Thunder Bay Regional Health Sciences Centre

Board of Directors
Open Meeting
Wednesday, February 5, 2020 – 5:00 pm Boardroom, Level 3, TBRHSC
980 Oliver Road, Thunder Bay
AGENDA

Vision: *Healthy Together*
Mission: *We will deliver a quality patient experience in an academic health care environment that is responsive to the needs of the population of Northwestern Ontario*
Values: *Patients ARE First (Accountability, Respect and Excellence)*

#	Time	Presenter	Item & Purpose	Expected Outcome				
				Recommendation /Decision/Action	Education	Discussion	Strategic Progress	Fiduciary Information
1.0	2	**CALL TO ORDER and WELCOME**						
1.1	5	M. Simeoni	Chair's Remarks*					X
1.2	1	M. Simeoni	Quorum (9 members total required, 7 being voting)					
1.3	1	M. Simeoni	Conflict of Interest					
1.4	1	M. Simeoni	Approval of the Agenda	X				
2.0	5	**PATIENT STORY** – Glenn Craig						
3.0	**PRESENTATIONS/EDUCATION**							
3.1	10	Dr. S. Kennedy	Physician Recruitment Update*		X			
3.2	10	Dr. P. Voros	Regional Mental Health Update*		X			
4.0	**CONSENT AGENDA**							
4.1	-		Board of Directors Open Minutes-December 4, 2019*	X				X
4.2	-		Patient Safety and Quality of Care Committee Minutes-December 18, 2019*					X
4.3	-		Patient Safety and Quality of Care Committee Minutes and Quarterly Scorecard -Jan 15, 2019*					X
4.4	-		Governance and Nominating Committee Minutes – December 6, 2019*					X
4.5	-		Q3 2019-2020 Wages and Source Deduction Attestation*					X
5.0	**REPORTS**							
5.1	10	J. Bartkowiak	Report from the President and CEO* 5.1.1 Current Challenges: a. Seven Youth Inquest/Racism b. Ontario Health Teams					 X X
5.2	5	Dr. Z. Ahmed	Report from the Chief of Staff*					X
5.3	5	Dr. V. Grdisa	Report from the Chief Nursing Executive*					X
5.4	2	G. Craig	Report from the Foundation*					X
6.0	**FIDUCIARY MATTERS**							
6.1	5	P. Lang	Report from the Chair of the Patient Safety and Quality of Care Committee: a. Mental Health Supports in the Emergency Department b. Infection Control Update c. Reputational Risk Matrix Process d. Critical Incidents Update					 X X X X

#	Time	Presenter	Item & Purpose	Expected Outcome				
				Recommendation /Decision/Action	Education	Discussion	Strategic Progress	Fiduciary Information
			e. Cardiovascular, Stroke, and Medicine					X
6.2	5	G. Wickham	Report from the Chair of the Governance and Nominating Committee: a. TBRHSC Board Policies* b. Committee Evaluations Process Change c. Tri-Board Retreat Update d. TBRHRI By-Law and Policy Review	 X				 X X X X
6.3	5	G. Walsh	Report from the Chair of the Resource Planning Committee: a. The People Plan Update b. Staff and Physician Engagement Update c. 19-20 Q3 Corporate Balanced Scorecard Review					 X X X
7.0	**FOR INFORMATION**							
7.1	-		Work Plans*					X
7.2	-		Webcast Statistics*					X
7.3	-		Report from the Health Research Institute*					X
7.4	-		Report from the Volunteer Association*					X
7.5	-		Report from the Northern Ontario School of Medicine* Northern Routes Link: https://us3.campaign-archive.com/?u=fc05ca9673eac8567682496b2&id=6c66f9f498 NOSM Strategic Plan 2020 Highlights and Engagement Link: https://strategicplan.nosm.ca/					X
7.6	-		Critical Incidents Update*					X
7.7	-		Reputational Risk Matrix Process*					X
8.0	**BOARD MEMBER COMMENTS**							
9.0	**DATE OF NEXT MEETING** – March 4, 2020							
10.0	**ADJOURNMENT**							

Ethical Framework

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The following questions should be considered for each decision:

1. Does the course of action put 'Patients First' by responding respectfully to the needs, values, and expectations of our patients, their families, and the communities?
2. Does the course of action demonstrate 'Accountability' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate 'Respect' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate 'Excellence' by fostering an environment of innovation and learning to provide a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making

BOARD OF DIRECTORS (Open)
February 5, 2020 – DRAFT

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
1.1	Agenda – February 5, 2020	"That the Agenda be approved as circulated."	Moved by: Seconded by:
4.0	Consent Agenda	"That the Board of Directors: 4.1 Approves the Board of Directors Open Minutes of December 4, 2019; 4.2 Accepts the Minutes of the Patient Safety and Quality of Care Committee meeting of December 18, 2019; 4.3 Accepts the Minutes of the Patient Safety and Quality of Care Committee meeting and Quarterly Scorecard of January 15, 2020; 4.4 Accepts the Minutes of the Governance and Nominating Committee meeting of December 6, 2019; 4.5 Accepts the Q3 2019-2020 Wages and Source Deduction Attestation, as recommended by the Resource Planning Committee, as submitted."	Moved by: Seconded by:
6.2.a	TBRHSC Board Policies	"That upon recommendation from the Governance and Nominating Committee, the Board of Directors approves the following TBRHSC Board policies: • BD-05 CEO Performance Evaluation and Compensation; • BD-07 Chief of Staff Performance Evaluation; • BD-11 Board and Committee Meeting Attendance; • BD-20 Review and Revision of Board Policies and By-Law; • BD-25 Education and Development; • BD-36 Public Attendance at Open Board Meetings; • BD-39 Board Committee Terms of Reference; • BD-44 President and CEO Succession Planning; • New Policy - Selection of Officers of the Board; as presented."	Moved by: Seconded by:

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
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Tel: (807) 684-6183
www.tbrhsc.net

Report from Matt Simeoni
Chair, Board of Directors
February 5, 2020

I am pleased to present my first report of 2020. This year marks the closing of the Strategic Plan 2020, which guided the Hospital's strategic activity over the past five years. I am extremely proud of the successes achieved, all of them moving us closer to our Vision of Healthy Together. A final, detailed report will be provided at a future meeting, but I can state that the vast majority (approximately 95%) of strategic activities are complete or on time. This is a remarkable achievement, and, on behalf of the Board of Directors, I extend congratulations to the staff, professional staff, scientists, patient family advisors, volunteers, learners and donors for enabling our success. We are inspired by the commitment to patients and families, to ongoing progress, and to the astounding ability to be responsive to the evolving health care environment.

As previously reported, the new Strategic Plan, called The Right Plan, will focus on the Right Care at the Right Time. The Right Plan will guide activity into 2021, and focus on overcapacity. Previous Strategic Plans have facilitated many successes and significant growth that have positive impacts to patients, families and our community. Overcapacity, however, remains an ongoing challenge. The Right Plan will focus on overcapacity by addressing patient flow in terms of:

- Enabling Success at Home;
- Optimizing the Acute Inpatient Care Journey;
- Ensuring Effective Transitions in Care.

The process to recruit the next Hospital President and CEO and Thunder Bay Regional Health Research Institute CEO is underway. An executive search firm will be selected in early March at the latest; this expert firm will guide the recruitment strategies. Mr. Bartkowiak has always been transparent regarding his planned retirement at the end of his existing contract. Our comprehensive recruitment strategy will ensure the selection of the most suitable successor to lead our Hospital and Health Research Institute.

I had the pleasure to represent the Board of Directors at the January 14 Long Service Celebration and Walk the Talk Awards to celebrate and recognize Hospital employees, professional staff and volunteers. I had the opportunity to present the Board of Directors Walk the Talk Award, which, this year, recognized the outstanding contribution of a team that has performed its responsibilities in an exemplary manner under extraordinary circumstances; the Award was presented to the Stores Department. The Department is responsible for ensuring the day-to-day availability of 3.5 million products used by the programs and services in our Hospital. Many of these products are vitally important to direct patient care. The dedicated staff in the Stores Department ensure, for instance, that each patient who undergoes surgery receives the right product to provide the best surgical outcome, which allows physicians, surgeons and nurses to focus on their patients. Congratulations to the Stores Department on being recognized with this year's Board of Directors Award.

Our Hospital is committed to improving Indigenous Health, and to addressing disparities in health status between Indigenous and non-Indigenous people. Racism experienced by Indigenous people is a serious issue and a barrier to accessing health care. Our Board of Directors, along with members of the Senior Leadership Council, participated in an anti-racism workshop on January 27 to better understand the impact of racism, be it individual or systemic, and to learn how to embed anti-racism into our practices.

Diane Smylie, Provincial Director of the Ontario Indigenous Cultural Safety (ICS) Program, Southwest Ontario Aboriginal Health Access Centre (SOAHAC), guided the design and co-facilitated the workshop.

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Joining Ms. Smylie were several of her colleagues, including Larry Spence, North West Regional Practice Lead, Ontario ICS Program; Leila Monib, Provincial Lead, Ontario ICS Program; Stephanie McConkey, Well Living House, Centre for Urban Solutions at St. Michael's Hospital, Unity Health Toronto; and from the British Columbia San'yas, Cheryl Ward and Jane Collins who have been addressing Indigenous specific racism in their provincial hospital system for the last five years. The San'yas: Indigenous Cultural Safety Training Program was created in response to the Transformative Change Accord First Nations Health Plan requirement to improve cultural competency within Health Authorities.

The Board of Directors is extremely appreciative of the knowledge and insights shared, as well as the subsequent inspired and challenging discussions. The workshop was intended to inform decisions regarding the priorities and accountabilities of our Board of Directors and Senior Leaders to address racism, especially systemic racist practices and to ensure that Indigenous patients and their families are provided culturally safe, empathic, and respectful care at our Hospital.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Physician Recruitment & Retention
PREPARED BY	Jamie Sitar, Physician Recruitment & Retention Specialist
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☐ NO ☐ N/A ☒
APPROVED BY	Dr. Michelle Langlois, Director of Medical Affairs
CO-SPONSER (if required)	n/a
PREPARED FOR:	President &CEO ☐ Board of Directors ☒ Other:
DATE PREPARED	January 2020

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

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☐ 4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE/ISSUE(S)

To provide the board with a yearly update on physician recruitment and retention challenges and successes.

BACKGROUND

Recruitment and retention is critical to the success of any hospital. A coordinated effort between Medical Affairs and Professional Staff Leadership is important to ensure the execution of good recruitment and retention practices. Professional staff leadership have updated their departments' annual human resource plans, which inform the hospital's recruitment efforts.

Some specialties continue to be challenging to recruit nationally.

Other specialties move through a multi-year cyclical imbalance between the amounts of physicians trained versus the job market needs. This imbalance is influenced by the average age of providers in a given specialty (i.e., stable profession for years but many retirements in a five year period) and also the evolving needs of the local patient population (complexity of care, aging population etc.).

ANALYSIS/CURRENT STATUS

TBRHSC continues to face some recruitment challenges in scarce specialties nationally. TBRHSC has also had some great successes with regard to locum dependence in key programs and recruitment in some historically challenging specialties.

RECOMMENDATION

Continue to invest appropriately in recruitment and retention of professional staff.

It is recommended that the Board endorse and approve the Professional Staff Human Resource Plans as updated in the fall of 2019 and associated recruitment plan.

NEXT STEPS

N/A

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

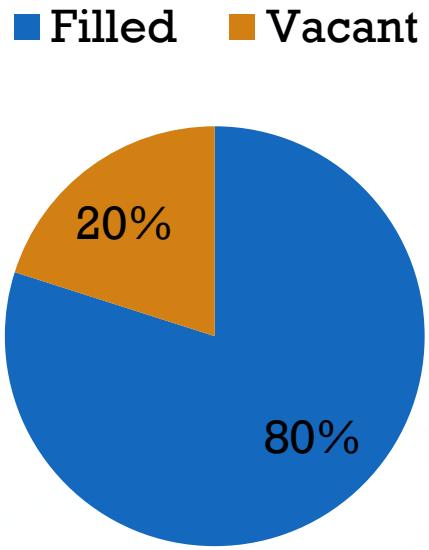
Powerpoint presentation

Recruitment Update

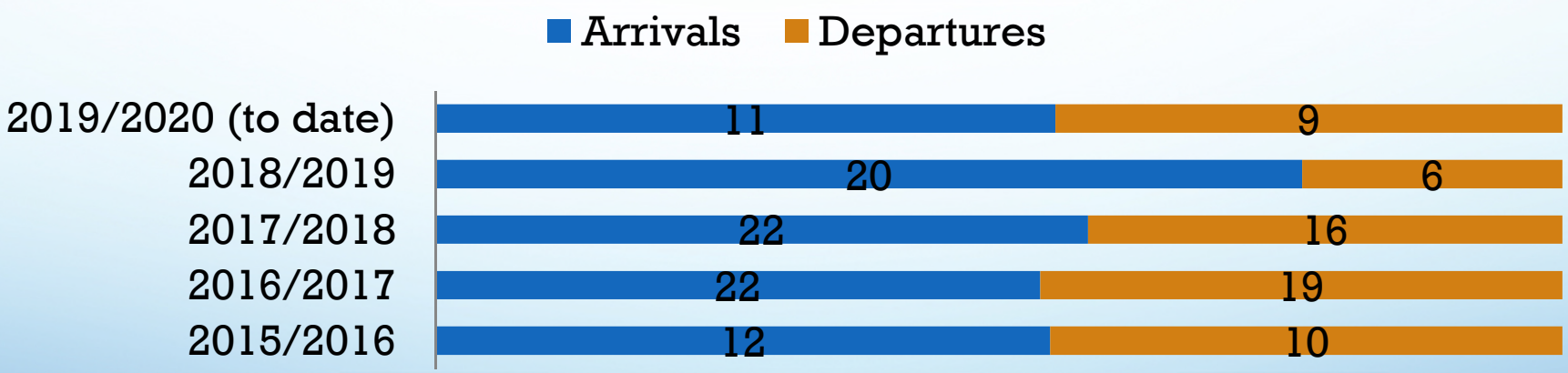
Board of Directors
February 2020

Dr. Stewart Kennedy
EVP Regional Programs, Clinical Supports and Medical Affairs

Physician Positions



Physician Retention



Current Physician Resources

Specialties:

- **266** Active & Associate Staff
- **173** Supportive/Courtesy Staff
- **187** Term Staff (80 Hospitalist locums)

General & Family Practice:

- **72** Supportive & Courtesy
- **54** GPs with Active/Associate Staff Status

Current Recruitment Needs

- **Professional Staff Health Human Resource Plan policy updated. All Departments completed HR plans in Sept 2019**

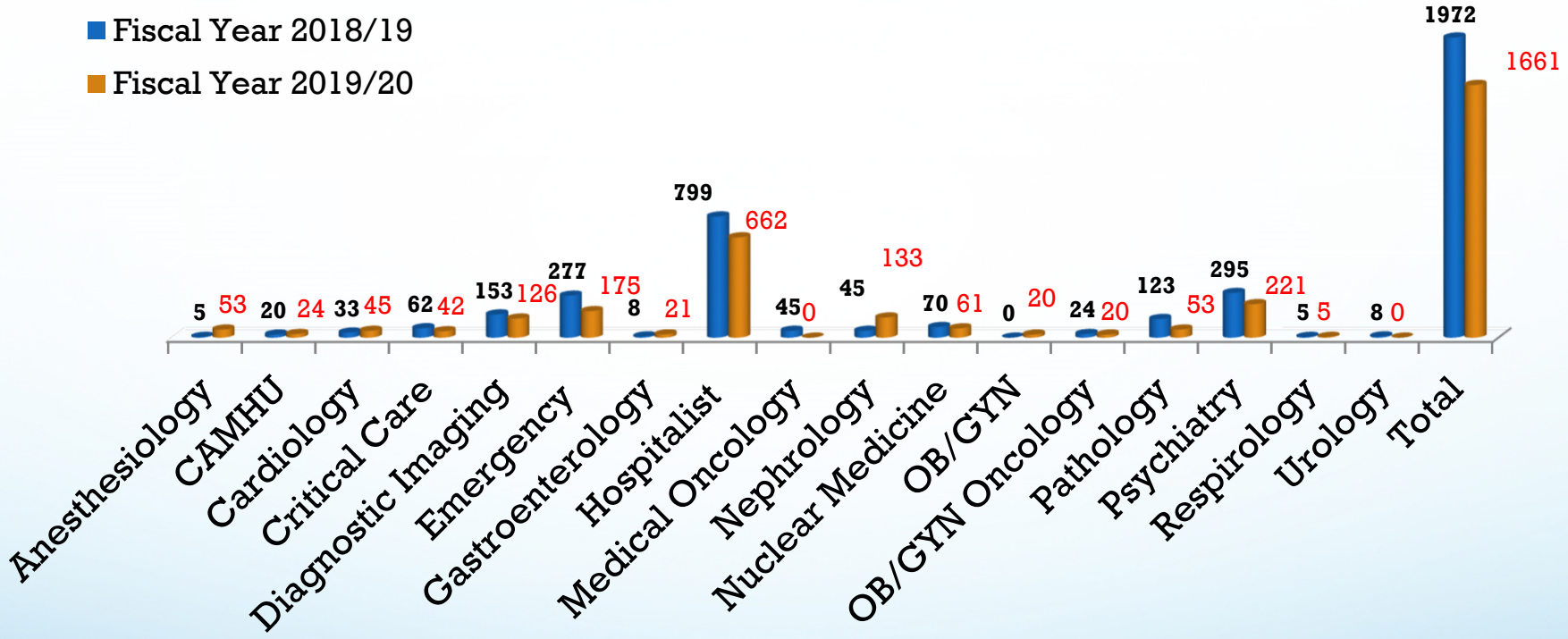
Human Resource Plan Vacancies for 2020/21		
Allergy & Immunology (1)	General Surgery (2)	Pathology (5)
Anesthesia (3)	Gerontology (1)	Physiatry (1)
Cardiac Surgery (3)	Hospitalist (1)	Plastic Surgery (1)
Cardiology (Interventional) (1)	Infectious Diseases (1)	Psychiatry (6)
Child & Adolescent Psych (3)	Neurology (1)	Radiology (3)
Critical Care (1)	Obstetrics & Gynecology (1)	Respirology (2)
Dermatology (1)	Oncology (GP) (1)	Rheumatology (1)
Emergency Medicine (3)	Ophthalmology (1)	Thoracic Surgery (1)
Endocrinology (1)	Orthopaedics (1)	Internal Medicine (2)

Pending Arrivals
Colorectal Surgery (1)
Gastroenterology (1)
Psychiatry AMH (1)
Dermatology (1)
Hematologist (1)
ENT (1)
Diagnostic Imaging (1)

Ongoing Focus: Locum Dependence

- **Effective recruitment & retention program leads to less locum usage and better continuity of care**
- **Supporting regional recruitment impacts physician workloads that are critical for retention (i.e. Primary Care's impact on ED)**
- **Total locum days across all specialties down 16%**
- **ED locum use reduced by 57% from 2016 to 2018**
  - Reduced a further 37% in 2019/20
- **Hospitalist locum usage cut from 33% to 18% year over year**

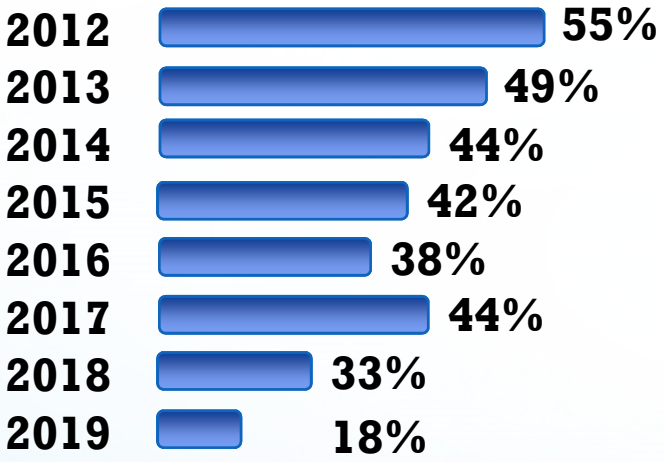
Locum Usage – Year Over Year

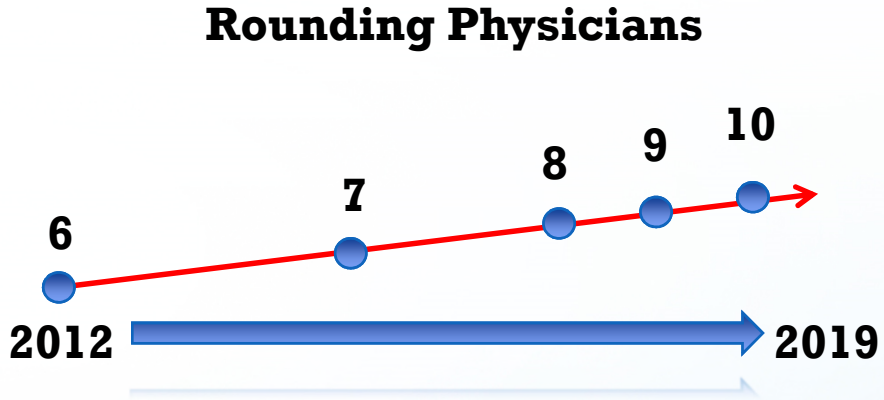


*** 2019/20 Projected Data for February & March**

Locum Usage

Hospitalist





- Decreasing locum usage reflects recruitment success of 3 FTEs in 2019

Recruitment News – Collaborative Efforts

- **Physician recruitment specialist holds a leadership role in the Northwestern Ontario Health Recruitment Association which supports recruitment to Thunder Bay & the region.**
  - Integral in organizing inaugural NOSM & HealthForceOntario Career Fair in Thunder Bay
- **Collaborative recruitment with Kenora to improve Psychiatric and Internal Medicine support to the region.**
  - Joint attendance at the Canadian Psychiatric Association Annual Conference + Canadian Society of Internal Medicine Conference.
- **Proactively working with the City of Thunder Bay's Community Economic Development Commission's Health Care Recruiter.**
  - Planning to jointly attend Quebec Medical Job Fair in February 2020.

