Perth and Smiths Falls District Hospital
Board Quality – Minutes (Closed)
Thursday, June 8, 2023
Via Zoom
7:30 a.m. – 9:00 a.m.

---

1. Call to Order – Dr. W. Hollis

MOVED by C. Dolgowicz
SECONDED by I. Boyle

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

2. Approval of Agenda

No formal agenda was presented.

3. Declaration of Conflict of Interest

No conflicts were declared.

4. Approval of Minutes

No previous closed minutes to approve.

5. Business Arising from the Minutes

Nil

6. New Business

6.1 Quality of Care Report – B. Smith

B. Smith gave a report on a recent QRCA (2003-3-217425) fall resulted in injury. The summary describes the hospital's conclusions and suggested corrective measures.

At the end of the presentation, B. Smith shared the presentation and summary of the case and evaluated the recommendations.

A 77-year-old man was not feeling well, so his family called the paramedics, who took him to Smiths Falls Hospital. His primary complaint was that he didn't feel well, and he has a history of cancer, high blood pressure, and chronic kidney disease.

B. Smith advised that some recommendations that were brought forward were:

1. The collection of the patient intake information was delayed therefore the risk of falls was not identified
    - Ensure Fall-Risk armband is applied in ED or soon after
    - Develop a post fall debrief tool to standardize the information collection post fall

2. Discrepancies around when to call a doctor; how long to wait for their response is inconsistent
    - Develop a post falls algorithm to ensure standard of care is provided
    - Develop an escalation policy to establish a standard approach to alerting/notifying and communicating with physicians

3. C-spine collar, backboard; it was unclear what equipment should be used based on findings and mechanism of injury.
    - Review best practice for spinal and c-spine mobilization
    - Ensure the necessary equipment is available on each inpatient unit

4. There was concern that the patient exited his bed and there was no audible alarm to alert the nurses.
    - Ensure all new bed purchased come with audible patient alarms (24 of the 26 beds have audible alarms)
    - Develop a post fall debrief tool to standardize the information collection post fall

C. Maloney - The policy for patients using unalarmed beds was brought forward. According to B. Smith, the patient would have been put in a bed with an audible alert if the medical staff had known that he was prone to falling.

G. Church questioned if there is a process in place to call another physician at home if the emergency doctor is unavailable and discussion ensued. Smith advises that we begin with an escalation policy, which specifies who to contact if the emergency doctor is unavailable.

D. Thomson questioned whether there would be more than one emergency physician available in the event of a serious disaster. According to A. Kuchinad, all doctors would be willing to stop their clinics in the event of a disaster and we have a protocol to support each site. M. Cohen additionally stated that a code orange would be issued and that all hands would be on deck.

There is no resolution as a result of this closed session.

7. Adjournment – Dr. W. Hollis

MOVED by G. Church
SECONDED by I. Boyle

THAT the PSFDH Board Quality Committee moved out of closed session at 8:12am.
CARRIED.