

Annual Report

Nipigon District Memorial Hospital

2015-2016



125 Hogan Road
Nipigon, ON P0T 2J0
www.ndmh.ca

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Vision

Excellence in rural health care and wellness promotion.

Mission

To provide excellent health care and wellness promotion services in order to improve the health of the population and the quality of life of all residents in our communities.

Values

Nipigon District Memorial Hospital is

accountable to the people we serve to provide
accessible health care through
collaboration with community and health services partners in a
safe environment that promotes
personal and professional growth recognizing that
people are our most important resource.

A Message from Dr. Rhonda Crocker Ellacott, President and CEO, and Kal Pristanski, Board Chair



Dr. Rhonda Crocker
Ellacott,
President and CEO



Kal Pristanski,
Board Chair

The past year has been an exciting and interesting year. In keeping with our mission, we have been working collaboratively with our partner organizations within our local Health Hub to explore opportunities to improve care, create efficiencies, and coordinate better services to improve the quality of life and health outcomes of our population.

With the support of our Local Health Integration Network, we have led the development of a Voluntary Integration Business Plan, to explore the feasibility and opportunity to better coordinate the delivery of care/services to our population through integration with the Nipigon District Family Health Team. Further work to this end is anticipated through 2016/17, with the potential to voluntarily integrate to better align and streamline operational care and services, while leading to improved outcomes.

In 2015/16, we continued to be challenged from a budgetary perspective, ending the year with a \$95,609.00 deficit, after one time funding support from the LHIN in the amount of \$325,000. We look forward to a more balanced and sustainable budget position in the future, through the creation of efficiencies in our operation made possible through integration opportunities with other partners.

With changes to the Excellent Care for All Act (2016), hospitals were asked to involve patients, residents, staff and community in the development of Quality Improvement Plans. To this end, NDMH has established an engagement process which includes the development of a Patient/Resident & Family Advisory Council. The goal being, to better engage both our hospital, and greater community in the work of our hospital. To support our overall hospital engagement efforts and advance best practices leading to better care, NDMH has made a conscious decision to move to a Patient/Resident & Family Centred Care Model, meaning we are committed to providing care – in collaborative partnership – with our patients/residents and their families. This model ensures that we are working together with patients/residents & families, recognizing the need for Dignity and Respect, Communication, Collaboration, and Participation as the 4 core concepts guiding our care, while corporately ensuring the input and advice of our patients/residents and community, on organizational matters.

NDMH saw activity remain relatively stable this year, while we continued to make improvements as demonstrated in our Quality Improvement Plan (QIP). Our success on our QIP is evidence of overall efforts to provide the best in rural care for our patients and

residents, while moving toward the creation of NDMH as a Health Care Hub. This year, we saw ongoing evidence of improvements in our care and outcomes! Through the collaborative efforts to work with our health care partners to improve the discharge process and streamline transitions in care, we saw our acute care length of stay reduce from 8.7 days in 2014/15 to 7.0 days in 2015/16, and a 0% readmission rate (30 days post discharge) in quarter 4.

The commitment of our staff/physicians to adhere to best practices is evidenced through efforts in hand hygiene, for example, leading to exceptional performance in the area of hospital acquired infections (<0.01%). Leading best practices in medication reconciliation resulted in 99% of all patients receiving medication reconciliation on admission – demonstrating our commitment to safety and quality of care and care outcomes.

In support of our efforts, our patient satisfaction scores, when asked “would you recommend this hospital to your family/friends” remained at 100% positive! A testament to your support and confidence in our care and services.

Thank you to our staff, volunteers, physicians and community partners for your continued dedication and commitment to deliver best care to the people of our community!

Together, our dedication and commitment to “Patients First” will ensure that we continue to provide excellence in rural health care and services to the people of our community, while improving our health and quality of life.

CHIEF OF STAFF



Dr. Ravinder Dhaliwal
Medical Advisory Committee Chair / Chief of Staff

My first year as Chief of Staff has been one of transition; the retirement of long time Chief of Staff, Dr. John Jackson Hughes combined with a fluctuating complement of physicians has posed a significant but not insurmountable challenge for our group.

Unilateral Ministry of Health cut-backs affecting salaries across Ontario have only added pressure to our recruiting efforts. Despite these adversities we have been able to retain a full complement of staff with Dr. J Fotheringham and Dr. M. Dimeo both returning to full time practice.

Further help appears to be on the horizon, with one to two physicians expressing significant interest in returning to practice in Nipigon following Residency; this is undoubtedly a direct result of our ongoing links with the Northern Ontario School of Medicine and our commitment to teaching.