Our Challenges – Anesthesia

(Department full complement = 13 FTE)

2019 Situation:

- 11.5 FTEs, Not sufficient to meet the basic needs of the surgical program
- Forecasting the need for 18-20 FTEs by 2023 to meet hospital plans
- Nationwide shortage of anesthetists and no real plans to address this crisis from the Royal College Physicians and Surgeons of Canada

Strategies Deployed:

- Focused recruitment efforts through all available channels including expanding scope to include international medical graduates
- Leveraging existing relationships with recruitment partners including HealthForceOntario, physician, and Medical School networks
- Approved for anesthesia assistants who can act as anesthesia extenders to make better use of existing human resources

2019/20 Results:

- Expected to recruit 3 new FTEs through use of above strategies
- Locum support approved via HealthForceOntario, growing locum pool
- Longer term have identified local candidates still in training to meet future forecasted need

Our Challenges – Internal Medicine

Respirology:

- Historically difficult to recruit for
- Nature of follow up work means locums are not a good solution
- Deploying technology to provide support for current respirologist

Rheumatology:

- Sub specialist in demand nationally
- Continue to market for right fit candidate
- Expanding search to include international medical gradates

Gastroenterology:

- Past recruitment success has led to expanded service
- Maternity leave and retirement aged physicians in 2020 adds pressure on existing group
- One signed letter of offer for 2020, two more promising leads

Our Success

Psychiatry:

- Three FTEs recruited
- Program stabilized

Dermatology:

- Signed Letter of Offer with an expected start date of summer 2020

Internal Medicine Clinic:

- Positive impact on workloads
- Plans to recruit 2 more FTEs in 2020

Activity:

- 22 Site Visits since May 2019
- Success ratio: signed letter of offers / site visits = 77%
  - Expected to increase to 86% in Jan 2020
- 9 Site Visits currently in planning for 2020

Forecasted Results:

- Expected to have 16 new physicians join in 2020/2021

Questions?

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Acute Mental Health in Northwestern Ontario
PREPARED BY	Dr. Peter Voros, Executive Vice President, In-Patient Care Programs
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☐ NO ☒ N/A ☐
APPROVED BY	N/A
CO-SPONSER (if required)	<Does this impact another E/VP's portfolio/program? Have they been consulted on this briefing note?>
PREPARED FOR:	President &CEO ☐ Board of Directors ☒ Other:
DATE PREPARED	January 22, 2020

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PURPOSE/ISSUE(S)

A presentation was requested as a Board Education topic. The presentation will assist the Board in understanding the current state of Acute Schedule 1 Mental Health services in NW Ontario.

BACKGROUND

NW Ontario has 2 Psychiatric Schedule 1 facilities, Thunder Bay Regional Health Sciences Centre (TBRHSC) and Lake of the Woods District Hospital (LWDH). In January of 2019, the only Psychiatrist in the west part of our region indicated his intent to retire in March 2019. This would leave the Schedule 1 beds at LWDH unable to operate and thus create a Psychiatric crisis for NW Ontario. TBRHSC took the lead in pulling together the region in an attempt to address the crisis and to address ongoing issues with Psychiatric care in the region. The Schedule 1 Design Event allowed for the creation of an immediate solution to the crisis and to the creation of a Regional Schedule 1 Steering Committee with 3 working groups to address 3 key gaps in Psychiatric Care: Psychiatry Resources, Regional Mental Health Emergency Assessments, and Acute Beds Alignment.

ANALYSIS/CURRENT STATUS

Currently, the Steering Committee's work continues and the 3 working groups are working to address the gaps and re-design the system moving forward.

Working Group 1: Psychiatry Resources - TBRHSC now has 5.8 FTE, with another FTE starting in the summer.

- LWDH continues to work with locum psychiatrists.

Working Group 2: Regional MHA – LHIN funded 6-week pilot.

Working Group 3: Bed Alignment – Boundaries removed. Data on flow is being collected.

RECOMMENDATION

N/A

NEXT STEPS

N/A

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

Acute Mental Health in Northwestern Ontario presentation attached.

Acute Mental Health in Northwestern Ontario

- An Opportunity for Integration -

Dr. Peter Voros, Executive VP, In-Patient Care Programs

February 5, 2020

Thunder Bay Regional Health Sciences Centre

healthy together

SCHEDULE 1 DESIGN EVENT

- **3 GAPS**
  1. Psychiatrist Resources
  2. Regional Mental Health Emergency Assessments
  3. Acute Bed Alignment
- **Created Regional Schedule 1 Steering Committee**

GAP 1

PSYCHIATRIST RESOURCES

- Thunder Bay Regional Health Sciences Centre (TBRHSC) and St. Joseph's Care Group (SJCG) staffed Lake of the Woods District Hospital (LWDH)

- TBRHSC & SJCG worked with LWDH & Health Force Ontario (HFO) to find locum coverage until January 2020

GAP 2

REGIONAL MENTAL HEALTH EMERGENCY ASSESSMENT

- Virtual MH Assessment &Telepsych Team
- 2 week Pilot
  - 95% seen by OTN (Ontario Telemedicine Network)
  - Initial contact Mean 21.8 Minutes
  - Telepsych Mean 2.6 hours
  - 67% diverted from Admission
- Future pilot with funding and Psychiatrist

GAP 3

ACUTE BED ALIGNMENT

- Removed artificial boundary
- Instituted best available bed
- Travel to Sioux Lookout to review space
- Reviewing bed data (#, type, location)
- Regional Emergency Safe Spaces

Fully Integrated Regional Schedule 1 Service

- Every Emergency has a safe space
- PIC and Acute beds in Sioux Lookout, Kenora and Thunder Bay
- Centralized, Virtual MH assessment
- Patient care in the best available bed
- Centralized Psychiatrist team

Thunder Bay Regional Health Sciences Centre

Board of Directors - *Open*

Wednesday, December 4, 2019

Boardroom – 5:00 p.m.

Action

***Present*:**

Matt Simeoni *(Chair)*	Jean Bartkowiak*	Anita Jean
Grant Walsh	Gordon Wickham (t-con)	Patricia Lang
Douglas Judson	Dr. S. Zaki Ahmed*	Dr. Valerie Grdisa*
Nathalie Coppola (t-con)	Micheal Hardy	Dr. Eric Davenport*
John Hatton	Gary Whitney	Dr. Sarita Verma (t-con)
John Friday	Joy Wakefield	

By Invitation – Senior Leadership:

Peter Myllymaa	Dr. Stewart Kennedy	Amanda Björn
David Murray		

By Invitation:

Angela Kutok, *Rec. Sec.*	Meaghan Sharp *(for Dr. Voros)*
John Ross	

Regrets Senior Leadership:

Dr. Chris Mushquash	Dr. Peter Voros	Glenn Craig

1.0 CALL TO ORDER – The Chair called the meeting to order at 5:00 p.m.

1.1 Chair's Remarks

Chair welcomed Board members, staff, and webcast audience to the meeting.

1.2 Quorum – Quorum was attained.

1.3 Conflict of Interest – None.

1.4 Approval of the Agenda

Motion

Moved by: ***Micheal Hardy***
Seconded by: ***Grant Walsh***

"That the Agenda be approved, as presented."

CARRIED

2.0 PATIENT STORY

Peter Myllymaa, Executive Vice President, Corporate Services and Operations shared a story about the collaboration between the Hospital's clinical and administrative teams in successfully managing a shortage of a vitally important product used by the programs and services in our Hospital.

3.0 PRESENTATIONS

John Ross was welcomed to the meeting.

3.1 Patient Flow Initiatives Update

Dr. Stewart Kennedy, Executive Vice President, Regional Programs, Clinical Supports, and Medical Affairs and John Ross, Director, Medicine, Patient Flow and Partnerships provided an update on patient flow initiatives and activities. Mr. Ross and Senior Leaders were commended for their collaborative approach to reducing length of stay while ensuring appropriateness of client care.

John Ross was excused from the meeting.

4.0 CONSENT AGENDA

Moved by:	***Gordan Wickham***	***Motion***
Seconded by:	***Patricia and Lang***	

"That the Board of Directors:

4.1 Approves the Board of Directors Open Minutes dated November 6, 2019;
4.2 Accepts the Patient Safety and Quality of Care Committee Minutes dated November 20, 2019;
4.3 Accepts the Broader Public Sector Travel and Expense Report for the period April 1, 2019 to September 30, 2019,

as presented."

CARRIED

5.0 REPORTS AND DISCUSSION

5.1 Report from the President & CEO

5.1.1 Current Challenges

The President and CEO report was pre-circulated for information. The following current challenges and activities were highlighted:

a. Minister Rickford Visit to TBRHSC:
The President and CEO has had several opportunities to engage with Minister Rickford and has extended an invitation to visit our Hospital to learn more about our organizational successes and challenges.

b. EVP Transformation and Integration Update:
Jessica Logozzo has been appointed as the Executive Vice President (EVP), Regional Transformation and Integration commencing January 13, 2020. This newly created position will enhance regional program development to support the small hospitals in Northwestern Ontario, as well as lead initiatives that will better integrate services across the Northwest.

5.2 2020 Q2 Strategic Plan Progress Report and Scorecard

The 2020 Q2 Strategic Plan Progress Report and Scorecard was pre-circulated. Over 95% of strategic initiatives are expected to be complete by the end of the year.

5.3 Report from the Chief of Staff

The Chief of Staff report was pre-circulated for information. A verbal update was deferred.

5.4 Report from the Chief Nursing Executive

Dr. Valerie Grdisa, Executive Vice President, Research, Quality, and Academics/Chief Nursing Executive, provided a report highlighting recent events and activities focusing on workforce pressures, addressing nursing workforce shortages, nursing leadership development, and the development of strategies to improve the quality of nursing care.

The Health Professions and Collaborative Practice update highlighted the improved standard operating practice for pharmacy technicians, standardization of social worker and kinesiology documentation, and the contributions of respiratory therapists in the implementation of a new smoking cessation model.

Moved by:	***Douglas Judson***	***Motion***
Seconded by:	***Gordan Wickham***	

"That the Board of Directors accepts reports dated December 4, 2019 from the:

5.1 President and CEO;
5.2 Chief of Staff written;
5.3 Chief Nursing Executive,

as submitted."

CARRIED

6.0 FIDUCIARY MATTERS

6.1 Patient Safety & Quality of Care Committee (PSQCC) Report

The Chair of the PSQCC, Patricia Lang, provided the following updates:

a. Regional Cancer Care Program:
Regional Cancer Program has conducted several Quality Improvement Projects including addressing mental health in cancer patients, prostate brachy therapy implementation, real-time order entry project, and nursing telephone practice implementation. A request was made for a presentation to the Board regarding Cancer Care Capital Needs (i.e. PET scanner) and contingency plans for aging equipment. ***Action***

b. International Models of Excellence in Nursing Care:
Various best practice models of nursing care were highlighted including the Magnet Recognition Program, which recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice.

c. *Auditor General Report*
The Office of the Auditor General of Ontario released the 2019 Annual Report which addresses specific programs and practices that impact public safety and the well-being of Ontarians.

7.0 FOR INFORMATION

7.1 Board and Committees Work Plans - For information.

7.2 Webcast Statistics - For information.

7.3 Report from the Health Research Institute - For information.

7.4 **Report from the Foundation** – For information.

7.5 **Report from the Northern Ontario School of Medicine** – For information.

7.6 **Environmental Compliance and Fire Safety Update** – For information.

8.0 **BOARD MEMBERS COMMENTS**

9.0 **DATE OF NEXT MEETING** – February 5, 2020

10.0 **ADJOURNMENT** - The meeting adjourned at 6:05 p.m.

_____ _____

Chair Board Secretary

_____

Recording Secretary

Action

Thunder Bay Regional Health Sciences Centre

DRAFT Patient Safety and Quality of Care Committee (PSQCC)
Wednesday, December 18, 2019
TBRHSC Executive Boardroom 3043 at 4:30 - 6:30 p.m.

Present:

Patricia Lang (Committee Chair)	Marga Bond	Filomena Gregorash
John Hatton	Anita Jean	Dr. S. Zaki Ahmed
Bonnie Nicholas	Kristin Shields	Joy Wakefield (via telecom)
Sandra Willson		

***Regrets*:**

Jean Bartkowiak	Lisa Beck	Michael Del Nin
Dr. Valerie Grdisa	Tyler Van Ramshorst	Shelly Sanderson
Micheal Hardy	Katherine Bell	John Ross
Matt Simeoni	Stephanie Erickson	
Gary Whitney		

***By Invitation*:**

1.0 CALL TO ORDER

The Chair, Patricia Lang, called the meeting to order at 4:30 p.m. and welcomed our newest member, Marga Bond replacing Dave Van Wagoner. The Chair confirmed that she brought forward a summary from the last PSQCC meeting to the Board of Directors including: Cancer Care Program and Centre funding challenges and equipment needs; international models of nursing and plans to move forward with the next exploratory phase into the Magnet Hospital Model.

1.1 Quorum – Attained, 9 members present, 5 regrets.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda

The agenda was approved as presented.

Moved by: ***Anita Jean***
Seconded by: ***Filomena Gregorash***

"That the Patient Safety and Quality of Care Committee approved the agenda as presented." ***Motion***

CARRIED

2.0 CONSENT AGENDA

2.1 Patient Safety and Quality of Care Committee Minutes of November 20, 2019

* Denotes Non-Voting Member

healthy together En santé ensemble

The committee received a revised version of the minutes at the meeting and the Chair requested that the committee review the changes noted at 4.1.

Moved by: *Bonnie Nicholas*
Seconded by: *Anita Jean*

"That the Committee approved the Patient Safety and Quality of Care Committee Minutes of November 20, 2019 as presented at the meeting." *Motion*

CARRIED

2.2 Healthcare Professionals Qualifications
Annual Medical Affairs Credentialing Report

Michelle Addison, Director of Health Professions & Collaborative Practice and Michelle Langlois, Director of Medical Affairs provided briefing notes outlining the credentialing process for Professional Staff, policies and processes that ensure healthcare professionals are properly qualified to practice at the Hospital.

The summary reports were accepted by the committee but noted that some policies were past their date of next review.

In the recent Auditor General's Report, one of the recommendations was to review registration for nurses applying from the United States. An update on internal processes will be provided to PSQCC in follow up.

CARRIED

3.0 SPOTLIGHT ON PROGRAM LEVEL

3.1 Emergency Services Presentation and Patient Story

The Committee welcomed Lisa Beck, Director, Trauma, Critical Care, Emergency Services and Nurse-Led Outreach Team, together with Tyler Van Ramshorst, Manager, Emergency and Trauma Services and Shelly Sanderson, Emergency Department Operations Coordinator at 4:35 p.m.

A patient story was shared regarding a 38 year old woman with no secured housing or family doctor who attended the Emergency Room for care in 2018 over 100 times for various reasons. Many of this individual's visits were to receive IV antibiotics. This situation is not unique; approximately 4000 visits to the Emergency Room per year are for IV infusions and antibiotics. One way to address this need is to partner with Shelter House and this work has been initiated.

Lisa, Tyler and Shelly provided a program overview on the Emergency Department (ED) and Nurse-Led Outreach Team. Highlights included volumes of patients served, outreach locations

where care is provided and provincial comparisons for wait times. The team is working on Patient Oriented Discharge Summaries, including the associated processes. Successes were shared, including a mobile crisis team in community working collaboratively with police to support individuals with mental health challenges—in one year this program diverted 2000 visits from the ED. Areas for improvement include the ED's physical space and layout to provide a dedicated area for mental health assessments. A Pre-Capital Submission for such improvement was submitted to the Ministry in the fall and awaiting response. Senior Leadership has approved minor Emergency Department renovations in the meantime to enhance patient privacy. Several strategies are underway to improve the patient experience and patient flow by diverting patients from the ED to the right level of care. Two examples include working with Anishnawbe Mushkiki to educate the public and staff about access to evening clinics and Dr. Bradley Jacobson, Chief of Emergency, was involved in a public campaign to educate the public about influenza and options other than accessing ED where not necessary.

The presentation was accepted by the committee and the Chair will share their presentation and needs with the whole Board at the next meeting.

Lisa, Tyler and Shelly left the meeting at 5:19 p.m.

4.0 QUALITY AND RISK MANAGEMENT

4.1 Infection Prevention and Control Update Briefing Note

The Committee welcomed Katherine Bell, Manager of Infection Control, Stephanie Erickson, Infection Control Practitioner, and John Ross, Director of Medicine, Patient Flow and Partnerships to the meeting at 5:20 p.m. Dr. Gamble sent his regrets.

Katherine provided an update on progress made in the Infection Prevention and Control Program since receiving recommendations from Public Health Ontario's (PHO) Infection Control Resource Team (ICRT) on reducing Vancomycin Resistant Enterococci (VRE). Other infectious diseases will be discussed at a future meeting.

Between December 2017 and March 2018, the Hospital was struggling to control the spread of VRE. Seven VRE outbreaks were declared on inpatient units (1A, 2A, 2B, 2C, 3A, 3B, 3C, and the Intensive Care Unit). In March 2018, the Hospital invited PHO's ICRT to review our infection control practices/processes and make recommendations.

The ICRT issued 36 recommendations related to various aspects of our infection control program; of the 36 recommendations, 6 were already in place. Since receiving these recommendations, individuals and departments across the Hospital areas have been hard at work implementing the many actions required to accomplish these recommendations.

Katherine, Stephanie and John left the meeting at 5:32 p.m.

4.2 2019-20 Q2 Quality Improvement Plan (QIP) Initiatives

4.3 2019-20 Q2 Results for Strategic & Operational Indicators (including QIP)

The committee welcomed Michael Del Nin, Director of Strategy and Performance to the meeting at 5:34 p.m.

Michael provided the Committee with an update on indicators included in the Quality Improvement Plan (QIP) and Hospital's broader balanced scorecard. In addition, the current status of the QIP work plan and remedial actions being undertaken to improve performance in certain areas were discussed.

The Committee requested that the actual target be implemented on the graph and to be reviewed at the next update.

Michael left the meeting at 5:56 p.m.

5.0 COMMITTEE BUSINESS

5.1 Identify Education Needs

The Quality and Risk Management team will be reporting on processes in January, including process for submissions of patient safety incidents and near misses, adverse reactions to medication and issues with devices, patient concerns and processes for Quality of Care reviews.

Recently Lifelabs' security system was breached and held for ransom. The Committee inquired how TBRHSC was reviewing this risk, and what systems were in place to prevent a similar attack. A presentation will be provided at the May PSQCC meeting. Dr. Ahmed shared that the Resource Planning Committee met and changes were underway to reduce the risks of breach of information.

5.2 Summary of Evaluations – Nov. 20, 2019
Committee Meeting Evaluations – *members to complete online*

The Committee accepted the summary as presented.

6.0 BOARD MATTERS

6.1 Chair's Report to the Board

The Chair will share the following points with the Board

- Emergency Department Services and support for proposal to support those with mental health by having a dedicated and separate area
- Infection Control Update

Action

6.2 **<u>Recommendations to the Board</u>** – *see above Chair's Report to the Board*

7.0 BOARD MEMBERS COMMENTS

8.0 DATE OF NEXT MEETING: Wednesday, January 15, 2020 at 4:30 p.m., TBRHSC Room 3043

Presentations from Medicine and Cardiology will be held at the January 15th, 2020 meeting and Prevention and Screening will be presented on February 19th, 2020 along with Surgical Services.

