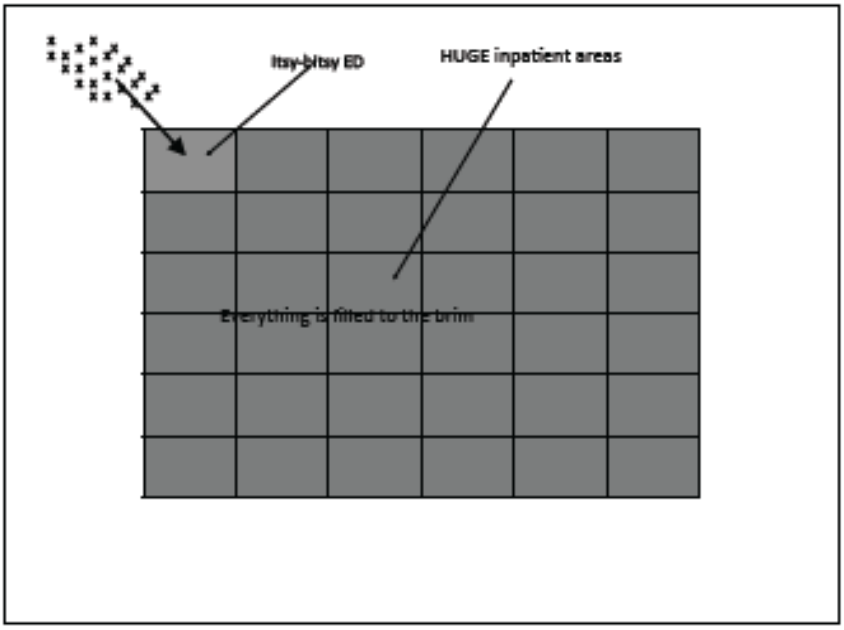
INPUT ⇨ THROUGHPUT ⇨ OUTPUT

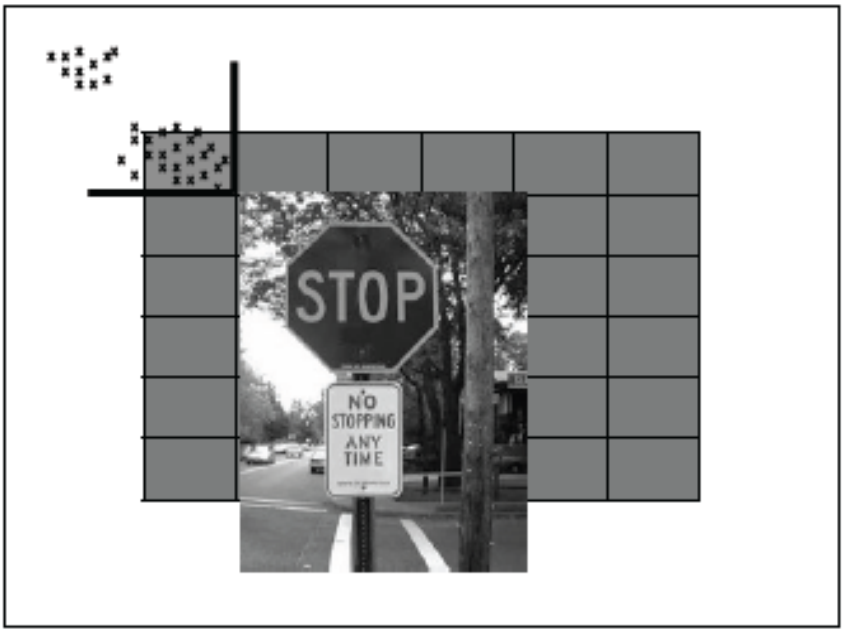
Lack of access to available acute care beds