Our proximity to Thunder Bay and our close links with TBHSC staff continue to facilitate excellent patient care in a rural setting; the expansion of Telehealth to cover dermatology and Critical Care is serving to increase our capacity for excellent local care.

I look forward to seeing what the upcoming year will bring with tighter integration between the Family Health Team and Hospital being pursued in the name of excellent patient care.

There are certainly advantages to leveraging the use of a shared Electronic Medical Record to facilitate seamless transitions between the hospital and community care.

Certainly this period of change has made my first year as Chief of Staff nothing if not interesting. I hope to continue in this role to see how many of these changes will unfold.

Medical Advisory Committee

Dr. Ravi Dhaliwal, Chief of Staff
Dr. Mike Dimeo
Dr. John Fotheringham
Dr. Dave Janhunen
Dr. Doug Scott
Sue Powell, Nurse Practitioner

Dr. Rhonda Crocker Ellacott, President and CEO
Dot Allen, Acting Chief Nursing Officer/Director, Patient Services

BOARD OF DIRECTORS

Ontario is the only Canadian province with an independent voluntary governance model for hospitals. As mandated by the *Public Hospitals Act*, each Board of Directors must oversee its individual hospital.

“Fiduciary Duty”

means that directors are required to act honestly, in good faith and in the best interest of the hospital and to apply the level of skill and judgment that is reasonable to expect of a person with their knowledge and experience.”

The Board of Directors of Nipigon District Memorial Hospital serves in a governance role and has a fiduciary responsibility to the Hospital when fulfilling their primary duties of financial oversight, developing a mission, vision, and strategic plan for the Hospital.

Within the framework of the *Excellent Care for All Act (ECFA)*, which was passed by the Ontario legislature in 2010, the responsibility of the Board has been strengthened regarding the oversight for the quality of care delivered at Nipigon District Memorial Hospital.

Boards are important decision makers in the overall direction of hospitals and must judiciously approve Management’s recommendations.

NDMH Board Composition

The Board of Directors of Nipigon Hospital is a mix of diverse skills which ensures an effective governance body.

Board of Directors, 2015-2016

- Kal Pristanski, Board Chair
- Eric Rutherford, Board Vice Chair
- Johan Pothof, Director
- Maureen Kusick, Director
- Evan Hill, Director
- Edward Wawia, Director

Boards must include specific members of the Management staff. These members are known as “*ex-officio*” Directors and include the Chief Executive Officer, Chief Nursing Officer, and Chair of the Medical Advisory Committee.

- Dr. Rhonda Crocker Ellacott, Chief Executive Officer
- Dot Allen, Acting Chief Nursing Officer/Director, Patient Services
- Dr. Ravinder Dhaliwal, Chair, Medical Advisory Committee/Chief of Staff

QUALITY IMPROVEMENT

2015-2016 Accomplishments

Quality improvement is a systemic approach to making changes that lead to improved patient/resident outcomes, enhanced quality of care, and increased efficiency.

Each year a new Quality Improvement plan is developed and specific goals are selected for improving quality of care and to promote excellence as health care providers.

During 2015/2016 strategies were developed and implemented for 6 different areas of focus.

- Reduction of unnecessary time spent in Acute Care by measuring the percentage of inpatient days designated as ALC (Alternate Level of Care) days. Our target was to reach 25 % and we unfortunately did not meet this target. We continue to struggle with high numbers of ALC days in our acute care setting. This year the percentage ranged from 47% to a high of 66 %.
- Reduction of unnecessary hospital readmissions within 30 days of discharge. Our target was set at 20 % and we actually finished the year at 0%.
- We had great success with three focus areas. We were able to reach 100 % compliance for improvement of the discharge process, improving patient satisfaction, as well as full compliance for all patients receiving medication reconciliation upon admission.
- We had another great year for minimizing hospital acquired infection rates with zero reported incidences of MRSA (Methicillin-Resistant Staphylococcus Aureus) and VRE (Vancomycin-Resistant Enterococcus) and one reported case of C-difficile (Clostridium Difficile).

2016-17 Plan

A Quality Improvement Plan is a formal, documented set of quality commitments aligned with system and provincial priorities that a health care organization makes to its patients, residents, staff and the community to improve quality through focused targets and actions.