9.0 ADJOURNMENT - meeting adjourned at 6:00 p.m.

Thunder Bay Regional Health Sciences Centre

DRAFT Patient Safety and Quality of Care Committee (PSQCC)
Wednesday, January 15, 2020
TBRHSC Executive Boardroom 3043 at 4:30 - 6:30 p.m.

Present:

Patricia Lang (Committee Chair)	Jean Bartkowiak	Marga Bond
Filomena Gregorash	Dr. Valerie Grdisa	John Hatton
Anita Jean	Dr. S. Zaki Ahmed	Bonnie Nicholas
Kristin Shields	Joy Wakefield (via telecom)	Gary Whitney
Sandra Willson		

Regrets:	***By Invitation***:	
Matt Simeoni	Meaghan Sharp	Tracie Smith
Micheal Hardy	Laurel Knowles	

1.0 CALL TO ORDER

The Chair, Patricia Lang, called the meeting to order at 4:30 p.m. The Chair and Committee extended thanks to the Human Resources team and Tracie Smith for putting on a wonderful event - Walk the Talk, Service Awards and congratulations to all recipients.

1.1 Quorum – Attained, 14 members present, 1 regret.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda

The agenda was approved with the addition of a discussion regarding the Magnet Presentation.

Moved by: ***Anita Jean***
Seconded by: ***Sandra Willson***

Motion

"That the Patient Safety and Quality of Care Committee approved the agenda with the additional discussion related to the Magnet Presentation."

CARRIED

2.0 CONSENT AGENDA

2.1 Patient Safety and Quality of Care Committee Minutes of December 18, 2019

Moved by: John Hatton
Seconded by: Dr. Zaki Ahmed

"That the Committee approved the Patient Safety and Quality of Care Committee Minutes of

Motion

December 18, 2019 as presented at the meeting."

CARRIED

Business Arising from the Minutes:

- Professional practice and credentialing: for nursing and allied health professionals registration and standing with Professional Colleges are reviewed every year.

- Process for hiring international nurses: The College of Nurses Ontario collects and reviews all information for national and international registration and standing.

- Process for hiring international physicians: NBME – National Board of Medical Education that collects all information and then reports to the College of Physicians and Surgeons of Ontario (CPSO), the CPSO will then review any gaps between years of practice.

- Magnet Presentation update: Valerie G. has arranged to meet with the Director of the Magnet program at Mount Sinai Hospital on January 28th.

3.0 SPOTLIGHT ON PROGRAM LEVEL

3.1 Cardiovascular, Stroke & Medicine Program and Patient Story

Meaghan Sharp, Director of Cardiovascular and Stroke Program presented the following patient story and presentation:

Patient Story

A female patient in her early 70's, very fit but had a stroke and history of breast cancer. After her stroke it caused mobility issues, large vessel exclusion and was not a candidate for endovascular therapy. (TBRHSC is one in 10 hospitals in Ontario and one in 24 in Canada that performs endovascular therapy for stroke patients.) She was admitted to the Hospital and since her family support was available in Sudbury, support was provided to transfer her there for follow up care. It was advocated to move the patient to Sudbury for family support and social treatment, as she was a resident of Manitouwadge. After overcoming many barriers, this transition was permitted. The family was very pleased with the care provided at TBRHSC and the advocacy to allow patients to transition inter-province from Acute Care to Post Acute Rehabilitative Care continues at provincial meetings.

Meaghan shared a brief overview of what her portfolio, including:

- Three in-patient medicine units, 2A, 2B and 2C
- Cardiac Cath Lab
- Healthy Lifestyle program, Cardiac rehabilitation

- Internal Medicine Clinics, Tele-Home Care that supports patients with congestive heart failure (CHF) and congested obstructive pulmonary disease (COPD).
- Tele-medicine – networking for patients outside of Thunder Bay
- Elder Life Program – supports seniors
- Transitional Care Unit – Hogarth Riverview Manor site
- 3TM – over-capacity recovery unit on 3rd Floor
- Regional Stroke Network – supporting regional best practices for stroke

Meaghan described quality improvement initiatives within her portfolio, including local data and provincial and/or best practice standards.

Cardiac and Stroke Care

Substantial focus on quality improvement for Code Stroke and Code STEMI (heart attack) has resulted in impressive changes affecting patient care and outcomes. Meaghan provided an overview of the internal processes for Codes Stroke and STEMI including collaborations with Emergency Medical Services (EMS). Successes from this work have included:

- In 2017-18 TBRHSC was ranked 14 out of 17 hospitals in Ontario by Core Health; in 2018-19, TBRHSC ranked 3 out of the 17.
- The median time for a patient to receive the medication tPA from the time they arrived at Hospital for stroke has changed from 70 minutes in 2014/15 to 36 minutes in Q2 2019/20. The goal is 30 minutes.

Areas for focus in the future will include:

- Awareness and education internally and externally. 2019 was the first year to celebrate Heart Month.
- Focus on female patients suffering from a heart attack. Through research at TBRHSC it is known that females can have a 10 minute longer wait prior to receiving treatment.
- Recruitment and retention of cardiologists, allowing for 24/7 coverage for interventions.

Senior Health Care

Great work is being done with the Elder Life Program, improving the quality and experience for seniors. The team is leading some positive ways to implement best practices along with partnering with Mount Sinai Hospital. A nurse practitioner has been temporarily funded, making a difference in the monthly admission and re-admission rates and CHF/COPD with ED visits.

A Clinical Nurse Specialist and an Elder Life Coach (temporarily funded to helping seniors get from acute care into the community) support this work. Focused education has also

taken place to support receiving the correct diagnosis of delirium, depression, or dementia, which present with similar symptoms.

Transitional Planning Risk Assessment Screen was adopted in partnership with Mount Sinai Hospital and is based on a four question scale that is asked within 24 hours of admission. The resulting score indicates the level of risk associated with discharge. Through this focused work, the length of stay for the 37 patients included resulted in an average length of stay of 6.9 days vs. the previous average of 12-13 days.

Rehabilitation staff (including kinesiologists) and focus is expected to continue to result in improved health outcomes, including decreased number of falls, injuries from falls and increased mobility and shorter lengths of stay.

Medicine

COPD and CHF re-admission rates, have been a major focus for the medicine team. A patient navigator (Nurse Practitioner), has been implemented to support patients with COPD and CHF through their journey, and to ensure they are connected to community resources. There has been significant decreases in admission and re-admission rates. The team are now focusing on improving in-patient length of stay.

4.0 QUALITY AND RISK MANAGEMENT & EDUCATION

4.1 Processes within Quality and Risk Management

The Chair welcomed Kristin Shields, Director, Quality and Risk Management and Laurel Knowles, Patient Safety Improvement Specialist, to the meeting to provide an overview of:

- Concerns and Compliments
- Safety Reporting
- Quality of Care Reviews

Quality and Risk Management (QRM) is currently made up of a team of one Director, one Secretary, one Patient Safety Improvement Specialist and have partnered with Patient Family Centre Care (PFCC) for one modified support person.

Compliments and Concerns

Compliments and concerns can be received in one or more ways as follows:

- By telephone
- By mail
- By online submission
- Hand delivered or walk in to our QRM office.
- By email from staff

- Five comment boxes located in various areas in the hospital and Medical Centre

All compliments/concerns are logged into our system and monitored daily. They are reviewed for the level of risk and urgency which will be shared with the Director and/or Manager of the area.

When QRM receives a concern, the process is to acknowledge by phone/correspondence in the form of a letter or email within 7 days. The managers are then tagged on the concern for review and direct response within a 45 period. QRM monitors the concerns and send reminders and requests for follow up.

If a compliment is received, it is logged into the console and the department/staff will send an acknowledgement in the form of a letter of thanks from the CEO with a brief summary of shared compliment.

A report of the total number of compliments (98) and concerns (403), including a summary by category for Q1-Q3 2019/20 was shared with the committee.

Safety Reporting Incident Learning Reports

All staff and physicians have access to a safety incident reporting icon on any computer in the Hospital. Through this icon, staff and physicians are able to enter information related to any incident (including medication error) or near miss. The Patient Safety Improvement Specialist processes all submissions, tagging appropriate individuals for follow up who then indicate the severity of incident (no harm event, mild, moderate, severe, and death) and ensures that follow up has taken place and has been recorded into the system.

In Q1-Q2 2019/20 there were five events resulting in severe harm and three in death. Six process reviews were completed and 1 critical incident review.

Overview of Quality of Care Review process

A critical incident is an unintended event that results in death or serious harm that was not an expected outcome or known risk of condition or procedure. In Quality of Care Reviews for critical incidents or process reviews for non-critical incidents, a multidisciplinary meeting is held, root causes are reviewed and system-level recommendations and resulting improvement(s) are made for patient safety.

The Q1-Q2 Quality of Care Reviews did not have similarities in situation, however the majority of the recommendations included additional standardizing, upgrades and expansion of the electronic medical record and training and education.

5.0 COMMITTEE BUSINESS

5.1 Reputational Risk Matrix

Tracie Smith, Senior Director of Communications and Engagement, presented the Reputational Risk Matrix to the Committee. The internally developed reputational risk matrix was developed for the QRM department to have a standardized scale to identify when the level of risk for a situation requires flagging for the Communications Department. The steps outlined in same document identify the process for bringing forward information to the CEO and Board of Directors.

The Committee agreed to share a briefing note and reputational matrix with the Board of Directors for information.

5.2 Identify Education Needs Briefing Note

- AODA Standards – request a copy of the report being shared with the Resource Planning Committee be shared with PSQCC for review.
- High level summary of most common categories for concerns expressed by patients and families.
- Safety of personal health information.

5.3 Review Summary of Committee Evaluations – December 18, 2019

The Committee reviewed the summary of evaluations and accepted as presented.

5.4 Complete Meeting Evaluations – *members to complete online*

The Committee accepted the summary as presented.

6.0 BOARD MATTERS

6.1 Chair's Report to the Board

- Reputational Risk Matrix
- Critical incident briefing note
- Cardiovascular, Stroke and Medicine Program overview

6.2 Recommendations to the Board – *see above Chair's Report to the Board*

7.0 BOARD MEMBERS COMMENTS

8.0 DATE OF NEXT MEETING: Wed., February 19, 2020 at 4:30 p.m., TBRHSC Room 3043

9.0 ADJOURNMENT - meeting adjourned at 6:30 p.m.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	2019-20 Q2 Results for Strategic & Operational Indicators (including QIP)
PREPARED BY	Michael Del Nin, Director, Strategy & Performance
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☐ NO ☐ N/A ☒
APPROVED BY	Dr. V. Grdisa, EVP, Research, Quality & Academics; CNE
CO-SPONSER (if required)	Not applicable
PREPARED FOR:	President &CEO ☐ Board of Directors ☐ Other: Patient Safety and Quality of Care Committee of the Board
DATE PREPARED	Dec 9, 2019

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The reader considers the following questions to ensure each decision are ethically responsible by indicating with a √:

☐ 1. We put '**Patients First'** by responding respectfully to needs, values, & expectations of our patients, families, and communities?
☐ 2. We demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally responsible?
☐ 3. We demonstrate '**Respect**' by honouring the uniqueness of each individual and his or her culture?
☐ 4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE/ISSUE(S)

This purpose of this briefing note is to report on results for 2019-20 Q1 indicators and to provide observations, reasons and remedial actions being undertaken to improve performance.

BACKGROUND

The balanced scorecards (BSCs) and related indicators are prepared, updated and published monthly by Decision Support. BSC results are reviewed monthly at various councils, as well as Senior Leadership Council (SLC) and overall Hospital leadership. For 2019-20 Q2 results, these reviews occurred in Nov 2019.

Following review by SLC and Hospital leadership, results are reported to the Board and various committees on a quarterly basis. To avoid duplication of reporting to the Board and its committees, indicators are now separated and presented in 3 distinct views:

1. Board Strategic (indicators used to assess progress regarding TBRHSC's strategy)
2. Patient Safety & Quality of Care Committee (indicators that emphasize quality, safety and customer experience, and include QIP indicators)
3. Resource Planning Committee indicators (indicators that measure use of resources, as well as the experience for staff and like)

ANALYSIS/CURRENT STATUS

Hand hygiene compliance – before & after contact:

Observations: 18-19 Q3 to 19-20 Q2 results declined and now below target.

Reason: Public Health Ontario reviewed TBRHSC's infection control practices earlier in 2018 and provided a comprehensive report including a number of recommendations for improvement. The recommendations were broadly communicated, supported and resourced, and led to increased awareness of the importance of hand hygiene. In late 18-19, Infection Control changed its hand hygiene monitoring processes to include a higher percentage of testing by non-unit staff. This resulted in the reduction in reported compliance.

Action: An outbreak team has been established to work on a variety of infection-related initiatives, including hand hygiene. It is expected these initiatives will improve hand hygiene compliance in the near future.

Medication reconciliation on admission (QIP):

Observations: 18-19 Q2 to 19-20 Q2 results declined and now considerably below target.

Reason: Sustaining performance with current nurse-lead model has proven very difficult. A new pharmacy tech led model was approved and implemented in late 18-19 but recruiting the required pharmacy techs has not yet been possible due to ongoing industry-wide shortages.

Action: The pharmacy tech shortages are expected to continue for an extended period. Alternative models are being investigated but improvements are not likely until late 19-20 at the earliest.

Surgical safety checklist compliance:

Observations: 19-20 Q2 results consistent with prior quarters.

Reason: Well established checklist and ongoing compliance monitoring in place.

Action: No action required other than ongoing monitoring.

30-day in-hospital deaths following major surgery (risk-adjusted):

Observations: 19-20 Q2 results consistent with 19-20 Q1 but remain worse than target.

Reason: A small number of surgeries were completed on patients who were palliative to assist in managing their symptoms, or victims of serious head trauma and/or in fragile health but decided to proceed with surgery despite the risks.

Action: Surgical & Ambulatory Care leadership and Chief of Surgery review individual case-level results on an ongoing basis.

Number of critical events:

Observations: 19-20 Q2 result consistent with past quarters and worse than target.

Reason: Single incident on zero target.

Action: Ongoing monitoring and review as per current practice.

Fall rate per 1,000 patient days:

Observations: 19-20 Q2 results consistent with past quarters and worse than target.

Reason: Much of growth is occurring in transitional care units, although fall rates have also increased in some medical and surgical units.

Action: Preliminary root cause analysis has been completed. Additional training on best practices has been completed and more is planned.

Length of stay (excluding alternate level of care days):

Observations: 19-20 Q2 results improved somewhat from prior quarters but worse than target.

Reason: Length of stay results plateaued in late 17-18, then regressed considerably and have remained at higher than targeted levels. Ongoing initiatives outlined in the Hospital's Quality Improvement Plan, as well as several identified during internal quarterly reviews were expected to lead to further improvements but have not yet been fully implemented. There are also concerns that expected length of stay may be understated due to coding inaccuracies.

Action: With its 2020 Strategic Plan nearing completion, the Hospital is planning the development of a transitional strategic plan that will focus entirely on patient flow. At a recent retreat, Senior Leadership reviewed comprehensive data on opportunities for improvement and discussed these at some length. The Advisory Board (an organization with 350 health care professionals and 4,400+ member health care organizations) provided a workshop for Hospital leadership and system partners on research-informed approaches for improving patient flow. The information presented and collected during these sessions will both inform and be leveraged to develop the Hospital's transitional strategic plan. While the plan is being developed, current improvement efforts will continue. As well, a recently completed coding audit identified a number of opportunities to improve the quality of coded data, which once implemented should increase the Hospital's expected length of stay somewhat.

30-day readmission rate for patients with CHF (non-risk adjusted) (QIP):

Observations: 19-20 Q2 results consistent with 19-20 Q1 and worse than than target.

Reason: The Hospital has been working with a consultant on improving effectiveness of ambulatory supports for CHF and COPD patients. Work is ongoing but preliminary results are encouraging.

Action: Work with the aforementioned consultant will continue.

30-day readmission rate for patients with COPD (non-risk adjusted):

Observations: 19-20 Q2 results have improved somewhat and are better than target.

Reason: The Hospital has been working with a consultant on improving effectiveness of ambulatory supports for CHF and COPD patients. Work is ongoing but preliminary results are encouraging.

Action: Work with the aforementioned consultant will continue.

90th Percentile ER length of stay for admitted patients (QIP):

Observations: 19-20 Q2 results improved considerably from 18-19 average but remain worse than target.

Reasons: Results are heavily dependent on overall occupancy, which improved somewhat in 19-20 Q2. A significant number of admitted patients who require isolation and/or telemetry experience long waits due to insufficient isolation and telemetry capacity in inpatient units.

Actions: Occupancy pressures have improved somewhat but are expected to continue. Ontario has committed to building more long-term care capacity, but this increased capacity will take some time to emerge. In the meantime, in 17-18 Q4, the Hospital worked with the NWHLIN, the SJCG and MOHLTC to temporarily transfer 32 ALC patients into Hogarth Riverview Manor, and an additional 32 ALC patients were transferred in 2018-19. Although ALC rates haven't dropped (the ALC patients transferred are still counted in the Hospital's results), the transfer has provided considerable relief of occupancy pressures at the Hospital's main site.

As noted earlier, the Hospital's upcoming transitional strategic plan is expected to assist with improving patient flow and reduce occupancy, both of which should enable shorter waits for ER admitted patients.

Percentage of acute inpatient cases completed within the Northwest Health Integration Network:

Observations: 19-20 Q2 results improved somewhat from 18-19 average and are now better than target.

Reason: A higher proportion of vascular surgery cases are being completed at the Hospital, so fewer patients are travelling to southern Ontario and Manitoba for required care. This trend will further increase once cardiac surgery is available at the Hospital.

Action: Continue monitoring and reviewing results.

Repeat unscheduled emergency visits within 30 days as percentage of total mental health visits:

Observations: 19-20 Q1 results have improved somewhat from 18-19 average but remain worse than target.

Reason: A significant number of mental health patients repeatedly visit the ED for care. This is an Ontario-wide problem and the Hospital's results are slightly better than the Ontario average.

Action: Establishment of a psychiatric stabilization and assessment unit, and ensuring sufficient psychiatry staffing are key actions to address this issue, and work continues on these.

Patient satisfaction: All dimensions - Inpatients:

Observations: 18-19 Q2 to 19-20 Q2 results improving steadily and considerably better than target.

Reason: Definitive causes of improvement are uncertain, but it is likely that ongoing comprehensive improvement efforts, combined with patient rounding and increased emphasis on communication related to discharge are all contributing to improvements.

Action: Continuation of current initiatives and efforts.

Patient satisfaction: All dimensions - ED:

Observations: 18-19 Q2 to 18-19 Q4 results improved steadily, while 19-20 Q1 – 19-20 Q2 results declined slightly and are just below target.

Reason: Definitive causes of recent regression are uncertain, but results declined considerably for a few specific questions. Additional analysis with ED leadership is underway.

Action: Complete analysis with ED leadership, adjust tactics if required, and continue current improvement initiatives and efforts.

Patient satisfaction: Leaving hospital, did you receive enough information - Inpatients & Maternal Newborn (QIP):

Observations: 18-19 Q2 to 19-20 Q1 results improving steadily. 19-20 Q2 results regressed slightly and are worse than target, but 19-20 year-to-date results remain better than target and considerably better than 18-19 results.

Reason: Definitive causes of improvement are uncertain, but it is likely that ongoing comprehensive improvement efforts, combined with patient rounding and increased emphasis on communication related to discharge are all contributing to improvements.

Action: Continuation of current initiatives and efforts.

RECOMMENDATION

What is the recommended course of action?

As outlined above. No additional actions required.

NEXT STEPS

What are the anticipated outcomes? What needs to occur next on this issue?

Continuation of results reviews and implementation of aforementioned actions.

STAKEHOLDER REACTION

Would there be any anticipated reaction from stakeholders? Is an issues management plan required?

None anticipated.

COMMUNICATIONS

What kind of targeted communication(s) is necessary?

Results have been shared with and reviewed by Hospital leadership.

FINANCIAL IMPACTS

Is it resource neutral or is there a cost involved?

Not applicable

APPENDIX SECTION

If there is related material, please provide here.