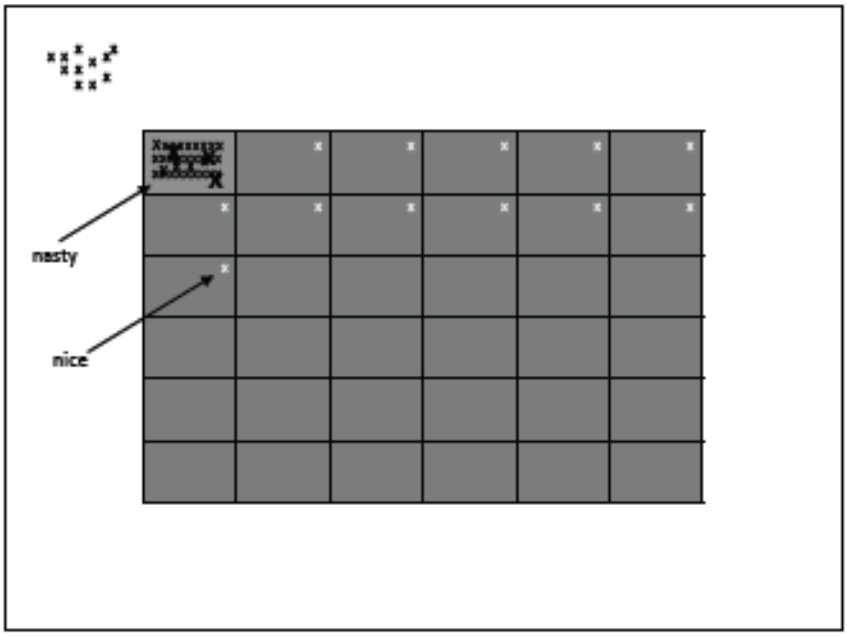
Admitted patients "boarded" in the ED

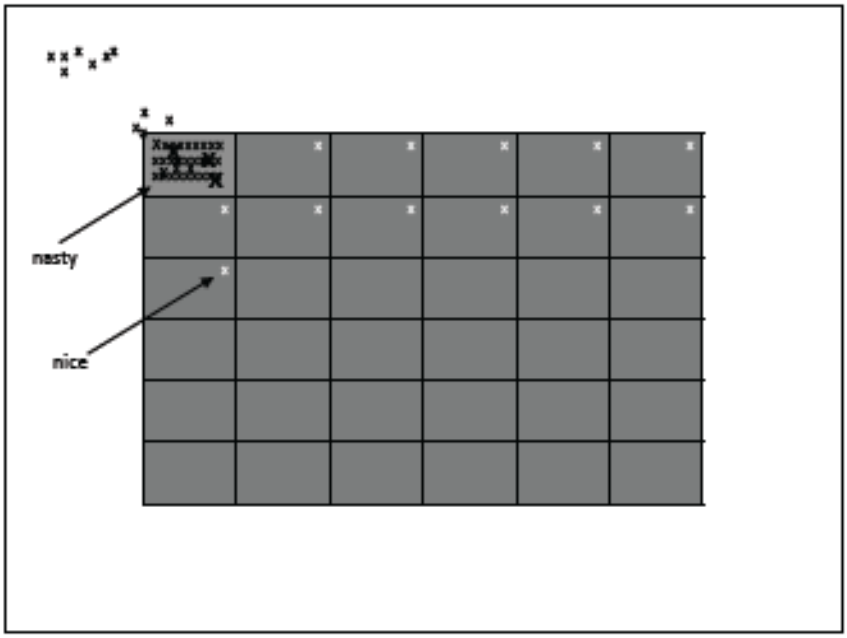
Fewer ED bed spaces available for patients in the waiting room

GRIDLOCK


Itsy-bitsy ED
HUGE inpatient areas
Everything is filled to the brim


STOP
NO STOPPING ANY TIME


nasty
nice


nasty
nice

Compare

**How essential is the emergency department?
Who is caring for the patients in the waiting room?**

- ED
- No space
- 15 additional admitted patients above usual number of patients
- Interferes with prime function of department
- "Wrong place"
- "Wrong expertise"

What happens if each ward takes just two patients?

- Unit B, C, D, E, F, G.
- No space
- No additional admitted patients above their usual number of patients
- Units designed for care of these patients
- "Right place"
- "Right expertise"

G.O.M.E.R.

- Faster bed turnaround times
- Faster exit of patient from ED
- Faster transfer to inpatient bed
- Better outcomes, fewer sentinel events
- Improved patient satisfaction
- Shorter inpatient length of stay

- Who pays for the boarded patient?

Surge Capacity

- Overcapacity protocols only temporize the problem by distributing the load
- Solution: access to more beds
- Hospital flow is optimized when average occupancy hovers around 85%
- Budget time…

Other Output Delays

- Waiting for inpatient bed turn-around
- Arrangement of follow-up services while still in the emergency department
- Transfer to other facilities
- Availability of transportation
- Overnight holds for am admission
- Waiting to go direct to the OR instead of the surgical ward

Solutions?

- Streamlining of registration/triage processes
- Waiting room experience
- Better informed patients in the WR
- Increased community resources to keep patients from getting sicker and needing ED/ inpatient care
- Availability of alternatives to ED care

Solutions?

- Enhanced throughput through increased resources, retention of experienced staff
- Access to diagnostic imaging tests 24/7
- Better access to local specialty care
- improved hospital bed capacity
- reduction in transfers to other communities

Solutions?

- Expedite patient output
  - Early evaluation of expectant inpatient d/c
  - Access to admitting MDs 24/7
  - Speedy transfer to inpatient wards
  - Use of overcapacity space/"buffering"
  - Fast exit of patients from ED – no excuses