This year we will have developed action plans and strategies to meet the following goals:

- Reduce readmission rates for patients with Chronic Obstructive Pulmonary Disease (COPD)
- Reduce inappropriate use of antipsychotics (without a diagnosis of psychosis) for residents in Long Term Care
- Implementation of Patient/Resident and Family Centred Care
- Improve Patient and Resident satisfaction

- Reduce the percentage of residents who have had a recent fall, and reduce falls resulting in critical injury
- Increase the proportion of patients receiving medication reconciliation upon admission

OUR ACCOMPLISHMENTS

Patient/Resident Family Centred Care

NDMH has been actively moving to a model of Patient/ Resident and Family Centred Care (PRFCC). PRFCC promotes “Patient/Resident First” - and approaches care from the perspective of “ working with” Patients/Residents and their families, vs. doing things “ to or for” Patients/Residents and Families (PRF). It shifts the focus from one of “serving” to one of “working with” PRF, in collaborative partnership.

PRFCC also welcomes persons with experiences in the health system to have the opportunity to share input into our programs, practices, and priorities, in a meaningful way, and advise us on matters that may improve the overall patient experience. Through this model, over the next year, we will now be engaging in clinical tactics at the bedside to improve communication, while also engaging with PRFCC at the operational, systems, and strategic planning levels to advance the organization.

We have recruited volunteers to form our Patient/Resident and Family Advisory Council as we continue our implementation strategy. As we move forward, we will provide education to all staff, promoting the core concepts of PRFCC, focusing on dignity and respect, and “listening” to give “voice” to our patients and residents. Implementation strategies will enable further participation, collaboration and communication and an overall review of our policies and practices that promote this concept.

We look forward to the opportunity to collaborate with our Patients/Residents, Families and Community in the advancement of this model !

Palliative Care

The Nipigon District Memorial Hospital’s Palliative Care Committee aims to provide holistic palliative and end of life care to the patients and residents of Nipigon District Memorial Hospital.

This involves addressing physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears; preparing for and managing self-determined life closure and the dying process; and coping with loss and grief during the illness and bereavement.

To better service the palliative care needs of Nipigon, Red Rock, Beardmore, Hurkett and Dorion; Nipigon District Memorial Hospital entered into a Service Agreement with the North West LHIN’s Regional Palliative Care Program. Our Palliative Care Committee successfully met all six deliverables and received \$10,000.00 for these accomplishments. These funds will be used to renovate the Palliative Care room and to provide Palliative Care education to front line staff.

Hospice North West has generously purchased a leather reclining sofa, mini fridge, a smart TV with wall mount, and a fireplace for our Palliative Care room.

Senior Friendly Hospital Strategy

The vision of the LHIN-led Ontario Senior Friendly Hospital (SFH) Strategy is to enable seniors to maintain optimal health and function while they are hospitalized so that they can transition successfully home or to the next appropriate level of care.

Nipigon District Memorial Hospital has set the goal that 85% of acute care patients aged 60 years and over will have no decline in their activities of daily living while admitted prior to December 31, 2016. To achieve this goal, the MOVE (Mobilization of Vulnerable Elders) program was implemented on acute care in July 2015. This program requires that all patients be mobilized at least three times a day. Since July 2015, over 90% of patients aged 60 years and over have had no decline in their activities of daily living while admitted at Nipigon District Memorial Hospital.

Chemotherapy Grant

In September 2015, Nipigon District Memorial Hospital was a successful applicant for capital equipment funding through the Health Sciences Foundation Northern Cancer Fund. This funding was used to purchase a Baxter Triple Pump for the administration of chemotherapy.

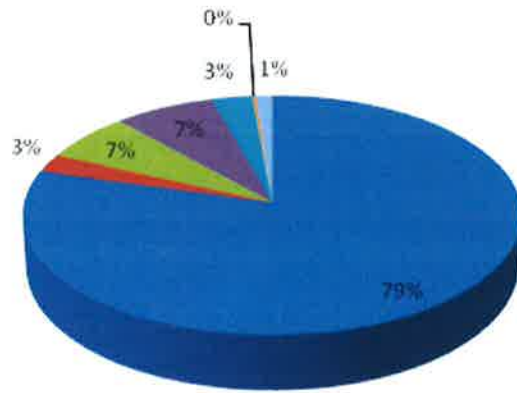
FINANCE

Nipigon District Memorial Hospital continues to manage resources effectively and efficiently but is challenged to balance its budget due to structural funding challenges. NDMH ended the 2015/16 fiscal year with an operating deficit of \$95,609.00 (2014/15 operating deficit of \$85,217.00). The LHIN provided operating pressure relief funding of \$335,000.00 (2014/15, \$178,374.00) which relieved otherwise increasing cost pressures. Refer to the table below for additional financial and statistical indicators and prior year comparatives.