2019-20 Q2 Balanced Scorecard - Strategic & Operational Indicators (including QIP) – For Patient Safety & Quality of Care Committee

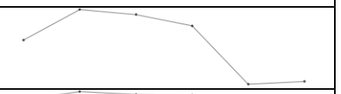
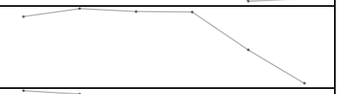
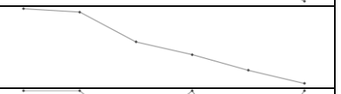
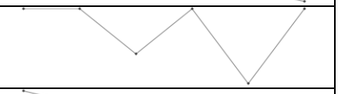
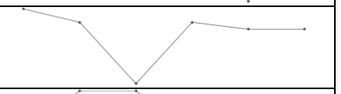
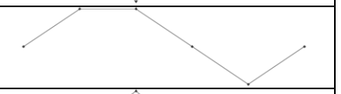
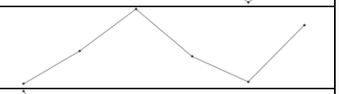
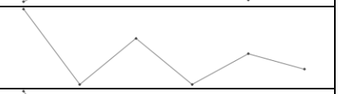
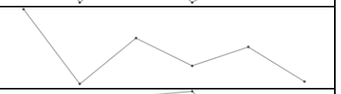
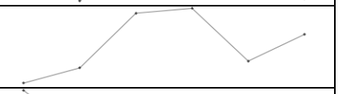
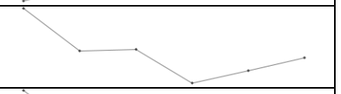
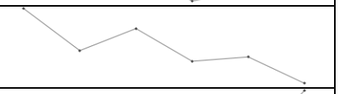
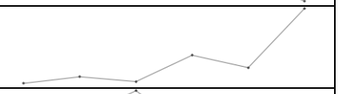
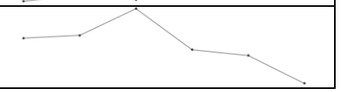
Thunder Bay Regional Health Sciences Centre

Balance Scorecard

Operational & Strategic Indicators

19-20 Q2 Report for Patient Safety & Quality of Care Committee

Updated 2019-11-28

			2018-19 Fiscal							2019-20 Fiscal						
Domain	**Indicators**	**Ind Type**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Actual**	**18-19 Target**	**18-19 Actual**	**18-19 Variance**	**Q1 Actual**	**Q2 Actual**	**19-20 Target**	**YTD Target**	**19-20 Actual**	**18-19 Variance**	**Trending (last 6 or available quarters)**
Safe	Rate of hand hygiene compliance before initial patient/environment contact	Strat	95.62%	93.66%	89.37%	67.10%	93.00%	86.44%	(6.56%)	68.12%	72.61%	93.00%	93.00%	70.36%	(22.64%)	
Safe	Rate of hand hygiene compliance after patient/environment contact	Oper	98.14%	97.02%	96.88%	82.94%	97.00%	93.74%	(3.26%)	70.66%	78.05%	97.00%	97.00%	74.36%	(22.64%)	
Safe	Medication reconciliation compliance on admission [QIP]	Oper	50.91%	50.35%	45.65%	43.64%	62.00%	47.64%	(14.36%)	41.16%	39.10%	65.00%	65.00%	40.13%	(24.87%)	
Safe	Rate of compliance for use of surgical safety checklist	Oper	100.00%	100.00%	99.97%	100.00%	100.00%	99.99%	(0.01%)	99.94%	100.00%	100.00%	100.00%	99.97%	(0.03%)	
Safe	30-day in-hospital deaths following major surgery (risk-adjusted) [QIP]	Strat	2.20	2.00	1.10	2.00	1.67	1.70	(0.03)	1.90	1.90	1.60	1.60	1.90	(0.30)	
Safe	Number of critical events	Strat	1	2	2	1	0	6	(6)	0	1	0	0	1	(1)	
Safe	Fall rate per 1,000 patient days [QIP]	Oper	6.62	7.01	7.51	6.94	5.30	7.06	1.76	6.64	7.32	5.30	5.30	6.98	(1.68)	
Safe	Pressure ulcer incidence	Strat		3.00%		2.00%	6.00%	2.50%	3.50%		1.0%	6.00%	6.00%	1.00%	5.00%	
Timely	Length of stay (excluding alternate level of care days) [QIP]	Oper	5.65	5.34	5.53	5.41	5.10	5.48	(0.38)	5.49	5.35	4.90	4.90	5.42	(0.52)	
Effective	30-day readmission rate for patients with CHF (non-risk adjusted)	Oper	19.3%	26.5%	27.2%	20.2%	20.6%	24.1%	(3.5%)	23.7%	***23.0%***	21.8%	21.8%	23.4%	(1.6%)	
Effective	30-day readmission rate for patients with COPD (non-risk adjusted)	Oper	19.3%	19.6%	13.4%	15.7%	24.3%	17.8%	6.5%	18.0%	***11.1%***	21.5%	21.5%	14.6%	6.9%	
Timely	90th Percentile ER length of stay (hours) for admitted patients [QIP]	Strat	50.0	40.1	45.2	37.6	31.0	43.2	(12.2)	38.6	32.4	28.8	28.8	35.5	(6.7)	
Equitable	Percentage of acute inpatient cases completed with Northwest Health Integration Network	Oper	84.92%	85.16%	84.98%	85.97%	87.00%	85.25%	(1.7%)	85.50%	87.72%	87.00%	87.00%	86.61%	0.4%	
Effective	Repeat unscheduled emergency visits within 30 days as percentage of total mental health visits	Oper	21.0%	22.3%	20.3%	20.1%	16.3%	20.9%	(4.6%)	18.7%		16.3%	16.3%	18.7%	(2.4%)	

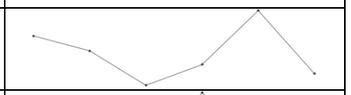
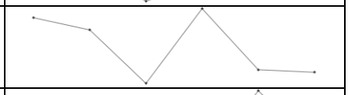
Thunder Bay Regional Health Sciences Centre

Balance Scorecard

Operational & Strategic Indicators

19-20 Q2 Report for Patient Safety & Quality of Care Committee

Updated 2019-11-28

			2018-19 Fiscal							2019-20 Fiscal						
Domain	**Indicators**	**Ind Type**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Actual**	**18-19 Target**	**18-19 Actual**	**18-19 Variance**	**Q1 Actual**	**Q2 Actual**	**19-20 Target**	**YTD Target**	**19-20 Actual**	**18-19 Variance**	**Trending (last 6 or available quarters)**
Patient/Family Centred	Patient satisfaction: All dimensions - Inpatients	Strat	70.83%	70.46%	69.59%	70.11%	60.30%	69.26%	9.0%	71.48%	69.88%	69.76%	69.76%	70.68%	0.9%	
Patient/Family Centred	Patient satisfaction: All dimensions - ED	Oper	74.01%	73.13%	69.23%	74.68%	61.80%	72.79%	11.0%	70.22%	70.04%	73.29%	73.29%	70.13%	(3.2%)	
Patient/Family Centred	Patient satisfaction: Leaving hospital, did you receive enough information - Inpatients & Maternal Newborn [QIP]	Oper	70.00%	68.50%	65.99%	65.76%	54.58%	67.57%	13.0%	71.72%	67.44%	68.07%	68.07%	69.58%	1.5%	

	At or better than target
	Slightly (less than 5%) worse than target
	Significantly (5% or more) worse than target
	Data not expected for reporting period or too few results to be meaningful
	Indicator has been discontinued and replaced
Blue text	Incomplete period or result not yet finalized

Thunder Bay Regional Health Sciences Centre

Governance and Nominating Committee

Friday, December 6, 2019
Boardroom – 7:30 a.m.

***Present*:**

Gordan Wickham, *Chair*	Grant Walsh	Matt Simeoni
Pat Lang	Jean Bartkowiak*	

Regrets:

Joy Wakefield	Micheal Hardy

By Invitation:
Angela Kutok, *Rec. Sec.*

1.0 CALL TO ORDER

The meeting was called to order at 7:35 a.m.

1.1 Quorum – Quorum was achieved.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda

The agenda was approved with the addition of 5.6 Fort William First Nations request for a dedicated Board position.

Motion

Moved by: ***Grant Walsh***
Seconded by: ***Pat Lang***

"That the Agenda be accepted, as amended."

CARRIED

2.0 PRESENTATIONS/EDUCATION – None.

3.0 CONSENT AGENDA

Motion

Moved by: ***Matt Simeoni***
Seconded by: ***Grant Walsh***

"That the Governance and Nominating Committee approves the Governance and

Nominating Committee minutes dated September 18, 2019, as presented."

CARRIED

4.0 WORK PLAN

4.1 Review Board Policies - TBRHSC

The Governance and Nominating Committee (GNC) is responsible to draft policies regarding the effective and efficient functioning of the Board as well as review and recommend changes to policies for Board approval. All Board policies are to be reviewed once every three years or as directed by the Board. The following policies were reviewed and edited as follows:

BD-05 CEO Performance Evaluation and Compensation:
Once the Hospital and Research Institute governance structure is implemented, there will be an opportunity to combine the CEO evaluations of both organizations into one.
In the meantime, the policy was revised to reflect the process changes that were trialed during the last evaluation cycle. Additional revisions include;

- Section 4.2, change to "all Board members are encouraged to participate;
- Section 4.4, add that goals and objectives must be consistent with STEEEP;
- Section 4.5, add the word "Ongoing" to the beginning of the first sentence;
- Section 5.1, add that the objectives must be consistent with STEEEP and PFCC;

BD-07 Chief of Staff Performance Evaluation:

- Section 4.1, add that goals and objectives must be consistent with STEEEP, no further changes to policy intent.

BD-11 Meeting Attendance:

- minor edits, more concise language.

BD-20 Review and Revision of Board Documents:

- minor edits.

BD-25 Education and Development:

- minor edits.

BD-36 Attendance at Open Board Meetings:

- minor edits.

BD-39 Board Committee Terms of Reference

- minor edits.

BD-44 CEO Succession Planning:

- minor edits, more concise language.

Moved by:	*Matt Simeoni*	*Motion*
Seconded:	*Grant Walsh*	

"That the Governance and Nominating Committee recommends that the TBRHSC Board of Directors approves the following policies,

- ***BD-05 CEO Performance Evaluation and Compensation;***
- ***BD-07 Chief of Staff Performance Evaluation;***
- ***BD-11 Meeting Attendance;***
- ***BD-20 Review and Revision of Board Documents;***
- ***BD-25 Education and Development;***
- ***BD-36 Attendance at Open Board Meetings;***
- ***BD-39 Board Committee Terms of Reference;***
- ***BD-44 CEO Succession Planning,***

as amended."

CARRIED

4.2 Review Board Polices - TBRHRI

The Thunder Bay Regional Health Research Institute policy review is deferred pending the appointment of a Research Institute member on the Committee. The President and CEO will follow up with the Research Institute Board. ***Action***

4.3 Committee Evaluations

Currently, all Board committee meeting evaluations are reviewed by the Governance and Nominating Committee twice per Board cycle. The Committee agreed to a process change, on a trial basis, as follows:

- The GNC Chair will review Board and Committee evaluations each month; areas of concern will be addressed immediately rather than wait until the next evaluation review period;
- The full summaries (raw data) will not be included for GNC review. A summary (themed) of the evaluations will be shared with the GNC twice per year according to the GNC work plan cycle.

The President and CEO will revise the current meeting evaluation tool to appropriately reflect fiduciary and strategic responsibilities. Aspects of the Net Promoter Score evaluation tool will be considered. | ***Action***

4.4 By Law Review - TBRHRI

Deferred.

5.0 COMMITTEE MATTERS

5.1 Governance and Nominating Terms of Reference

The Committee terms of reference was updated to reflect the addition of the Institute oversight. Further edits will be required prior to finalizing. | ***Action***

5.2 Selection of Officers of the Board – Revised Draft Policy

According to the May 2018 Accreditation Canada report, it was noted that the Hospital had an "unmet" criteria in relation to the process for the selection of a Board Chair. As a result, a draft Board policy was developed to provide a written formal process for the Board Chair appointment as well as for the appointment of Officers. The Committee approved the policy as presented.

Moved by:	***Patricia Lang***	***Motion***
Seconded by:	***Matt Simeoni***	

"That the Governance and Nominating Committee recommends that the TBRHSC Board of Directors approves the following policy,

- ***Selection of Officers of the Board,***

as presented.

CARRIED

5.3 Tri-Board Retreat Planning Update

A Tri-Board Steering Committee met on October 29, 2019 to begin preliminary planning of a retreat for the Hospital, Research Institute, and Foundation Boards. A shorter, less formal retreat focusing on relationship building was proposed by the Board Chair. The Committee

supported the following:

- Retreat will be a lighter, shorter session than previously proposed;
- relationship building and common successes will be the primary focus;
- possible theme of crisis management with facilitators as recommended by the Foundation CEO; and/or,
- possible strengths workshop facilitated by EVP, People, Culture, and Strategy;
- afternoon session with social gathering in the evening;
- consider inviting senior leaders.

5.4 Resource Planning Committee Community Member

Replacement of the Resource Planning Community Member position will be deferred until the next Board recruitment cycle.

5.6 FWFN Request for Dedicated Board Position

The Committee considered a request for a dedicated Fort William First Nations representative on the Hospital Board. The Senior Director of Indigenous Collaboration and the Indigenous Advisory Council will be consulted regarding this request. ***Action***

Discussion ensued about the Board's commitment to Indigenous Health. A generative discussion at a future Board meeting will focus on the Board's role in supporting the Hospital to address systemic and institutional racism, and the disparity in health status between Indigenous and non-Indigenous people.

6.0 FOR INFORMATION

6.1 Committee Meeting Evaluation

Committee members were requested to complete the committee meeting evaluation via the on line survey link.

7.0 BOARD MATTERS

7.1 Chair's Report to the Board

To be determined.

7.2 Recommendations to the Board

The following items will be recommended for Board for approval:

- Board Policies

8.0 **BOARD MEMBER COMMENTS -** None.

9.0 **DATE OF THE NEXT MEETING –** February 19, 2020.

10.0 **ADJOURNMENT -** The meeting adjourned at 9:05 a.m.

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
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ATTESTATION

TO: The Board of Thunder Bay Regional Health Sciences Centre, (the "Board")

FROM: Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer

DATE: January 21, 2020

RE: **Q3 2019-20** Wages and Source Deductions for Fiscal Year Beginning April 1, 2019 and ending March 31, 2020 (the "Applicable Period")

On behalf of the Thunder Bay Regional Health Sciences Centre (the "Hospital") I attest that:

- all wages owing to employees have been recorded, processed, accrued and/or paid accordingly as per established payroll cycle and other scheduled payouts;
- all source deductions relating to the employees, which the Corporation is required to deduct and remit, pursuant to all applicable legislation, including without limitation, the Income Tax Act (Canada), the Canada Pension Plan (Canada), the Unemployment Insurance Act (Canada), and Employer Health Tax Act (Ontario), have been made and remitted to the proper authorities within established timelines;
- all taxes collected pursuant to the Harmonized Sales Tax have been collected, claims filed and/or remitted as required to the proper authorities;
- the Corporations Information Act Annual Return required of Registered Charities under the Income Tax Act (Canada) has been filed;
- that the systems in place, as established by the Board, for the preparation and submission to the Board of compliance certificates, confirming that wages, source deductions and other taxes have been accomplished, are in place, are functional, adequate and monitored

during the Applicable Period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a President and CEO in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

Dated at Thunder Bay, Ontario this 21 day of January, 2020.

_____

Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

Thunder Bay Regional Health Sciences Centre

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Report from the President & CEO
and Senior Leadership Team
February 5, 2020

The report below summarizes strategic activities since the November 2019 Board meeting. As of December 31, 2019, 95% of 2020 initiatives had been completed.

Patient Experience:

Objective 4.5: Develop and implement supports and structures to keep staff safe at work.

Workplace violence prevention is an ongoing preoccupation. We have accomplished our goal related to the QIP as we have observed an increase in reporting of aggressive actions with a decrease in severity types. Aggressive behaviours are defined as any verbal or physical acts of aggression. Year to date reported incidents totaled 556 as compared to 222 in fiscal 18-19; of the 556 reported incidents, 92% were classified as a hazard meaning no staff were hurt, but a hazardous situation was identified, 2% required some sort of first aid as a result of the violence they experienced and 0.8% lost time away from work as a result of experiencing violence.

The clinical process group reviewed current work safety processes and practices, identifying areas of improvement and potential gaps. Some of the recent developments include the following initiatives:

- Transitional Care Unit staff completed the Gentle Persuasion Approach (GPA) training; 43% of staff responded to a post education survey. Respondents provided positive feedback in using this training. This training will now be rolled out onto the medical units;
- The new Workplace violence electronic learning module is now available and will be mandatory training for all staff;
- Security has completed a review of the areas that need to be locked after hours; the clinical process group will identify what times the various Hospital entrances will be locked, with the input of Patient Family Advisors.

Comprehensive Clinical Care:

Objective 2.3: Complete the implementation of the cardiac surgery program.

Capital Project: the Hospital is still awaiting a response from the Ministry of Health and Long Term Care (MOHLTC) Capital Branch regarding the Stage 1 submission.

Cardiovascular Sciences (CVS) Program Structure & Quality: the new structure for ensuring CVS program quality will go live once the new program structure is implemented, currently expected in February 2020.

CV Surgery Operating Budget: the MOHLTC (Provincial Programs Branch) confirmed a $1.5 M incremental operational funding for 2019/20. This brings CV surgery total envelope to $7.8m annually. Negotiations underway with MOHLTC will move the Hospital to a more formalized “rate x volume” funding model in either 2020/21 or 2021/22.

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International Interest: the Hospital's and University Health Network's (UHN) "1 Program on 2 Sites" model has been selected by the British Journal of Medicine to provide a poster presentation about the unique approach to delivering cardiovascular services at the prestigious International Forum on Quality and Safety in Healthcare Conference in Copenhagen, Denmark this summer. Our Hospital and UHN will jointly support a team member to attend the conference and share the story.

Vascular Surgery Development: The Program reached a new milestone by performing an endovascular aneurysm repair (EVAR) for a ruptured aorta. The repair was a life-saving procedure that included a challenging long-distance transfer from Geraldton, a trip that was supported by staff from Geraldton District Hospital. In addition to vascular surgeons Drs. Ignves, Elrasheed, and MacDonald, the Hospital's Anaesthetists and Intensivists as well as staff from the Emergency Department, Diagnostic Imaging, and Operating Room all contributed to this successful case.

The following highlight priority operational activities since the December 4, 2019 meeting of the Board of Directors.

Our Hospital has been experiencing surge capacity challenges near the end of December. However, thanks to the Transitional Care Unit (TCU) at Hogarth Riverview Manor, inpatient overcapacity numbers are lower and more manageable than in previous year. The TCU relieves some of the surge capacity pressures at our Hospital and provides a more appropriate care environment for patients who no longer require specialized acute or rehabilitation care hospital, but need a temporary place to stay until we determine their next phase of care. Our staff are to be commended for their extraordinary dedication to providing safe quality care while in overcapacity. We are also grateful to our community partners who collaborate with us to ensure that patients receive the right care, at the right time, and by the right provider. As the flu season develops, we anticipate an influx in patients at our Hospital; our Communication team will, through different media, encourage people to consider alternate care options for non-urgent medical issues – such as walk-in clinics by reminding them to contact 211. Our messaging to the population will also reinforce hand hygiene as a priority to reduce the spread of influenza.

In an effort to improve confidentiality during the triage process, starting January 20, 2020 the Emergency Department central triage desk was relocated to three private triage rooms accessible from the main waiting room. The newly renovated space provides improved privacy and offer patients with mental health issues an opportunity to openly interact with staff. Additionally, the new triage location and process reduce the number of steps required to register and be assessed.

It is with sincere sadness that I shared notice of the resignation of Dr. Valerie Grdisa, Executive Vice President, Research, Quality and Academics/Chief Nursing Executive (CNE). She will continue in her role until March 13, 2020 and then be more available to focus on family health demands. This will be a substantial loss to our Hospital and Health Research Institute. Since joining our Senior Leadership team in March, 2019, Val has excelled at constructing and strengthening her portfolio. Val will be missed, and I extend my gratitude to her for her dedication, professionalism and positive impact.

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From January 13 to 17, our Hospital celebrated Employee Recognition Week (ERW). Several events and activities provided the opportunity to recognize staff, professional staff, scientists and volunteers for their contributions to patients and families in our community and region. Our Hospital is recognized for providing quality patient and family centred care thanks to all our employees who play a very important role for the people of Northwestern Ontario. A highlight of ERW is the presentation of Walk that Talk Awards, which celebrate champions who 'Walk the Talk' and go above and beyond the call of duty. Their attitudes, ideas, focus, and enthusiasm influence coworkers, as well as patients and their caregivers.

