Perth and Smiths Falls District Hospital
Board Quality – Minutes (Closed)
Thursday, February 10th, 2022
Via Zoom
7:30 a.m. – 9:00 a.m.

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1. Call to Order – L. Drynan

MOVED by K. Clupp
SECONDED by G. Church

THAT the PSFDH Board Quality Committee Meeting move into a closed session at 7:33am.
CARRIED.

2. Approval of Agenda

MOVED by K. Clupp
SECONDED by G. Church

THAT the February 10th, 2022 Board Quality Committee Agenda be approved as circulated.
CARRIED.

3. Declaration of Conflict of Interest

No conflicts were declared.

4. Approval of Minutes

MOVED by C. Dolgowicz
SECONDED by K. Clupp

THAT the November 4th, 2021 Board Quality Committee closed session meeting minutes be approved as circulated.
CARRIED.

5. Business Arising from the Minutes

5.1 Your Health System Report – Embargoed

M. Cohen informed the committee that there was only one outstanding item in relation to administration expenses. The reality is that Ontario as a whole was flagged and PSFDH is actually quite efficient when it comes to administration expenses.

This item can be removed from the agenda.

5.2 HIS Information Update

M. Cohen shard that PSFDH is starting to prep for the new Health Information System that is scheduled to begin in April. The Novari e-booking and scheduling system will be done in advance to separate the workload between the two projects. Novari has always been a part of the HIS system. Discussion ensued regarding the Communication framework and M. Cohen felt that the Communication will resume again in the upcoming weeks.

6. New Business

Nil

7. Critical Event – N. Shaw

Quality Care Report –

M. Cohen advised that the board has three core functions to determine strategy, oversight over quality and fiduciary matters. M. Cohen felt that It is important to be open and transparent in regards to the quality of care issues that arise.

M. Cohen created a formal presentation of a recent critical case that occurred on the Smiths Falls site. The summary outlines the hospital's findings and recommendations for remedial actions.

M. Cohen shared his presentation/summary of the case and H. Mostamandi reviewed the recommendations at the end of the presentation.

It was identified that the falls protocol of care was not followed, as well the POA was not notified of the incident and nor was the administrator on call.

H. Mostamandi advised that some recommendations that were brought forward were:

- Ensure there is a C-Spine collar and backboard for each in-patient unit
- Add mandatory falls education quarterly for all nurses. This will be done on LMS.
- Reminder to all staff to review the falls policy after each critical fall
- Laminate algorithms and place in each patient room
- Generic reminder to place blue high risk falls sign over patients and blue wristbands
- Increasing mock codes
- Add timeline and most responsible person to notify POA and Manager on Call on Falls algorithm
- Address gap between minor injury and critical fall – should be labelled as minor, major, serious injury and then critical.
- Consideration of a medical code (such as code 99)
- Audit all beds on Med Surg unit for bed alarms
- Ensure PT/OT involvement to assess fall prevention

D. Thomson - Discussion ensued regarding Hi/Low beds and the possibility of borrowing backboards from the paramedics until our new boards arrive.

C. Dolgowicz questioned whether the critical incident was a result of being understaffed or having inexperienced staff on the floor when the incident occurred? H. Mostamandi noted that Human Resources played a factor as some of the nurses were fairly new and the nurse to patient ratio was higher than normal. The units always have a charge nurse onsite regardless of the time of day; as well there is always a manager on-call.

Dr. Kuchinad questioned whether there any thought about doing an anonymous survey to try and narrow down factors such as delirium, age and etc... As, Dr. Kuchinad felt people tend to be more open when it's anonymous. H. Mostamandi clarified that the physician was notified right away and the physician came when they could, which is what contributed to the 45 minute gap. Dr. Kuchinad noted that this is a prime example where a physician needs to be in two or more places at once, which just isn't reasonable.

D. Thomson questioned what investigation was done when he came into the hospital? Discussion ensued whether or not the patient had injuries from the previous fall at home, which may have contributed to the fall at the hospital. There were no investigations done before the patient came to the floor and the chief has to do a review on why this didn't occur.

C. Rustan will alter the presentation to incorporate the following under the findings: "No investigation done on PT, prior to being admitted to the floor"

M. Cohen we did identify a potential claim with our insurance provider and it was noted that the patient had no family and his neighbour/friends were familiar with his history and understood the situation.

8. Adjournment - L. Drynan

MOVED by M. Quigg
SECONDED by K. Clupp

THAT the PSFDH Board Quality Committee moved out of closed session at 8:11am.
CARRIED.