The Hospital continues to invest in important capital. Equipment purchased during the year included a server and cell booster for IT, coagulation and Clinitek Advantus analyzers for the Lab, a defibrillator, stretcher, and IV pumps for nursing, as well as masonry repairs to the building.

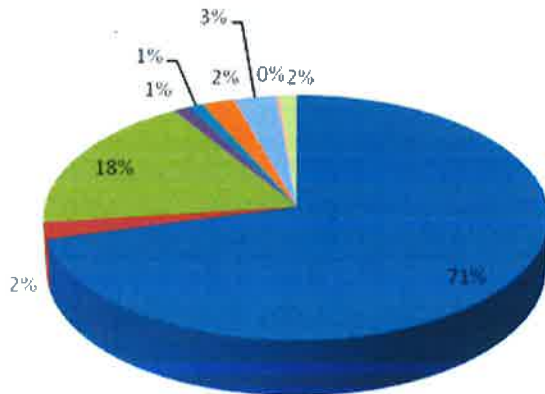
Select Financial & Activity Indicators	2015/16	2014/15
Financial Activity		
Operating Revenue	8,593,858	8,333,431
Operating Expenses	8,689,467	8,418,648
Operating Surplus / (Deficit)	(95,609)	(85,217)
Surplus / (Deficit) Including Net Building Amortization	(199,336)	(193,938)
Operating Margin %	1.10%	1.02%
Current Ratio	1.30	1.60
Working Capital	\$404,606	\$788,579
Inpatient (IP) Cost per Patient Day (Q3)	\$269	\$274
IP Food Expense per Patient Day	\$35	\$35
Patient Activity		
Acute Patient Days	1,561	1,816
ALC Days	2,152	1,656
Acute % Occupancy	68%	63%
LTC/CCC Patient Days	7,956	7,781
LTC/CC % Occupancy	99%	97%
Emergency Visits	4,663	5,385
Physiotherapy Attendance Days	3,411	3,451
Diagnostic Imaging Exams	4,002	3,927
Staff Activity		
Full-time Equivalents all funds	76.1	75.1
% Paid Sick Time of full-time hrs (Q3)	5.90%	5.60%
% Paid Overtime of all hours (Q3)	1.50%	1.50%
Average Hourly Rate with benefits (Q3)	\$42	\$41

STATEMENT OF OPERATIONS - REVENUES



- MOHLTC and LHIN - \$6,828,882
- Patient services - \$213,477
- Preferred accommodation and co-payments - \$556,637
- Other revenue - \$618,159
- Beardmore Regional Health Centre - \$251,237
- Fundraising - \$16,834
- Assisted Living Program - \$108,632

STATEMENT OF OPERATIONS - EXPENSES



- Salaries, wages and employee benefits - \$6,085,689
- Medical staff remuneration - \$187,168
- Supplies and expenses - \$1,565,165
- Medical and surgical supplies - \$95,682
- Drugs and medical gases - \$87,698
- Amortization of major equipment - \$190,487
- Beardmore Regional Health Care - \$253,034
- Fundraising - \$16,909
- Assisted Living Program - \$108,632

HEALTH AND SAFETY

The Hospital's Joint Occupational Health and Safety Committee have made great advancement in the review and revision of our Emergency Preparedness Program.

We continue to be diligent in our Fire Safety education and training. In compliance with the Office of the Fire Marshall and Emergency Management Ontario; our Senior Management and Supervisory staff have successfully completed online learning to enhance fire safety knowledge and skills for our vulnerable patients/residents.

Our Fire Plan was enhanced this year to include separate appendices for the Jackson Hughes Medical Clinic, Garage/Apartments, and EMS Building. In February the Plan, together with its appendices, was approved by the Nipigon's Chief Fire Official and once again we demonstrated our competent response to an annual mock fire emergency.

As a JHSC, we have provided much education on fire safety to our co-workers and tenants.

The Ministry of Labour introduced Health and Safety Awareness education in July of 2014. This education was a mandatory requirement of the MOL and provides a basic understanding of the Occupational Health and Safety Act. A "proof of completion" certificate must be maintained in each worker's personnel file upon successful completion of the online learning module.

The JHSC is pleased to report that at year end, we have achieved 98% compliance rate.