The President's Walk the Talk Award of Excellence recognizes staff members who inspire other employees to act in a positive and courteous manner towards patients, families, volunteers and coworkers. The recipients must demonstrate a commitment to patient care, the team and the Hospital, act as a mentor for new employees, support and advance the strategic directions, demonstrate excellence in contributing to the mission, vision, and values, and act as an ambassador of our Hospital. This year's President's Award of Excellence was presented to two very deserving individuals: Tyler Van Ramshorst and Larry Bertoldo.

Tyler Van Ramshorst began his career with our Hospital 10 years ago, and has been a mainstay in the Emergency Department throughout his tenure here, working as a Nurse, then as a Charge Nurse, followed by his time as a Coordinator. Since July 2018, he has been the Manager in the Emergency Department. Tyler is a highly respected leader among his peers, co-workers, physicians and staff because he 'walks the talk' by doing things such as voluntarily spending an entire night shift helping out in the "pit" when the ED is short staffed, and he is the embodiment of going above and beyond for his patients and his colleagues. He often brings new ideas to the table, and his dedication and positivity have pulled the Emergency Department team together after a recent summer filled with challenges.

Larry Bertoldo has worked in health care for more than 26 years, beginning his career as a Pharmacist in 1993 at the McKellar site. In 2011, he was promoted to Pharmacy Clinical Lead at our Hospital. Larry is viewed by many of his colleagues as an exceptional pharmacist whose knowledge and work ethic exceed expectations. He is passionate about his profession as a pharmacist and continues to move the practice of pharmacy forward within our Hospital. Larry always puts patients first and goes above and beyond in his role.

Congratulations to Tyler and Larry for receiving this year's President's Award, and to the following additional Walk the Talk Award recipients:

- Dr. Ranjit Baboolal - Professional Staff Award;
- The Cardiovascular Surgery Tour Team, comprised of Christine Erickson, Jolyne Fadyshen, Terri Gurney, Dawn Korol, Wayne Taylor and Arlene Thomson - Foundation Award;
- Matthew Saj - Respect Award;
- Sandy Brooks - Accountability Award;
- Paul Sabotig - Patients First Award;
- Georgia Carr - Excellence Award;
- Dennis Hildebrand - Volunteer Award;
- Stores Department - Board of Directors Award.

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On January 13, Jessica Logozzo began in her new role as Executive Vice President, Regional Transformation and Integration. Jessica is a welcome addition to the Senior Leadership Council and we look forward to the enhanced collaboration and integration she will facilitate among partner organizations throughout Northwestern Ontario.

On January 15, The Seven Youth Inquest Nishnawbe Aski Nation (NAN) Political Table held a meeting at our Hospital. The participants discussed the efforts they collectively are pursuing to make Thunder Bay a safer place, especially the Indigenous students. Through our participation at that Table, our Hospital is ere is committed to making the necessary improvements to become a culturally safer and welcoming care place. We are actively engaged to collaborate with our Indigenous community to gather their valuable input to guide us. We extend our gratitude NAN and other Political Territory Organizations in Northwestern Ontario for their guidance in several initiatives. NAN appointed representatives contributed to the establishment of the Indigenous Health & Reconciliation Steering Committee at our Hospital, participated in the selection committee to hire our Senior Director of Indigenous Collaboration, and advised me on operational activities as members of our Indigenous Advisory Circle. Ongoing collaboration with Indigenous communities and leaders is valued and essential to eliminate systemic racist barriers established over centuries of colonialism. Together, we will make progress as allies.

The new strategic plan – The Right Plan – is rapidly developing. Ensuring access to the Right Care at the Right Time is one of the most prevalent challenges affecting patients at our Hospital. The plan is intended to ensure that only those that need specialized acute care are admitted, that once admitted, they move in an inpatient bed sooner, and they are rapidly and safely discharged back in the community. In other words, the Right Plan addresses capacity challenges by focusing on Enabling Success at Home, Optimizing the Acute Patient Journey and Ensuring Effective Transitions in Care. With input from our Patient Flow Steering Committee, a Right Plan Steering Committee membership has been confirmed and will start overseeing development of the plan in the coming weeks. In addition, a Working Group to address Optimizing the Acute Patient Journey will soon be established to identify priorities.

Starting in February 2020, the teams that support Cardiovascular, Medicine and Stroke will be organized under two new programs, called Cardiovascular Sciences and Acute Medicine, Stroke and Seniors'. Arlene Thompson's retirement as Senior Director, Cardiovascular Surgical Program Development, where she achieved tremendous progress on a number of initiatives, presented an opportunity to implement this restructuring while continuing to serve patients at the highest level.

The Cardiovascular Sciences Program will oversee:

- Inpatient Cardiology, Inpatient Stroke, PCI Short Stay Recovery;
- Cardiac Catheterization Lab, Pacemaker Clinic/Devices Visiting Clinics, Cardiac Rehabilitation and Healthy Lifestyles;
- Wound Care and Limb Preservation Service;
- Vascular & Cardiac Surgery Program Development.

Meaghan Sharp has accepted the position of Director, Cardiovascular Science Program (CV Science Program). An official start date will be determined in the coming weeks. Meaghan will work in partnership with the Program Medical Director, CV Science Program, and the Joint Program Medical Director with the University Health Network. Meaghan will lead the CV Science

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Program at an overall strategic and planning level to provide optimal patient care and the delivery of high-quality cardiovascular services. She will be responsible for the oversight of nursing care, care provided by allied health professionals, administrative and support services.

The Acute Medicine, Stroke and Seniors' Program will oversee:

- Regional Stroke Network, Stroke Prevention Clinic, Telemedicine;
- Inpatient General Medicine 2A, HELP;
- Inpatient General Medicine 2B/MCTU;
- Internal Medicine Clinic, Telehome Care and INR;
- Transitional Care Unit;
- CHF/COPD Navigation.

The search is currently underway to fill the leadership position of Director, Acute Medicine, Stroke and Seniors' Program.

A new point of care laboratory test in the Emergency Room that assists in diagnosing heart attacks is being evaluated thanks to a Pay for Results funding initiative. The test has started being assessed beginning January 17, 2020; it is intended to provide specific lab results within 15 minutes, a significant improvement over the 90 minutes previously required. The impact of this new lab test will be evaluated in three months.

Finally, I want to extend my congratulations to two Hospital employees who won the Northern Ontario Visionary Award (NOVA). The January 18 NOVA Awards ceremony, recognized 20 young professionals in Northwestern Ontario for their business or community service. Jamie Sitar, Physician Recruitment Specialist, received the Leadership Award, and Jason Veltri, Contract Procurement Specialist, was awarded the SHIFT Disturber NOVA for his role as Chair of the Thunder Pride Association. This is a testament to their leadership, community engagement, professional achievement, volunteerism, and mentorship in our community.

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Chief of Staff
Médecin chef

Chief of Staff Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre

January 2020

NOSM Vision and Collaboration with TBRHSC

- Dr. Sarita Verma, Dean, President & CEO met with the Medical Advisory Committee and presented the Northern Ontario School of Medicine's vision of its undergraduate and postgraduate training programs. Dr. Verma discussed her interest in improving physician health at both the training and practice levels.

Coding Audit

- Following a recommendation from a Health Record's Coding Audit, education will take place with Professional Staff focusing on clinical documentation. A Discharge Summary template has also been developed to ensure primary care providers receive relevant, concise and value-added info to enable timely and appropriate follow up care.

Attendance at Department Meetings

- To increase attendance and engagement, Professional Staff may now begin attending department meetings by audioconference or possibly Zoom web meeting programming following a trial by the Department of General and Family Practice.

Digital Order Sets

- Interviews have taken place for a new Clinical Lead for Digital Order Sets and an announcement has been made.

Director, Medical Affairs

- Interviews will be taking place at the end of January for the position of the Director of Medical Affairs.

Recruitment

- Dr. Anastasia Shamsuyarova (Dermatology) has accepted a position and will be joining us in August 2020.
- Upcoming Site Visits are planned for Anesthesia, Radiation Oncology, Interventional Cardiology, Internal Medicine, Neurology and Orthopedics.

Professional Staff Evaluations

- Professional Staff Evaluations will begin in January 2020 initially with the Department of Surgery. This will be a pilot with evaluations completed in collaboration with NOSM and will include both clinical work as well as academic activity.

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Chief Nursing Executive Open Report to the Board of Directors

February 5, 2020

Nursing Workforce Planning

An *Integrated Workforce Strategy – Working Group* has been formed to ensure that current staffing needs are met and that future needs are forecasted based on internal and external market trends/forces – to ultimately, enable the Hospital to achieve its vision, mission and strategic priorities. The executive sponsors of the working group are the EVP People, Culture and Strategy and EVP Research, Quality & Academics and CNE The work plan, priorities and recommended strategies arising from the working group will be tabled at Senior Leadership Council.

A planning meeting led by Human Resources in collaboration with Nursing, Health Professions and Clinical Programs leadership occurred on January 10, 2020. The Working Group will ensure that workforce planning efforts are coordinated, integrated and based on leading practices and the best available evidence. A final report will be presented to the Resource Planning Committee, as requested. In addition, the Regional CNEs will be focusing their March 2020 meeting on integrated workforce planning, building from their inaugural workforce planning session on November 22, 2019.

Current vacancies for the inpatient care areas, as reported by the clinical managers via the monthly vacancy report are 32.73 FTE RN and 10.34 FTE RPN, for a subtotal of 43.07 FTE combined vacancies. Congratulations to the clinical program managers for all of their recruitment efforts to fill 46.43 FTE positions (of 89.5 FTE combined vacancies)!

Current vacancies for the Nursing Resouce Team (NRT) are 10 FTE RN and 4 FTE RPN, for a subtotal of 14 FTE combined vacancies (most of which are temporary positions). Notably, a combined 28 NRT FTEs were filled since November 2019 and another six interviews are underway to fill the remaining vacancies. Congratulations to Rita Grenier Buchan, Manager, NRT and Staffing Office for all of her recutiment efforts to fill 20.5 FTE positions (of 34.5 FTE combined vacancies)!

Total vacancies are **57.07 combined FTEs,** representing a significant decrease from 124.09 combined FTE vacancies reported at the December 2019 Board meeting.

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2020 Spring Hire

The 2020 spring hire interviews is being held off site at the Victoria Inn Hotel and preliminary feedback by the candidates has been extremely positive. **Sixty-five (65) new graduate RN candidates have been invited for interviews.** The interview process is based on best practices which involves 4 concurrent candidates participating in circulating interviews with 4 dyads of Hospital managers (includes behaviour-based questions and a medication knowledge test). After each round of interviews, the candidates return to a separate room where beverages and snacks are available. The next stage of the interview process involves an information/Q&A session with an Human Resouces representative. The candidates are solicited from their immediate feedback on our refined hiring process and in follow-up, the candidates will be sent a survey for completion.

Evolution of Nursing Resource Team Staffing Model

As previously presented, the Nursing Resource Team (NRT) staffing model continues to evolve based on detailed recommendations that were summarized at the November 2019 Resource Planning Committee. Over the past year, several steps have been taken to realign specialty area FTEs from the NRT complement into the identified Clinical Program. This supports NRT nurses better enculturation within their clinical specialty area and empowers the unit manager / program to support their intra/inter-professional and oversee their unit-based staffing decisions. The current state of the NRT evolution includes:

- Emergency Department (ED) – Plan to return staff to the ED via attrition – COMPLETED
- Hemodialysis Unit – Plan to return FTE to the unit via attrition – 2.5 FTE outstanding
- ICU – Plan to return FTE to the unit via attrition – 4.5 FTE of 9 FTE outstanding
- Woman and Childrens (W&C) Program – Create a Resource Team specific to the W&C program – 4 FTE filled with an additional 4 FTE to be hired
- Mental Health – Create a Resource Team specific to the Mental Health Program – Process newly initiated

Congratulations to Dawna-Maria Perry, Director of Nursing and Rita Grenier Buchan for their collaborative efforts with the Program Directors and Managers to make this happen!

Finally, the Academic Practice Plan continues to move forward with the EVP/CNE executive sponsorship and a preliminary report is planned for March 2020. The CNE conducted a site visit on January 28, 2020 at Mount Sinai Hospital (MSH) in Toronto to gain an in-depth understanding of how MSH has moved forward the Magnet Recognition Program, which is a Hospital Board priority. MSH has integrated their Quality Framework, Magnet Recognition Program, Academic Practice Plan and Health Workforce Planning

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and Optimization initiatives, and their Director would be delighted to present their successes and lessons learned to the PSQCC and/or the Hospital Board.

Health Professions & Collaborative Practice Updates

Support for Patients and Families Experiencing Pregnancy and Infant Loss

- Spiritual Care Providers have taken training that will enable them to provide greater support to parents and families who are experiencing Pregnancy and Infant Loss (PAIL), as losses of this nature occur on a daily basis in the ED. In addition to providing compassionate support to parents and families who are experiencing a miscarriage or infant loss, Spiritual Care Providers will make the connections to the local branch of the PAIL Network in Thunder Bay, which was recently established.

Social Workers – Standardizing Documentation & Advocating for Patients

- Standardized Documentation – The Social Work Documentation Working Group is implementing an intervention in the electronic medical record (EMR) at the end of the month. This change in practice will see Social Workers and the Social Service Worker use one common intervention, which will result in consistency in documentation and ease of reading for other health care providers. Training took place January 22nd and 23rd.
- Social Needs – Five social workers representing the Renal, Paediatrics, Medical, and Surgical units are part of an interprofessional Social Needs Working Group that recently held its first meeting. The group is exploring creative, sustainable solutions to (primarily) address the food-shortage among low-income patient companions, patients, and patients' extended family members when they are at the hospital.

Best Practice in Children's Mental Health

- The Child Youth Worker Practice Lead and Transition Specialist (Social Worker) from CAMHU participate in regularly scheduled Northern In-Patient Units Knowledge Exchange Sessions. These teleconference sessions are held with the Ontario Network of Child and Adolescent Inpatient Psychiatry Services (ONCAIPS) to discuss topics such as best practices and staffing models across Ontario Children's Mental Health Units.

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Quality Patient Care in Medical Laboratory

- Best Practice Implementation – Based on best practice guidelines, the lab has introduced enhanced technological advances and new equipment for diagnostic tests, allowing for automation of processes and optimal use of staff. These improvements are intended to improve turnaround time and reduce length of stay.
- Scope Optimization – A review of roles and scope was carried out for Medical Laboratory Assistants and Medical Laboratory Technologists, resulting in scope optimization for both professions and more efficient resource alignment.
- Education Delivery – Ongoing continuing education is being offered to staff with regards to specialized testing and administration of laboratory services. This ensures staff are familiar with best practices and IQMH (Institute for Quality Management in Healthcare) standards, and understand the importance of processes to ensure the delivery of quality patient care.

Congratulations to Michelle Addison, Director of Health Professions and Collaborative Practice for her leadership with the Practice Heads, Practice Leads and Program Directors and Managers to make this happen!

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Northern Cancer Fund

Northern Cardiac Fund

Health Sciences Discovery Fund

Report to the Thunder Bay Regional Health Sciences Centre Board of Directors
February 2020

Where do you get your HOPE?
The 24 anniversary of the Bearskin Airlines Hope Classic is fast approaching! This incredible ladies bonspiel weekend is set for February 7-9, 2020 at the Fort William Curling Club. These exceptional ladies have raised **over $3.2M** in support of breast cancer research, education and treatment here in Thunder Bay and throughout Northwestern Ontario. This outstanding event has been pivotal in making the success of the Linda Buchan Centre for Breast Screening and Assessment possible. Curlers will be collecting pledges. To support your fellow friends participating in the event or interested in more details please visit https://www.healthsciencesfoundation.ca/bearskin-airlines-hope-classic

February is for Hearts!!
Share a Hear Floral- Starting February 1 for every special occasion you have, consider ordering a Share a Heart bouquet from Bloomers and the Brown House, From the Heart Florist, Grower Direct, Rollason Flowers and Vaillant Flowers. These local florists will donate 10% of their sales for the remainder of the year to support the Our Hearts at Home Cardiovascular Campaign. For more information please contact:
Elaine Graydon, Manager Special Events at 684-7278

What will your legacy be?
February means time for tax planning – thinking ahead to what 2019 will have in store for you and your family. It's important to be sure your plan extends beyond 2019 to the bigger picture of what you want to impact – the things that touch your family and friends closest. It's likely that you or someone you love has been a patient at the Health Sciences Centre in some way – whether as an inpatient, a visit to the Emergency Department or a visitor – you know the impact health can have on all of our lives.

Take some time this month to think about how you could impact healthcare offered in our region. A gift to the Health Sciences Foundation in your will could have significant positive implications for the administration of your estate and will help put tools in the hands of the gift professionals at the Health Sciences Centre – offering better care to your children and grandchildren for the future.

Every gift makes a difference and we hope that you've taken the time to think about what your legacy could be.

Want to know where your gift could make a difference? Please contact **Terri Hrkac, Director, Legacy and Major Gifts at 684-7109** for more information.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Review of Board Policies-TBRHSC
PREPARED BY	Angela Kutok, Board Liaison
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☐ NO ☐ N/A ☒
APPROVED BY	Jean Bartkowiak, President and CEO
CO-SPONSER (if required)	n/a
PREPARED FOR:	President &CEO ☐ Board of Directors ☒ Other: Governance and Nominating Committee – December 6, 2019 Updated for Baord of Directors – February 5, 2020
DATE PREPARED	November 29, 2019 and updated January 30, 2020

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The reader considers the following questions to ensure each decision are ethically responsible by indicating with a √:

☐ 1. We put '**Patients First'** by responding respectfully to needs, values, & expectations of our patients, families, and communities?
2. We demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally responsible?
☐ 3. We demonstrate '**Respect**' by honouring the uniqueness of each individual and his or her culture?
☐ 4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?
☐

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE/ISSUE(S)

To review the TBRHSC Board policies as a function of the Governance and Nominating Committee (GNC) annual work-plan and subsequent approval by the Board of Directors.

BACKGROUND

According to the GNC Terms of Reference, the committee is responsible to draft policies regarding the effective and efficient functioning of the Board as well as review and recommend changes to policies for Board approval.

Policy BD-20 Review and Revision of Board Polices and Hospital By-Law, states that all Board Policies are to be reviewed at least once every three years or as directed by the Board. A third of the Board polices are reviewed each year on a rotational basis.

Following review, the GNC recommends policies to the Board for approval.

ANALYSIS/CURRENT STATUS

The following policies have been recently reviewed by the CEO prior to being brought forward for revision at the December 2019 GNC meeting. Once these policies are approved, the next review date will be November 2022.

- BD-05 CEO Performance Evaluation and Compensation;
  - NOTE: This policy has been revised to reflect the process changes that were trialed last cycle (2018-2019);
  - FOR CONSIDERATION: There are currently 2 separate CEO evaluations for the HRI and HSC. As the governance functions for these organizations are being combined, there is a potential to combine the evaluations into one. If this approach is mutually agreed upon by both organizations, the policy will be revised to reflect the change.
- BD-07 Chief of Staff Performance Evaluation - minor edits, no changes to policy intent;
- BD-11 Board and Committee Meeting Attendance – minor edits, more concise language;
- BD-20 Review and Revision of Board Policies and By-Law – minor edits;
- BD-25 Education and Development – minor edits;

- BD-36 Public Attendance at Open Board Meetings – minor edits;
- BD-39 Board Committee Terms of Reference – minor edits;
- BD-44 President and CEO Succession Planning – minor edits, more concise language.

RECOMMENDATION

That upon recommendation from the Governance and Nominating Committee, the Board of Directors approves the TBRHSC Board Policies as presented.

NEXT STEPS

1) Seek agreement from both Boards to move forward with a combined evaluation of the CEO. If approved, the policy will revised and presented at a future Board meeting.

2) Update policies and post to internal websites.

STAKEHOLDER REACTION

n/a

COMMUNICATIONS

The GNC Chair will present the revised policies to the Board at the February 5, 2020 for approval.

FINANCIAL IMPACTS

n/a

APPENDIX SECTION

BD-05 CEO Performance Evaluation and Compensation
BD-07 Chief of Staff Performance Evaluation
BD-11 Board and Committee Meeting Attendance
BD-20 Review and Revision of Board Policies and By-Law
BD-25 Education and Development
BD-36 Public Attendance at Open Board Meetings
BD-39 Board Committee Terms of Reference
BD-44 President and CEO Succession Planning

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices		No. BD-05
Title: CEO Performance Evaluation and Compensation	**X Policy**	**X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a	
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** **Approval Date:** **Next Review Date:**	December 2019 February 2020 November 2022

CROSS REFERENCES: *If applicable.*

NOTE: This policy has been revised to reflect the process changes that were trialed last cycle.

1.0 PURPOSE

To outline the process for the CEO Performance Evaluation.

2.0 POLICY

The performance of the CEO must be reviewed annually as a basis for compensation adjustments.

3.0 Performance Evaluation~~:~~

The CEO Performance Evaluation is comprised of the following two elements~~, which are comprised of the following~~:

- CEO Objectives;
- CEO Competencies.

~~3.0~~4.0 PROCEDURE

~~3~~4.1 January
The Board Chair or designate(s) initiates CEO Performance Evaluation process.

The Chair appoints a Performance Evaluation Committee (Sub-Committee of the Executive Committee) of at least four (4) members.

~~3~~4.2 February
The CEO completes a self-assessment via the 360 web-based tool. The 360 tool is also completed by:

- All direct reports to the CEO (~~All~~ Executive Vice Presidents, and ~~Chief Nursing Executive (CNE)~~Senior Directors;
- ~~and~~ Chief of Staff (COS);
- Three (3) or more external stakeholders; and
- All ~~Any~~ Board members ~~who want~~would like to~~to~~are encouraged to participate.

~~3~~4.3 March/April
The Board Chair or designate(s) meets with direct reports to the CEO, Chief of Staff and at least one (1) external stakeholder to gather feedback about the CEO's performance.~~;~~

The Board Chair or designate(s), 1st Vice Chair, and EVP, People, Culture and Strategy ~~to~~ collaborate to ~~create~~draft a summary report of all 360 and verbal feedback.~~;~~

The Board Chair or designate(s) and EVP, People, Culture, and Strategy facilitates a feedback planning meeting with the Board to discuss the feedback and the Board's impressions of the CEO performance.~~:~~

The Board Chair or designate(s) and Performance Evaluation Committee meet~~s~~ with the CEO to review the 360 results, discuss strengths, concerns, and create a plan for development if necessary.

~~3~~4.4 May
Based on the feedback received, the CEO submits to the Performance Evaluation Committee their proposed annual priorities for the next fiscal year, including related metrics~~,~~ and desired outcomes and timing. The CEO Goals and Objectives ~~will~~must be consistent with the STEEEP Quality Framework, the ME to WE to ALL framework, and important organizational goals as ~~indicat~~defined in~~by documents such as~~ the Quality Improvement Plan (QIP) and Strategic Plan.

~~3~~4.5 Ongoing
Ongoing ~~S~~structures and processes ~~will~~ strengthen the CEO performance evaluation process including evaluation at the Restricted In Camera portion of the monthly Board meeting~~s~~.

A summary of monthly feedback ~~will be~~is provided to the CEO by the Board Chair following the Board meeting.

~~4.0~~5.0 CEO Objectives:

~~4.1~~5.1 In April or May of each year, the CEO submits to the voting members of the Performance Evaluation Committee, the proposed annual objective priorities for the next fiscal year, including related performance indicators such as desired outcomes and timing. The CEO Objectives must be consistent with the ~~'ME to WE to ALL'~~STEEEP Quality ~~F~~framework, the PFCC Philosophy, and the Hospital's Quality Improvement Plan (QIP).

~~4.2~~5.2 Once approved, the Board Chair prepares a summary report of CEO's annual priorities. The summary is presented to the Board by the Chair at the May Board meeting.

~~4.3~~5.3 The CEO Objectives represent the CEO's Annual Work Plan founded on the Job Description, Quality Improvement Plan, Strategic Plan and the Balanced Scorecard. Quarterly, progress is reviewed by the Board Chair in order to assess any appropriate changes to the Work Plan.

~~4.4~~5.4 At year end, the completed Work Plan, including the CEO input on achievements, is forwarded to the voting members of the Performance Evaluation Committee.

~~4.5~~5.5 The final assessment of the achievements represents one of the two parts of the CEO Performance Evaluation. A summary is presented to the Board by the voting members of the Performance Evaluation Committee.

~~4.1~~5.6 This annual process is subject to changes proposed by the Governance & Nominating Committee as approved by the Board of Directors. ~~(see section: Role of the Governance & Nominating and voting members of the Performance Evaluation Committees).~~

~~5.0~~6.0 CEO Competencies:

~~5.1~~6.1 The essential competencies to the success of the CEO comprise the second element of the CEO's Performance Evaluation.

~~5.2~~6.2 A competency is defined as any knowledge, skill, trait, motive, attitude, value, or other personal characteristics that are essential to discharge the responsibilities of the CEO and that differentiate good from superior performance. The essential competencies and their subsets are as follows:

Achieving Results:
1. Building strategic partnerships;
2. Collaboration;
3. Impact and influence;
4. Organizational awareness;
5. Results orientation;
6. Service and quality orientation.

Leading Effectively:
1. Building organizational capacity;
2. Holding self and others accountable;
3. Visionary leadership.

Thinking Critically:
1. Business acumen;
2. Strategic orientation.

Leading Self:
1. Interpersonal sensitivity;
2. Leadership presence.

~~6.~~07.0 CEO Compensation

The benchmark for comparing the CEO compensation is the OHA annual survey of hospitals with 300 to 499 beds. The target rate is set at the 50th percentile.

Compensation includes base salary, pay at risk, pay for performance, and relevant perquisites. To ensure an appropriate record of performance evaluation and compensation, the Chair on behalf of the voting members of the Performance Evaluation Committee ~~shall~~ writes to the CEO confirming the performance evaluation results and any compensation adjustment the Board elects to grant consistent with Hospital policy and any relevant legislation.

~~7.~~08.0 Role of the voting members of the Performance Evaluation and Governance & Nominating Committees

The voting members of the Performance Evaluation Committee review annually the process of the CEO Performance Evaluation and recommend any changes to the Governance & Nominating Committee.

The Governance & Nominating Committee then recommends changes to the Board of Directors. This process occurs at the end of the CEO Performance Evaluation cycle, and should be completed by September of each year.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-07
Title: Chief of Staff (COS) Performance Evaluation and Compensation	**X Policy** **X Procedure** **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Approval Date:** February 5, 2020 **Reviewed/Revised Date:** December 2019 **Next Review Date:** November 2022

CROSS REFERENCES: *if applicable*

1. PURPOSE

To outline the process for the COS Performance Evaluation.

2. POLICY

The performance of the COS must be reviewed annually as a basis for compensation adjustments.

3. Performance Evaluation Elements:

The COS Performance Evaluation is comprised of the following elements~~two elements, which are comprised of the following~~:

1. COS Objectives.
2. COS Competencies.

4. PROCESS

The Chair and President & CEO initiate ~~s~~ the COS Performance Evaluation in March of each year. The voting members of the Executive Committee and the President & CEO ~~will~~ assist the Chair in the COS evaluation.

4.1 COS Objectives

In March of each year, the COS ~~will~~ submits to the voting members of the Executive Committee and the President & CEO, the ~~COS~~ proposed annual objectives ~~priorities~~ for the next fiscal year, including related performance indicators such as desired outcomes and timing. The COS Objectives must be consistent with the STEEEP Quality Framework and the Hospital's Quality Improvement Plan (QIP) and ~~the Hospital's~~ Strategic Plan.

Once approved, the COS Objectives represent the COS Annual Work Plan. Quarterly progress is reviewed by the Board Chair and the President & CEO in order to ~~review and~~ assess progress and any appropriate changes to the Work Plan.

At year end the completed Work Plan, including the COS input on achievements is forwarded to the voting members of the Executive Committee and the President & CEO.

The final assessment of the achievements represents one of the two parts of the COS Performance Evaluation. A summary is presented to the Board by the voting members of the Executive Committee and the President & CEO.

This annual process is subject to changes proposed by the Governance and Nominating Committee ~~as~~ and approved by the Board of Directors (see section: Role of the Chief of Staff Evaluation ~~&~~and Compensation and Governance and Nominating Committee).

4.2 COS Competencies

The essential competencies to the success of the COS ~~shall~~ comprise the second element of the COS' Performance Evaluation.

A competency is defined as any knowledge, skill, trait, motive, attitude, value, or other personal characteristics that are essential to discharge the responsibility of the COS and that differentiate~~s~~ good from superior performance. The essential competencies and their subsets are as follows:

Teamwork:
1. ~~Teambuilding~~Team building;
2. Team leadership;
3. Leading by example.

Interpersonal Skills:
1. Building relationships;
2. Relationship management;
3. Resolving conflict.

Effective[1] Communicatione~~s Effectively~~:
1. Communication style;
2. Promoting internal communication;
3. Listening.

~~Demonstrates~~ Flexibility:
1. Adaptability;
2. Leading change;
3. Time management.

Continuous Improvement:
1. Championing innovation;
2. Innovative problem solving;
3. Focus on patient safety and ~~customers/~~quality.

~~Drives~~ Outcomes Driven:
1. Decision making;
2. Planning;
3. Directing and delegating.

Continuous Learning:
1. Professional development;
2. Performance management;
3. Developing leadership.

In April, Board members ~~are asked to~~ participate in the COS Performance Evaluation to assist in the competency assessment.

Furthermore, the COS ~~may~~ will elects ~~to have up to~~ six peers and direct reports to participate in the evaluation process, in addition to the Board members. ~~Should he/she elect this option, the~~The peers and ~~/~~direct reports selected by the COS must be agreeable to ~~by~~ the Board Chair and the President and CEO. ~~Additonal~~Additional peers may ~~be recommended to~~ be added by the Board Chair and President ~~&and~~ CEO.

By the end of April, the President ~~&and~~ CEO prepares a performance evaluation summary report.

The Board Chair and President & CEO ~~will~~ meet with the COS for a preliminary review of the competency assessment.

The Board Chair and the President & CEO, with the voting members of the Executive Committee, meet~~s~~ with the COS to review the results from the competency assessment, and to discuss the ~~achievements in the~~ COS A~~a~~nnual Objectives achievements.

A summary representing both elements is presented to the Board by the Chair at the May Board meeting.

5~~4~~. COS Compensation

The COS compensation is consistent with compensation paid to other physicians in executive positions at the Hospital to ensure fair~~appropriate record of performance evaluation and~~ compensation. The Chair, on behalf of the voting members of the Executive Committee and President & CEO, writes to the COS confirming the performance evaluation results and any compensation adjustment~~s~~ the Board elects to grant consistent with the Hospital's policy and any relevant legislation.

6~~5~~. Role of the voting members of the Executive Committee, President & CEO and Governance Committees

The voting members of the Executive Committee and the President ~~&and~~ CEO review~~s~~ annually the ~~process of the~~ COS Performance Evaluation process and recommend~~s~~ changes to the Governance and Nominating Committee. The Governance and Nominating Committee then recommends changes to the Board of Directors. This process occurs at the end of the COS Performance Evaluation cycle, and should be completed by September of each year.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices		No. BD-11
Title: Board &~~and~~ Committee ~~m~~Meeting Attendance	**X Policy** **X Procedure** ☐ **SOP**	
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a	
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** ~~Nov. 18, 2015~~December 2019 **Approval Date:** ~~Feb. 3, 2016~~February 5, 2020 **Next Review Date:** ~~Nov. 2016~~November 2022	

CROSS REFERENCES: *if applicable*

1. PURPOSE

To ensure that Board and Committee members contribute their expertise and judgment to the business and affairs of the Hospital by attending and participating in Board and Committee meetings.

2. POLICY

Board ~~members~~ and Committee members are expected to maintain a meetings attendance rate of at least 75%~~attend all Board meetings and all meetings of the Committees to which they are assigned~~.

~~It is recognized that Directors and Committee members may be unable to attend some meetings due to conflicts with other commitments or other unforeseen circumstances. An attendance rate of at least 75% is acceptable.~~

3. SCOPE

All Board members and community~~non-Board~~ members of Committees.

4. PROCEDURE

Where a Board~~Director~~ or Committee member fails to attend 75% of the meetings of the Board or of a Committee in a 12-month period, or is absent for three consecutive meetings, the Chair ~~shall~~ discusses the reasons for the absences with the member and may ask the individual to resign.

A member's record of attendance ~~shall be~~ is considered with respect to renewal of a Board term or future assignment to a Committee.

Where the Board or Committee member is an *ex-officio* member of the Board, the Chair may discuss the member's attendance with the organization the member is affiliated with, and such organization may be requested to remove the member and appoint a new *ex-officio* member to the Board.

The Chair ~~shall, in the Chair's~~ has sole discretion~~,~~ to determine if a Board or Committee member's absences are excusable and may grant a Board or Committee member a limited period to rearrange their schedule so that there are no conflicts with regularly scheduled Board or Committee meetings.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-20
Title: Review ~~and Revision~~ of Board Policies ~~&~~and ~~Hospital~~ By-Law	☒ **Policy** ☒ **Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** ~~Jan 2019~~December 2019 **Approval Date:** ~~Feb 6, 2019~~February 5, 2020 **Next Review Date:** ~~Nov. 2019~~November 2022

CROSS REFERENCES: *if applicable*

1. PURPOSE:

To ensure ~~a~~all Board policies and ~~Hospital~~ By-Law are current.

2. POLICY:

The Board of Directors regularly ensures that Board policies and By-Law are up-to-date, accurate, and consistent with ~~the~~ current legislation and government requirements.

3. PROCEDURE:

3.1 Board Policies:

3.1.1 The Governance and Nominating Committee reviews ~~all~~ Board policies and recommends ~~any~~ changes to the Board of Directors for approval;

3.1.2 All policies are reviewed at least once every~~in~~ three years;

3.1.3 In addition to planned reviews, ~~an~~ unscheduled review of a policy is initiated if it is required by a new legislation or regulation, new government policy, a resolution of the Board of Directors, or otherwise required to ensure accuracy and relevance.

3.2 By-Law:

3.2.1 The Governance and Nominating Committee reviews the Administrative section of the By-Law on an annual basis;

3.2.2 Suggested amendments to the Professional Staff section of the By-Law are submitted by the Medical Advisory Committee to the Governance and Nominating Committee for review on an annual basis;

3.2.3 The Governance and Nominating Committee recommends ~~any~~ amendments to ~~the Administrative and Professional Staff sections of~~ the By-Law to the Board of Directors for approval;

3.2.4 Amendments to the By-Law, approved by the Board, are presented for confirmation at the next annual general meeting or to a special general meeting called for that purpose.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-25
Title: Education and Development	**X Policy** **X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** ~~May 18, 2016~~December 2019 **Approval Date:** ~~Feb. 3, 2016~~February 5, 2020 **Next Review Date:** ~~Nov. 2016~~November 2022

CROSS REFERENCES: *if applicable*

1. PURPOSE

To ensure thate Board members are sufficiently informed to exercise their responsibility.

2. POLICY

Every Board member must attend an orientation session when newly appointed and at least one internal or external education session annually thereafter to ensure they are sufficiently informed to exercise their responsibilities.

3. PROCEDURE

There ~~will be~~ is at least ~~minimum of~~ one ~~(1)~~ Board retreat annually~~per year~~.

Educational ~~topics and~~ sessions are provided monthly to Board members at ~~every~~ open Board meeting ~~on a monthly basis~~. Educational topics may also be presented at Board Committee meetings.

Board members may request participation in educational programs and conferences through the Board Chair. Board members are required to provide a summary report to the Board, highlighting information learned at the educational sessions they attend.

~~Board members are required to report to the Board information learned at the educational sessions they attend~~.

A record of attended educational sessions is maintained by the Board Liaison. Arrangements for registration and attendance at approved external educational sessions may be made through the Board Liaison.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-36
Title: ~~Attendance of~~ Public Attendance at Open Board Meetings	**X Policy** ☐ **Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** ~~Nov 15, 2017~~December 2019 **Approval Date:** ~~Dec 6, 2017~~February 5, 2020 **Next Review Date:** ~~Nov. 2019~~November 2022

CROSS REFERENCES: *if applicable*

1. PURPOSE

To outline the process for the attendance of members of the public at the open Board meetings.

2. POLICY

The public is welcome to observe the open Board meetings deliberations to generate trust, openness, accountability and transparency regarding governance decisions and practices.

3. PROCESS

3.1. Open Board Sessions:
Members of the public may attend the meetings of the Board in person or via webcast, in accordance with the following provisions:

a. Notice of Meeting

A schedule of the dates, location and time of the regular meetings of the Board is available from the President's Office and is posted on the Hospital's website.

b. Attendance

The Chair of the Board may limit the number of attendees if space is insufficient.

c. Conduct During the Meeting

Public attendees are not allowed ~~R~~recording devices, videotaping and photography ~~are prohibited by the public~~.

The Chair may require anyone who displays disruptive behaviour~~conduct~~ to leave.

d. Agendas and Board Documentation

Agendas are posted on the Hospital's website. Supporting documentation is posted on the Hospital's website the day after the Board meeting.

3.2. In-Camera Board Sessions:

The Board holds in-camera meetings for the following matters:

- property transactions~~matters~~;
- litigation ~~matters~~;
- material contracts;
- human resources matters;
- professional staff appointments, re-appointments and credentialing;
- patient care matters;
- any other sensitive or reputational Hospital matters.

The Chair consents to allow guests or counsel to attend in-camera sessions.

3.3. Procedure For Members of the Public Addressing the Board

During Open Board meetings, members of the public may address or ask questions of the Board with the permission of the Chair as follows:~~.~~

1) Written notice of the request to address the Board must be provided to the ~~Executive Assistant~~Board Liaison no later than 10 working days prior to the meeting date. A brief description of the specific matter to be addressed must be included in the request;

2) Requests to address the Board on a specific subject are granted (generally in order of the receipt of the requests) if approved by the Chair of the Board. Persons not permitted to address the Board are notified;

3) The Chair of the Board may limit the number of presentations or questions;

4) Persons addressing the Board are required to limit their remarks to five minutes. If a group wishes to make a submission, a spokesperson for the group must be identified;~~.~~

5) The Chair is not obligated to grant a request to address the Board and the Board is not obligated to take any action on the presentation it receives.

3.4. Committee Meetings

Meetings of committees are not open to the public.

3.5. Contact Information

~~Executive Assistant/Office Manager.~~Board Liaison

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-39
Title: Board Committees Terms of Reference	**X Policy** **X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** ~~Nov.18, 2015~~ December 2019 **Approval Date:** ~~Feb. 3, 2016~~February 5, 2020 **Next Review Date:** ~~Nov.~~ 2016November 2022

CROSS REFERENCES: *Board Committee Terms of Reference*

PURPOSE

To establish ~~the format for the~~ Board Committees Terms of Reference format ~~all Board Committees~~.

POLICY

The Board ~~will~~ establishes Committees that are required ~~by it~~ to ~~assist with the work of the~~carry out Board responsibilities. ~~The Terms of Reference for all Board Committees shall follow the same format.~~

PROCEDURE

The Terms of Reference for ~~each~~ Board Committees ~~shall~~must include:

1) Duties and responsibilities
   A specific list of activities the Committee is to undertake, usually without setting out in detail the process the committee is to follow.

2) Membership and voting
   Set out the number of appointed and *ex-officio* Committee members and whether they are voting or non-voting.

3) Chair
   Identify the Chair of the Committee.

4) Frequency of meetings and manner of call
   Specify if a minimum number of meetings must be held and who may call a meeting.

5) Quorum
   If there are non-Board members on the Committee, the quorum should reference the Board members.

6) Resources
   Specify if a member of management is to be assigned to the Committee as a resource and Committee support.

7) Reporting
   Specify how the Committee reports. It will usually be to the Board, but a Sub-Committee may report to a Committee.

8) Authority
   Specify all powers/authority given to the Committee by the Board of Directors.

9) Date of Last Review

~~9)~~10) Date approved by the Board

REFERENCES

Board Committee Terms of Reference

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-55
Title: ~~C~~President & CEO Succession Planning	**X Policy** ☐ **Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Reviewed/Revised Date:** ~~May 18, 2016~~December 2019 **Approval Date:** ~~March 4, 2015~~February 5, 2020 **Next Review Date:** ~~Nov. 2017~~November 2022

CROSS REFERENCES: *if applicable*

1. PURPOSE

To outline the process for urgent, interim, or permanent succession for the President &~~and~~ CEO.

2. POLICY

The Board of Directors must ensure continuity of leadership with a documented process for succession should the President & CEO position become vacant.

3. PROCEDURE

~~1.~~ 3.1 Sudden Vacancy (e.g. death, resignation, termination, extended leave)~~:~~:

The President & CEO ~~will~~ identifies~~y~~ in confidence to the Board Chair in writing at the beginning of each year two candidates to fill the role of interim President & CEO, if sudden vacancy of the latter~~CEO position~~ occurs. The appointment of an interim President & CEO is subject to approval by the Board.