Our plans for the coming fiscal year include a refresh of our:

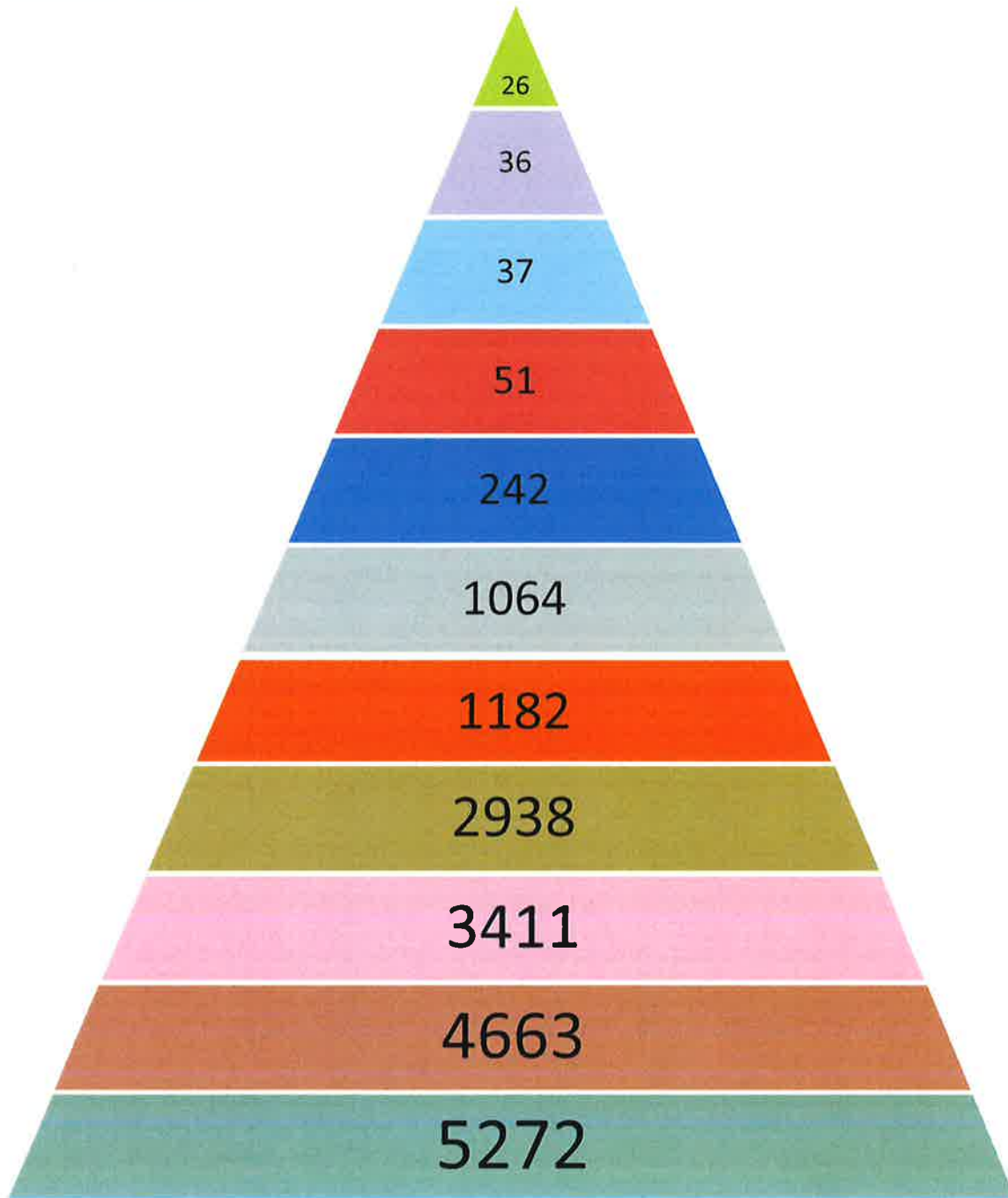
"competent person" means a person who,

- a) is qualified because of knowledge, training and experience to organize the work and its performance,***
- b) is familiar with this Act and the regulations that apply to the work, and***
- c) has knowledge of any potential or actual danger to health or safety in the workplace***

- Workplace Inspection Program
- Workplace Violence Prevention Program
- Supervisory Program, and
- continued work on our Emergency Preparedness Program

Our goal is to ensure our workers are *competent* and know their rights so that, together, we can ensure that every worker returns home safely at the end of each work day.

IN ONE YEAR



Oncology Visits	
Pulmonary Function Tests	
Telehealth Visits, Beardmore	
Cardiac Stress Tests	
Acute Care Admissions	
Ultrasounds	

Telehealth Visits, Nipigon	
X-Rays	
Physio Visits	
ER Visits	
Outpatient Lab Tests	