~~2.~~ 3.2 Search Committee~~Vacancy~~:

- a. The Board establishes a President & CEO Search Committee~~:~~;
- b. So as to ensure continuity and the integrity of a search, an “ex officio” committee member as noted above whose tenure in a position as described comes to an end before the completion of a search, shall remain a member of the Search Committee with all of the rights and obligations of a member;
- c. The Chair of the Board acts as Chair of the Search Committee. Under circumstances as determined by the Board, the Board may appoint an alternate member of the Search Committee to act as its Chair;
- d. The Search Committee appoints a Secretary responsible for maintaining a record of the committee’s activities;
- e. The Search Committee may, at its discretion, select a search firm to assist with the process;
- f. The Search Committee, after interviewing qualified~~appropriate~~ candidates, recommends to the Board its candidate of choice for app~~r~~ointment~~val~~;

- g. In the event a new President & CEO has not been appointed prior to the departure of the current President & CEO, the Board appoints an interim President & CEO in accordance with section 3.1~~(A)~~ of this Policy.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Board Succession and Process for Appointment of Officers
PREPARED BY	Angela Kutok, Board Liaison
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☐ NO ☐ N/A ☒
APPROVED BY	
CO-SPONSER (if required)	n/a
PREPARED FOR:	President &CEO ☐ Board of Directors ☒ Other: Governance and Nominating Committee (GNC)–December 6, 2019
DATE PREPARED	December 2, 2019

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The reader considers the following questions to ensure each decision are ethically responsible by indicating with a √:

1. We put '**Patients First'** by responding respectfully to needs, values, & expectations of our patients, families, and communities?
2. We demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally responsible?
3. We demonstrate '**Respect**' by honouring the uniqueness of each individual and his or her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE/ISSUE(S)

To recommend a policy which outlines the selection and appointment process for Officer positions including Chair, First Vice-Chair, Second Vice-Chair, Treasurer, and Chair of the Patient Safety and Quality of Care Committee.

BACKGROUND

According to the May 2018 Accreditation Canada report, it was noted that the Hospital had an "unmet" criteria in relation to the process for the selection of a Board Chair. As a result, a draft Board policy was developed to provide a written formal process for the Board Chair appointment as well as for the appointment of Officers.

The draft policy was presented to the Governance and Nominating Committee in November of 2018. At that time, there were concerns regarding the proposed 'expression of interest for officers process' and it was decided that the policy required further review prior to implementation. As such, the historical method of officer selection was used for the 2019 Inaugural meeting.

The draft policy was reviewed again at the September 18, 2019 GNC meeting, and additional revisions were recommended as follows:

- Procedure, Section 1, Term and Duties of Officers - maximum number of consecutive terms of officers to be changed from six to five;
- Addition of Chair of the Patient Safety and Quality of Care Committee to the list of Officers to be elected.
-

ANALYSIS/CURRENT STATUS

Currently the process to recruit Officers is an informal one, whereby the Chair informally canvasses Directors about their interest to serve as an Officer of the Board.

By adopting this policy, the Hospital will meet the Accreditation Canada requirements.

RECOMMENDATION

Approve the policy as presented for recommendation to the Board of Directors for approval at the next monthly meeting.

NEXT STEPS

Once the GNC agrees on the revisions to the policy, the next steps are:

1. Finalize the policy and make a motion that the policy be recommended to the Board of Directors for approval on Feb 5, 2020.

STAKEHOLDER REACTION

n/a

COMMUNICATIONS

n/a

FINANCIAL IMPACTS

n/a

APPENDIX SECTION

Revised Draft Policy- Selection of Officers of the Board

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. **BD-DRAFT**
Title: Selection of Officers of the Board	**X Policy** **X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Approval Date:** **Reviewed/Revised Date:** **Nov 21, 2018** **Next Review Date:**

CROSS REFERENCES: *TBRHSC By-Law Article 9*

1. PURPOSE

To outline the Officer selection and appointment processes for Officer positions including Chair, First Vice-Chair, Second Vice-Chair, ~~and~~ Treasurer, as well as the Chair of the Patient Safety and Quality of Care Committee (PSQCC).

2. DEFINITIONS

"Director" means an elected member of the Board.

"Officers" means, the Chair, the First Vice-Chair, the Second Vice-Chair, the Treasurer, the Secretary, and the President and Chief Executive Officer, as more particularly described in Article 9 of the By-law. Per Article 9.6 b), the President and Chief Executive Officer shall be Secretary of the Hospital and Secretary of the Board.

~~**PURPOSE**~~

~~To outline the selection and appointment processes for Officer positions including Chair, First Vice-Chair, Second Vice-Chair, and Treasurer.~~

3. POLICY

There shall be a Chair, First Vice-Chair, Second Vice-Chair, a Secretary, ~~and~~ a Treasurer and Chair of the PSQCC, each of whom shall be a Director elected or appointed by the Board from among their number.

The Hospital Board of Directors ensures that Directors with the appropriate ~~combination of~~ qualifications, and experience are elected or appointed to serve as Officers or members of standing committees of the Board to effectively discharge its governance responsibilities.

4. PROCEDURE

~~1.~~ 4.1 Term and Duties of Officers

The term of Officers is one year. No Director can serve longer than five (5) ~~six (6) ?~~ consecutive terms in the position of Chair, First Vice-Chair, Second Vice-Chair, ~~or~~ Treasurer, or Chair of the PSQCC.

The duties and responsibilities of Officers are defined in the Hospital By-Law.

~~2.~~ 4.2 Expression of Interest for Officer Positions

Annually, the Governance and Nominating (TBD) shall:

- Canvass ~~Board Members~~Directors for their interest to serve as Officer for the coming year through a formal request for Eexpression of Iinterest ~~in officer positions.~~.
- Review ~~the summary of~~ the results of the Expressions of Interest poll and determine if there are ~~any~~ vacancies of potential officers the election.
- Prepare a list of candidates for officer positions ~~for consideration at the first meeting of the Board following the Annual General Meeting;~~.
- Appoint the Secretary as~~a~~ President of Elections ~~who will proceed with the election of Chair of the Board by calling for prospective candidates; ~~;
- At any time, the Board Chair, or delegate, may meet with prospective Officer candidates to validate their commitment, qualifications, and relevant experience;

~~3.~~ 4.3 Protocol of the Meeting to Conduct Election of Officers

a) Election of O~~o~~fficers shall be conducted as the first order of business at the first meeting of the Board of Directors following ~~of~~ the Annual General Meeting, in accordance with this procedure.

4.4 Process for the Selection of Officers

a) The President of Elections (Secretary) shall preside over the initial part of the meeting to elect ~~Officers~~ the Chair of the Board. Immediately following the election of Chair of the Board, the elected Chair of the Board shall assume office and preside over the remainder of the meeting.

b) The remaining Officer positions are then elected in the following order:

- First Vice-Chair
- Second Vice Chair
- Treasurer
- Chair of the PSQCC

~~4.~~ 4.4 Nominations and Voting Process

Nominations may be considered from the expressions of interest list provided by the Governance and Nominating Committee ~~(or Exec TBD)~~ and may also be accepted until the start of voting for that position.

Voting Process:

- a) The presiding officer will announce the position of office being voted on;
- b) Nominations will be taken from the floor;
- c)A nomination will only be valid if the candidate declares orally at the meeting, or in writing or by electronic mail prior to the meeting, that the candidate is willing to take office if elected;
- d)A~~ny~~ candidate may make a statement to the Board regarding their candidature. The presentation of such a statement shall take no longer than five minutes.
- e)When no further nominations are forthcoming, provided there are no other candidates running for a position a voice ballot/motion will take place;

- f)The successful candidate will be announced;
- g)A new call for candidates is made and the voting process restarts in the case where there is a single candidate but that candidate does not receive enough affirmative votes or when a candidate declines the nomination;~~.~~
- h)In the case there are more than two candidates running for a position, voting will take place by secret ballot. The vote is retaken in the case of a tie~~ for first place. .~~Two people, one of whom may be the ~~President and CEO~~ Secretary will serve as counters/tells of the vote.
- i) A candidate who fails to be elected for a position may be nominated for a subsequent position.

~~5.~~1. 5. Record of the Meeting

The minutes shall record the candidates nominated for each position and the elected candidate.

Thunder Bay Regional Health Sciences Centre Board of Directors Work Plan
Updated: February 5, 2020

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

Legend:
BD: Board of Directors
EC: Executive Committee

olumn	Accountability	Activity	Responsible Body	As Needed	October	November	December	February	March	April	May	June	Comments
1	Governance	Monthly education topics for the Board	BD		x	x	x	x	x	x	x	x	
2	Governance	Approval of By-Laws	BD									x	
3	Governance	Approve Slate of Nominees to fill Board vacancies	BD									x	
4	Governance	Approval of all Committee terms of reference	BD									x	
5	Governance	TBRHRI update	BD			x							
6	Governance	TBRHS Foundation update	BD		x								
7	Governance	Board Members to complete self assessment questionnaire	BD				x						Reviewed by Chair in Feb.
8	Governance	Board Members to complete Team Effectiveness Scale	BD							x			Sept.2019 - will be replaced with OHA on line tool in 2019-2020
9	Governance	Board Members to complete Board Annual Evaluation	BD							x			Sept.2019 - will be replaced with OHA on line tool in 2019-2020
10	Legal Compliance	Environmental compliance and fire safety update	BD		x		x		x			x	
11	Legal Compliance	Accessibility update	BD	x									

olumn	Accountability	Activity	Responsible Body	As Needed	October	November	December	February	March	April	May	June	Comments
12	Quality Oversight	Critical Incidents Update	BD					x			x		Moved from December to February to align with PSQCC Workplan. May did not change.
13	Quality Oversight	Research Ethics Board appointments	BD	x									
14	Quality Oversight	Research Ethics Board Annual Report	BD									x	
15	Performance Measurement and Monitoring	Strategic Plan and Scorecard quarterly update	BD		x		x		x			x	
16	Oversight of Management	Physician recruitment plan update	BD					x					
17	Oversight of Management	Participate in CEO evaluation via website	BD							x			
18	Oversight of Management	Participate in COS evaluation via website	BD							x			will take place in Nov 2019 - timelines to be reviewed
19	Oversight of Management	CEO evaluation	EC								x		
20	Oversight of Management	COS evaluation	EC								x		
21	Oversight of Management	Approve CEO evaluation	BD									x	
22	Oversight of Management	Approve COS evaluation	BD									x	
23	Performance Measurement and Monitoring	Committee Scorecard and BN to be appended to committee minutes	BD			x		x		x			Nov 2018 - added

WORKPLAN: Patient Safety and Quality of Care Committee - 2019-2020

Updated: October 31, 2019

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Activity	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY	COMMENTS
1.0	**Spotlight on Program Level**									
	Patient and Family Centred Care	X								
	Cancer		X							
	Prevention and Screening					X				
	Medicine				X					
	Emergency Department			X						
	Surgical					X				
	Cardiology				X					
	Women and Children						X			
	Mental Health and Addictions						X			
	Lab, Pharmacy and Diagnostic Imaging							X		
	Renal							X		
	Trauma and Critical Care								X	
	Patient Flow								X	
2.0	**Quality and Risk Management**									
	Quality Improvement Plan (QIP)			X		X		X		
	Patient Safety				X			X		
	Infection Control			X				X		
	Integrated Risk Management							X		
	Organizational Data	X		X				X		
	Professional Practice			X						
	Research					X				
	Accreditation							X		
3.0	**PSQCC Education**									
	Magnet Hospital		X							
	Patient Safety and Improvement Processes				X					
	TBD						X			
	Cardiovascular Program								X	
4.0	**Committee Business**									
	Terms of Reference review	X					X			
	Identify education needs	X	X	X	X	X	X	X	X	
	Committee evaluation review		X			X				
	Annual Summary								X	

Governance and Nominating Committee 2019-2020

Updated: December 6, 2019

Colour Legend
Completed by target
In progress
Delayed

Committee legend:
G - Governance
N - Nominating business
R - Research Institute

Meetings Held:
Governance-September, November, February, May
Nominating-March, April (interviews)

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	July	Comments
1	Governance	Review Committee work plan for upcoming year	G		x								x		approved in May for following year and reviewed in Sept for any adjustments
2	Governance	Review Gov/Nom Committee terms of reference	G		x										
3	Governance	Identify education needs, monthly Board education topics, and department tours for coming year	G		x										
4	Governance	Review Evaluation Tools	G		x										Evaluation Tools include: 1)Board Monthly Evaluation, 2)Board Committee Evaluation, 3)Board Self Assessment(Dec), 4)Team Effectiveness(Dec&Apr) 5)Annual Board Evaluation(Apr) - under review
5	Governance	Review Board vacancies	G							x					
6	Governance	Discuss Board re-appointments/vacancies in preparation for June AGM								x					**NEW*** from RI/HSC governance model restructuring 2019
7	Governance	Review Board policies - Hospital	G				x								Only a portion of the policies to be reviewed annually on a three year rotation.
8	Governance	Review Board policies - Research Institute	R				x								**NEW*** from RI/HSC governance model restructuring 2019
9	Governance	Plan annual Board retreat	G										x		Retreat to be held in September of each year **NEW*** 2019 - removed from RI workplan and only on HSC workplan
10	Governance	Review Board committees terms of reference	G										x		Nov 21/18 - moved from November to May
11	Governance	Review Committee evaluations for the semester	G				x						x		Nov-review May, June, Sept, Oct May-review Nov, Dec, Jan, Feb, Mar, April
12	Governance	Review Board and Board Committee attendance	G										x		
13	Governance	Review team effectiveness scale summary	G							x			x		Distributed to Board members at December/April Board meetings. - 2018/2019 replaced with OHA evaluation tool on a trial basis for this year

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	July	Comments
14	Governance	Appoint community member on Board member interview panel	N							x					
15	Governance	Review Board member Selection and skills criteria (Policy BD-45)	N							x					
17	Governance	Review Board member skills matrix inventory	N							x					-Feb- review skills matrix inventory/summary to assist in determining booard recruitment needs and advertising -Refer to BD-45
18	Governance	Approve Application for Membership form	N							x					
19	Governance	Review Board of Directors recruitment ad, interview questions and schedule	N							x					***Updated Sept 2019:*** Ensure ad is bilingual
20	Governance	Deliberate outreach for potential future Board Directors	N							x					*Added Sept 19, 2018* -Maintain a list of potential candidates as names arise
21	Governance	Expressions of Interest for slate of Officers including Chair, if applicable	N							x					*Added Sept 19, 2018* -Process for Expressions of Interest (to be developed) -working group to review draft policy
22	Governance	Proposed slate of Officers for recommendation to the Board	N									x			*Added Sept 19, 2018* -Formal process under development
23	Governance	Review applications (Board and Community)	N								x				
24	Governance	Interview Board member candidates	N									x			
25	Governance	Propose slate of nominees for Board	N									x			
26	Governance	Review By-Law - Hospital	G										x		
27	Governance	Review By-Law - Research Institute	R				x								**NEW*** from RI/HSC governance model restructuring 2019 - moved from May to November per Sept 18 GNC meeting **NOTE:** Moved to Feb or March22020 for this year as the details of the affiliation are being finalized.
28	Governance	Review new Board member orientation program	G										x		
29	Governance	Review Board annual evaluation summary	G										x		Distributed at April Board meeting
30	Governance	Review annual education session summary	G										x		
31	Governance	Determine Board Committees membership	G											x	

RESOURCE PLANNING COMMITTEE WORK PLAN

2019-2020

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
TBRHSC ITEMS														
1	Oversight of Management	2019-20 Work Plan for information only		x	x	x	x	x	x	x	x	x		
2	Financial Oversight	Monthly Hospital Statistics for information only		x	x	x	x	x	x	x	x	x		
3	Financial Oversight	Marketed Services & Medical Remuneration Reports for information only		x	x	x	x	x	x	x	x	x		
4	Performance Measurement and Monitoring	People, Culture & Strategy Update		x	x	x	x	x	x	x	x	x		
5	Performance Measurement and Monitoring	Personal Emergency Leave Report for information only		x	x	x	x	x	x	x	x	x		
6	Financial Oversight	Attestation: Wages and Source Deductions		x	x			x			x			
7	Financial Oversight	Financial Statements and Variance Report		x		x			x			x		
8	Financial Oversight	Financial Statements for information only		x	x		x	x		x	x			
9	Financial Oversight	Investment Policy Annual Review: BD-16		x										
10	Financial Oversight	Investment Portfolio Reviews									x			
11	Oversight of Management	Work Plan Review 2019-20		x										
12	Governance	Terms of Reference Review 2019-20		x										
13	Financial Oversight	Operating Plan Update with Budget Planning Targets & Directives 2020-21		x	x	x								
14	Financial Oversight	Operating Plan Approval 2020-21					x							
15	Financial Oversight	Capital Budget Update 2020-21			x									
16	Financial Oversight	Capital Budget Approval 2020-21					x							
17	Financial Oversight	Northern Supply Chain Performance and Medbuy Update			x									

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
18	Performance Measurement and Monitoring	Corporate Balanced Scorecard			x			x		x				
19	Financial Oversight	H-SAA 2019-20 Operating Plan Agreement Review			x									
20	Risk Identification and Oversight	Approval Authorities Policy Review: ADMIN-21			x									*Completed in September*
21	Performance Measurement and Monitoring	Sick Time & Overtime Initiatives Report for information only				x	x		x			x		*Completed in December*
22	Financial Oversight	Broader Public Sector Travel & Expense Report				x						x		
23	Financial Oversight	Funding HBAM and Quality Based Procedures Update				x								
24	Financial Oversight	CAPS 2020-21 Approval					x							
25	Financial Oversight	HAPS 2020-21 Approval					x							
26	Financial Oversight	Non Union Compensation					x							
27	Quality Oversight	Emergency Preparedness Report					x							*transferred from PSQOCC*
28	Financial Oversight	Capital Equipment and Capital Projects Update 2019-20						x			x			
29	Financial Oversight	Insurance Review						x						
30	Performance Measurement and Monitoring	Staff & Physician Engagement Update						x						*transferred from PSQOCC*
31	Oversight of Management	Work Plan Annual Approval 2020-21							x					
32	Governance	Terms of Reference Annual Approval 2020-21							x					
33	Performance Measurement and Monitoring	Accessbility Plan Update							x					*transferred from PSQOCC*
34	Risk Identification and Oversight	Informatics Update								x				
35	Performance Measurement and Monitoring	Labour Relations, Grievances and Arbitrations Update								x				
36	Legal Compliance	Occupational Health and Safety Program Update								x				
37	Legal Compliance	Public Sector Salary Disclosure								x				
38	Legal Compliance	Broader Public Sector Accountability Attestation Certificate										x		
39	Legal Compliance	Broader Public Sector Use of Consultants Attestation										x		
40	Oversight of Management	H-SAA Declaration of Compliance Attestation										x		
41	Oversight of Management	M-SAA Declaration of Compliance Attestation										x		
42	Financial Oversight	Numbered Companies Unaudited Financial Statements 2019-20										x		

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
43	Financial Oversight	Unaudited Preliminary YE Financial Statements to 2020-03-31										x		
44	Quality Oversight	Report on Financial Pressures Related to Risk										x		*transferred from PSQOCC*
TBRHRI ITEMS														
45	Financial Oversight	Attestation: Wages and Source Deductions		x	x			x			x			*transferred from RI FARM*
46	Financial Statements and Variance Report			x		x			x			x		*transferred from RI FARM*
47	Financial Oversight	Financial Statements for information only		x	x		x	x		x	x			*transferred from RI FARM*
48	Financial Oversight	Investment Policy Annual Review: FN 5.05		x										*transferred from RI FARM*
49	Financial Oversight	Operating Plan Update with Budget Planning Targets & Directives 2020-21		x	x	x								*added to align with Hospital budget process*
50	Financial Oversight	Operating Plan Approval 2020-21					x							*transferred from RI FARM*
51	Financial Oversight	TBRHRI 2019-20 Operating & Capital Budget Report and Sustainability Updates				x					x			*previously listed above*
52	Risk Identification and Oversight	TBRHRI 2020-21 Unaudited Financial Statements Review										x		*previously listed above*

AUDIT COMMITTEE

2019-2020 WORK PLAN

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
TBRHSC ITEMS														
1	Oversight of Management	2019-2020 Work Plan for information only						x		x		x		
2	Financial Oversight	2019-2020 Audit Plan Overview - Grant Thornton						x						
3	Governance	Terms of Reference Annual Approval 2020-2021						x						
4	Oversight of Management	2020-2021 Work Plan Approval						x						
5	Performance Measurement and Monitoring	Review Results of May 2019 Evaluation of Auditors						x						
6	Financial Oversight	Independence Questionnaire 2019-2020						x						
7	Risk Identification and Oversight	Policy Review: Admin-19 Whistleblower & Admin-28 Ethical Business Conduct						x						*deferred to March*
8	Risk Identification and Oversight	Expense Test Audit						x						
9	Risk Identification and Oversight	Interim Audit Review 2019-2020								x				
10	Performance Measurement and Monitoring	Discussion of Year End Reporting Issues 2019-2020								x				
11	Financial Oversight	Audit Statement Review 2019-2020								x				
12	Financial Oversight	Individual Program Audit Reports								x				
13	Financial Oversight	Summary of Audit Fees Paid for 2019-2020								x				
14	Financial Oversight	2019-2020 Year End Financial statements for Board Approval										x		
15	Financial Oversight	2019-2020 Audit Results - Grant Thornton										x		
16	Oversight of Management	2019-2020 Management Letter										x		
17	Risk Identification and Oversight	2019-2020 Litigation Review & Claims Summary										x		
18	Risk Identification and Oversight	Analysis of Legal Fees as at March 31, 2020										x		
19	Performance Measurement and Monitoring	Evaluation of Auditors for 2019-2020										x		
20	Performance Measurement and Monitoring	Recommend Appointment of Auditors for 2020-2021										x		
TBRHRI ITEMS														
21	Financial Oversight	2019-2020 Audit Plan Overview - Grant Thornton						x						*transferred from RI FARM*
22	Risk Identification and Oversight	Policy Review: GV 1.10 Ethical Conduct and Whistleblower						x						*transferred from RI FARM deferred to March*
23	Financial Oversight	2019-2020 Audit Results - Grant Thornton										x		*transferred from RI FARM*
24	Performance Measurement and Monitoring	Recommend Appointment of Auditors for 2020-2021										x		*transferred from RI FARM*
25	Risk Identification and Oversight	Analysis of Legal Fees as at March 31, 2020										x		*transferred from RI FARM*
26	Financial Oversight	2019-2020 Year End Financial statements for Board Approval										x		*transferred from RI FARM*

FISCAL ADVISORY COMMITTEE

2019-2020

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Stakeholder Communication and Accountability	Financial Statements and Variance Report				x								
2	Stakeholder Communication and Accountability	Operating Plan 2019-20				x								
3	Stakeholder Communication and Accountability	Q2 2019-20 Financial Review				x								
4	Stakeholder Communication and Accountability	Work Plan 2019-20 Review				x								
5	Stakeholder Communication and Accountability	Financial Statements as at 2019-08-31				x								
6	Stakeholder Communication and Accountability	Financial Statements and Variance Report									x			
7	Stakeholder Communication and Accountability	Operating Budget 2020-21									x			
8	Stakeholder Communication and Accountability	Q3 2019-20 Financial Review									x			
9	Stakeholder Communication and Accountability	Financial Statements as at 2020-01-31									x			
10	Stakeholder Communication and Accountability	Terms of Reference Annual Approval									x			
11	Stakeholder Communication and Accountability	Work Plan 2020-21 Approval									x			
12	Stakeholder Communication and Accountability	Hospital Monthly Statistics for information only				x					x			
13	Stakeholder Communication and Accountability	Vacancy, Overtime & Sick Time Report				x					x			

Page Views: Open Board Meeting Webcast

September 2017 – December 2019

Month	# of Page Views	Month	# of Page Views	Month	# of Page Views
September 2017	--	September 2018	--	September 2019	--
October 2017	18	October 2018	*No views due to technical difficulties*	October 2019	14
November 2017	26	November 2018	13	November 2019	16
December 2017	17	December 2018	18	**December 2019**	**13**
January 2018	--	January 2019	--	January 2020	
February 2018	15	February 2019	12	February 2020	
March 2018	33	March 2019	17	March 2020	
April 2018	13	April 2019	24	April 2020	
May 2018	10	May 2019	24	May 2020	
June 2018	17	June 2019	17	June 2020	
Yearly Total # of Page Views	**149**	**Yearly Total # of Page Views**	**125**	**Yearly Total # of Page Views**	

Thunder Bay Regional Health Research Institute

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Thunder Bay Regional Health Research Institute Report for TBRHSC Board – January, 2020

Submitted by: Mr. Jean Bartkowiak, CEO and Dr. Valerie Grdisa, EVP Research, Quality & Academics/CNE January 24, 2020. In alignment with the main directions of the Institute's *2020 Strategic Plan* we are pleased to share the following:

Improving the Health of People of NWO and Beyond

TBRHRI Strategic Plan: As our *2020 Strategic Plan* draws to a close, staff and the Board of Directors are considering how best to enter into the next phase of planning for research that will improve the health of the people of Northwestern Ontario and beyond. Given upcoming changes in leadership and impending changes across the province (i.e. Ontario Health Teams, Council of Academic Hospitals of Ontario and the Ontario Hospital Association, etc.), the development of a transitional plan, as the Hospital has done, will likely be the best course of action. The Institute wants to ensure that the next plan reflects what it should be doing, is actionable, and is aligned with the Hospital's Strategic Plan. Staff are currently identifying some of the strengths, opportunities as well as barriers and foundational issues that need to be addressed to put research at the Hospital and the Institute on the right path and will develop a strategy that will lead to the creation of the Institute's next Strategic Plan.

Generating Revenue through Science & Partnerships

Congratulations to **Dr. Alla Reznik who recently received $448,800 from the Canadian Cancer Society** to continue research into a new method of diagnosing breast cancer earlier than current technology. The *Innovation to Impact* grant will be used over the next three years to ensure Dr. Reznik continues to develop her Positron Emission Mammography (PEM) technology. The first clinical trial has successfully been completed at the Princess Margaret Cancer Centre and work continues to establish a clinical trial in Thunder Bay.

Congratulations as well to **Dr. Oleksandr Bubon for receiving the *Mitacs & National Research Council - IRAP Award for Commercialization*.** Dr. Bubon has been working with Dr. Reznik on the new PEM technology. The award recognizes him for his work to develop a cutting-edge medical imaging technology that delivers high-resolution pictures at a much lower dose of radiation, providing a breast imaging alternative to mammography and other imaging devices.

Thunder Bay Regional Health Research Institute

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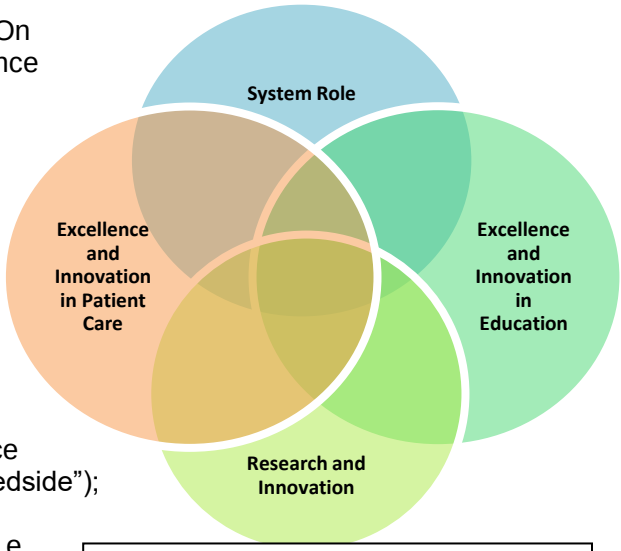
nohfc An Agency of the Government of Ontario

Northern Innovation Program – Industrial Research Chair Applications: NOHFC assists in the establishment of research capacity at Northern Ontario universities, colleges and research institutes that will lead to greater research opportunities. Financial assistance is available for up to 50% of eligible costs to a maximum of $1M for a period of up to five years. Eligible costs include salary and benefits, equipment and consumables. Qualified projects must involve research and development or commercialization activities for new technologies in existing and emerging priority economic sectors (e.g. health sciences, the digital economy, natural resources, etc.). The Institute is excited to be assisting with two applications for Dr. Michael Campbell (lead by TBRHRI) and Dr. Zubair Fadlullah (lead by Lakehead University).

Enhancing the Academic Environment

Advancing our Academic Practice Mandate Together: On November 21st Dr. Grdisa lead a planning exercise to advance the Hospital's academic mandate. Approximately 100 employees attended including Hospital Directors, physicians, Managers, front line Coordinators, and other health professions. Facilitated discussions took place around five domains including one for Research & Innovation. Four preliminary priorities were identified for Research & Innovation:

1. Celebrate and create **awareness of research activities** within the Hospital and Institute;
2. Support all professions to **advance their knowledge and capabilities** along the translational continuum (basic science discovery to clinical research to practice implementation), with a focus on the point of care ("bedside");
3. Create opportunities for clinical providers to **increase involvement in research and scholarly activities** (i.e. present at conferences, teach, etc.);
4. Establish **stronger partnerships and collaboration opportunities** both internally and externally to carry out research.



CAHO: Accountabilities of Research Hospitals

Staff are working on next steps towards the development of an integrated Academic Practice Plan. As well, input received from this exercise will feed the Institute's Strategic Planning efforts.

2020 Showcase of Health Research: The Centre for Applied Health Research at St. Joseph's Care Group will be holding the 2020 Showcase of Health Research on February 7th at the Victoria Inn. For more information or to register for this free event, contact Hillary Maxwell, Research Coordinator at 343-2431 ext. 2107 or maxwellh@tbh.net or visit https://www.cahr.sjcg.net/news/category/Showcase

Volunteer Association
to Thunder Bay Regional
Health Sciences Centre

Volunteer Association to TBRHSC Report – February 2020

On behalf of the Volunteer Association, I would like to extend a thank you to the following people: Donna Jeanpierre, Megan Valente and Sam Stovel (Volunteer Services Department) for all their assistance in 2019; Seasons Gift Shop staff and volunteers for their contributions in the day-to-day operations and success of Seasons Gift Shop; Terri Hrkac, for arranging a tour of the Sim Lab and Cardiovascular Suite. Several V.A. Board attended; Terri Hrkac, Karen Wood, Elaine Graydon and Katelyn Fletcher of the Foundation for arranging to have Foundation volunteers sell Quilt Raffle tickets in lobby and in the Donation Office.

We received the following donations in 2019: $1,063 from Foundation Employee Giving, towards Clothing Cupboard (Social Services); Hospital Bridge Group - $1,520; and personal donations of $213.50 from two TBRHSC volunteers.

The Volunteer Association made donations in the amount of $71,000 in 2019 to the following: $32,000 to “Our Hearts at Home, Cardiac Campaign”; $30,000 to Family Care Grants; and $9,000 in scholarships and bursaries.

The Quilt Raffle generated approximately $1,385 that will be given directly to the Cardiac Campaign. Thank you to quilters Vicky Butt, Cindy Cockell, Sharron Detweiler, Doreen Everitt and Marjorie Dubois for donating the beautiful quilts and to TBRHSC volunteers Brenda H., Carol W., Anne D., Heather K. and Linda H. who sold Quilt Raffle tickets in the hospital. Congratulations to the winners R. Stolz, K. Kenney, S. Harris, K. Madore and S. Aris.

Finally, thank you to the hospital craft volunteers for making tray favours for patients at Christmas and Easter. These ladies meet weekly to make items that are sold at the annual craft sale. The November Craft sale proceeds were approximately $1,772.

The Seasons Gift Shop inventory was completed on December 31, 2019. Louisa G. (Manager) and Pierina B. (volunteer in Seasons) attended the Toronto Gift Fair from January 26 – 29, 2020. This is when the bulk of the year’s major purchases are made, including clothing, giftware and Christmas items. Delivery of merchandise is ongoing throughout the year.

The year-end requirements have been received from Grant Thornton for the 2019 Engagement Review. Susan E. (Bookkeeper) and Mary P. (Volunteer Association Treasurer) are working together to get financial requirements completed. Grant Thornton will present their report at the Volunteer Association Annual meeting in May 2020.

Respectfully submitted.

Shirley Wragg, Vice-President
Volunteer Association to Thunder Bay Regional Health Sciences Centre.

“SUPPORTING PATIENT FAMILY CARE”

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Critical incidents, Q1-3, 2019/20
PREPARED BY	Kristin Shields, Director, Quality and Risk Management
REVIEWED BY DECISION SUPPORT (if required)	<Does this have financial impacts to the hospital's budget? Has a Decision Support Analyst been consulted on this briefing note?> YES ☐ NO ☒ N/A ☐
APPROVED BY	Dr. Valerie Grdisa
CO-SPONSER (if required)	<Does this impact another E/VP's portfolio/program? Have they been consulted on this briefing note?>
PREPARED FOR:	President &CEO ☐ Board of Directors ☒ Other:
DATE PREPARED	January 23, 2020

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The reader considers the following questions to ensure each decision are ethically responsible by indicating with a √:

☐ 1. We put '**Patients First'** by responding respectfully to needs, values, & expectations of our patients, families, and communities?
☐ 2. We demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally responsible?
☐ 3. We demonstrate '**Respect**' by honouring the uniqueness of each individual and his or her culture?
☐ 4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE/ISSUE(S)

To provide a summary of the number of critical incidents in Quartered 1-3 of 2019/20, including a summary of Quality of Care Reviews completed, including critical incidents and process improvements.

BACKGROUND

Contextualize the item being presented with an appropriate amount of background information; in doing so, assume limited familiarity with the particular issue.

The Quality and Risk Management (QRM) Department tracks safety incidents, near misses, medication errors and concerns and compliments. Reviews are completed for all critical incidents as well as incidents that cover multiple departments of the Hospital where processes could potentially be improved to result in better outcomes.

Quality of Care Reviews include critical incident and process reviews, defined as:

Critical Incident:

- any unintended event that occurs when a patient receives treatment in the Hospital that results in death or serious harm to the patient;

AND

- does not result primarily from the patient's underlying condition or from a known risk inherent in providing the treatment.

Process Review: a multidisciplinary review of the event to bring about systems-level improvements to patient safety.

ANALYSIS/CURRENT STATUS

What are the implications for TBRHSC? What stage of development is this item/issue in? Is a briefing required and if so when?

For fiscal Q1-Q3 2019/2020, QRM processed 98 compliments, 403 concerns and 3829 incidents as depicted below:

Report (Q1-3)	# Submitted
Compliments	98
Concerns	403
Learning (Pt Safety) Incidents	3829

For Q1-Q3 2019/20, nine Quality of Care Reviews were completed, including two Critical Incident Reviews* and seven Process Reviews. The recommendations from all Quality of Care Reviews are monitored by QRM and 'identified leads' are tasked with follow up, ensuring that all recommendations are completed.

Quality of Care Review (Q1-3)	# Reviews
Process Review	7
Critical Incident*	2

*Note: There has been one critical incident in 2019/2020 fiscal year and the other critical incident was reviewed in Q1, but occurred during the 2018/19 fiscal year.

RECOMMENDATION

What is the recommended course of action?

Continue and improve current processes.

NEXT STEPS

What are the anticipated outcomes? What needs to occur next on this issue?

Critical incident data will continue to be provided to the Board of Directors bi-annually.

STAKEHOLDER REACTION

Would there be any anticipated reaction from stakeholders? Is an issues management plan required?

n/a

COMMUNICATIONS

What kind of targeted communication(s) is necessary?

Recommendations are shared with SLC, Medical Advisory Committee, and Quality of Care Committee for all Quality of Care Reviews.

High-level summary of themes is presented to Patient Safety and Quality of Care Committee of the Board bi-annually.

FINANCIAL IMPACTS

Is it resource neutral or is there a cost involved?

n/a

APPENDIX SECTION

If there is related material, please provide here.

n/a

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Incident Communications to Board of Directors
PREPARED BY	Tracie Smith, Senior Director, Communications & Engagement and Kristin Shields, Director, Quality & Risk Management
REVIEWED BY DECISION SUPPORT	YES ☐ NO ☐ N/A ☒
APPROVED BY	Jean Bartkowiak, President & CEO
CO-SPONSER	Dr. Valerie Grdisa, EVP, Research, Quality & Academics/Chief Nursing Executive
PREPARED FOR:	Board of Directors
DATE PREPARED	January 16, 2020

Our Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. Leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The reader considers the following questions to ensure each decision are ethically responsible by indicating with a √:

☐ 1. We put '**Patients First'** by responding respectfully to needs, values, & expectations of our patients, families, and communities?
☐ 2. We demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally responsible?
☐ 3. We demonstrate '**Respect**' by honouring the uniqueness of each individual and his or her culture?
☐ 4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics.

PURPOSE

To familiarize the Board with a process to alert Hospital Board members of incidents with high reputational risk.

BACKGROUND

At the December 4, 2019 meeting of the Board of Directors, it was determined that a new process would be implemented to alert members of the Board of anticipated or likely media activity regarding an incident involving our Hospital.

ANALYSIS/CURRENT STATUS

The Reputational Risk Matrix was created to be used by Quality & Risk Management. It is an internal resource to guide decision-making and actions as they relate to notification to the Board of Directors regarding incidents.

Due to the acuity and complexity of the care provided at our Hospital, incidents of varying severity occur. Incidents are unplanned or unintended events or circumstances which could have or did result in harm to an individual.

The Hospital has practices in place to report, manage and learn from incidents. These are led by the Quality & Risk Management department.

The attached reputational risk assessment scale and process has been endorsed by the Senior Leadership Council and the Patient Safety & Quality Committee of the Board.

The Reputational Risk Matrix is separate from the extensive resources and guidelines in place to guide actions and communications regarding Emergency Codes and Incident Management (for example, Code Red – Fire, Code Orange – External Disaster, Code Black – Bomb Threat, etc.).

RECOMMENDATION

The attached reputational risk assessment scale will be applied by the Quality & Risk Management Department as part of Quality of Care Reviews as well as other incident reviews.

An assessment of "Moderate" or "High" indicates the likelihood that the subject of the Quality of Care Review may appear in media. The Moderate or High rating triggers the following:

1. Notification to the Senior Director, Communications & Engagement, who prepares in collaboration with the Director of Quality & Risk Management a summary for the CEO;
2. The CEO determines appropriateness of notification of Board Directors;
3. If appropriate, Board Liaison issues notification to the Board. Notification will advise that an incident with moderate to high reputational risk has occurred. The notification will include high-level key messages to support Board members to respond to potential community inquiries;
4. The same notification will be issued to the North West LHIN by the CEO's office;
5. Board member questions or concerns are to be directed to the CEO only;
6. In collaboration with the Board Chair, the CEO will determine whether specific Board discussions are required, and if so, when and with whom;
7. Media requests will be coordinated by the Senior Director, Communications & Engagement;
8. Communications & Engagement and Quality & Risk Management will monitor and evaluate media activity and develop as appropriate additional notifications, media responses and/or communications strategies to be applied.

NEXT STEPS

Implement reputational risk assessment scale and process.

STAKEHOLDER REACTION

The proposed process supports stakeholder interactions and dissemination of key messages.

COMMUNICATIONS

As above.

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

Incident reputational risk matrix.doc

Thunder Bay Regional Health Sciences Centre

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Reputational Risk Matrix

Instructions for use by the Quality and Risk Management Department:

1. Complete the following matrix assessment;
2. Notify the Senior Director, Communications & Engagement (or designate) of "Moderate" or "High" ratings.

Reputation with stakeholders (including community, donors, government, partners)

Risk	Factors (check all that apply)	Anticipated Media Response/Impact
Very low	☐ Family only, focus on information	-Highly unlikely
Low	☐ Associated rumours ☐ Potential stakeholder concern	-Possible social media content -Possible local media coverage with low impact/response (media may be advised by external sources, but unlikely or unable to pursue)
Moderate	☐ Elements of multiple stakeholder expectations not being met ☐ Social media content exists, with some user responses/sharing ☐ Incident may be perceived as intentional ☐ Patient/family has provided notice of intent to inform media	-Local media coverage likely, with sustained and high response -Significant social media content and activity -Unlikely potential for political involvement/reaction -Short-term reduction in stakeholder confidence
High	☐ Political leadership involvement ☐ Notice of intent to engage media ☐ Social media content exists, with high user responses/sharing ☐ Implications/accusations of discrimination ☐ Potential for class action litigation	-National media coverage likely -High potential for political involvement or intervention -Moderate to high potential for Hospital staff terminations -Medium-to-long-term reduction in stakeholder confidence

Please note that any checks in the Moderate or High rating triggers the following:

1. Notification to the Senior Director, Communications & Engagement, who prepares in collaboration with the Director of Quality & Risk Management a summary for the CEO;

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2. The CEO determines appropriateness of notification of Board Directors;
3. If appropriate, Board Liaison issues notification to the Board. Notification will advise that an incident with moderate to high reputational risk has occurred. The notification will include high-level key messages to support Board members to respond to potential community inquiries;
4. The same notification will be issued to the North West LHIN by the CEO's office;
5. Board member questions or concerns are to be directed to the CEO only;
6. In collaboration with the Board Chair, the CEO will determine whether specific Board discussions are required, and if so, when and with whom;
7. Media requests will be coordinated by the Senior Director, Communications & Engagement;
8. Communications & Engagement and Quality & Risk Management will monitor and evaluate media activity and develop as appropriate additional notifications, media responses and/or communications strategies to be applied.